

AUSTRALIA / JUDGMENT

AAI Limited trading as AAMI v Patsalis

AAI LIMITED trading as AAMI v Patsalis [2026] NSWSC 953

COURT

Supreme Court

DECIDED

07 August 2026

BEFORE

Harrison AsJ

CASE / FILE NUMBER

2025/00146657

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Supreme Court

New South Wales

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Hearing dates: 04 December 2025

Date of orders: 07 August 2026

Decision date: 07 August 2026

Jurisdiction: Common Law

Before: Harrison AsJ

Decision:

1. The Summons dated 15 April 2025 is dismissed.
2. The plaintiff is to pay the first defendant's costs.

Catchwords: ADMINISTRATIVE LAW – judicial review – Personal Injury Commission – medical assessment under Motor Accident Injuries Act 2017(NSW)

Legislation Cited: Motor Accident Injuries Act 2017 (NSW), Part 3.4, ss 1.3, 4.11, 4.12, 7.17, 7.21, 7.23
7.26, Sch 2, s 2.
Personal Injury Commission Act 2020 (NSW), ss 18, 33(1)(b)
Motor Accident Guidelines, ss 6.17, 6.18, 6.21, 6.31, 6.41, 6.213

Cases Cited:

Abdal v Insurance Australia Limited t/as NRMA Insurance [2025] NSWSC 478
Allianz Australia Insurance Limited v Bell [2025] NSWCA 187
Allianz Australia Insurance Ltd v Cervantes [2012] NSWCA 244
Bradley v IAG t/as NRMA Insurance Limited [2020] NSWSC 792
Boyce v Allianz Australia Insurance Ltd [2018] NSWCA 22
Buestami v Allianz Australia Finance Ltd [2025] NSWSC 465
Della Bruna v Health Care Complaints Commission [2025] NSWCA 105
Dominice v Insurance Australia Limited (2017) 81 MVR 249; [2017] NSWCA 171
Dranichnikov v Minister for Immigration and Multicultural Affairs (2003) 77 ALJR 1088; [2003] HCA 26
Farr v Insurance Australia Limited t/as NRMA Insurance [2014] NSWSC 1435
Frost v Kourouche [2014] NSWCA 39
Insurance Australia Group Ltd t/as NRMA Insurance v Keen [2021] NSWCA 287
Insurance Australia Limited t/as NRMA Insurance v Momand [2024] NSWSC 1529
Insurance Australia Limited t/as NRMA Insurance v Warren [2019] NSWSC 1126
Insurance Australia Limited trading as NRMA Insurance v Brown (2019) 89 MVR 508; [2019] NSWSC 1236
Lederer v Insurance Australia Limited trading as NRMA Insurance [2022] NSWSC 322
LPDT v Minister for Immigration, Citizenship, Migrant Services and Multicultural Affairs (2024) 280 CLR 321; [2024] HCA 12
Mandoukos v Allianz Australia Insurance Ltd [2024] NSWCA 71
Mason v Demasi [2009] NSWCA 227
Minister for Immigration & Ethnic Affairs v Wu Shan Liang [1996] 185 CLR 259; HCA 6
Minister for Immigration and Multicultural and Indigenous Affairs v SGLB (2004) 78 ALJR 992; [2004] HCA 32
Minister for Immigration and Multicultural Affairs v Bhardwaj (2002) 209 CLR 597; [2002] HCA 11
Oeding-Erdel v Allianz Australia Insurance Limited [2021] NSWSC 1264
QBE v Miller (2013) 67 MVR 322; [2013] NSWCA 442
Rodger v De Gelder (2015) 71 MVR 514; [2015] NSWCA 211
Wingfoot Australia Partners Pty Limited v Kocak (2013) 252 CLR 480; [2013] HCA 43
Zahed v IAG Limited t/as NRMA Insurance (2016) 75 MVR 1; [2016] NSWCA 55
Zilic v QBE Insurance (Australia) Ltd [2025] NSWSC 11

Category:

Principal judgment

Parties:

AAI Limited trading as AAMI (Plaintiff)
Andrew Patsalis (First Defendant)
Medical Assessor Appointed by the President of the Personal Injury Commission under s 33 of the Personal Injury Commission Act 2020 (NSW) (Second Defendant)
The President of the Personal Injury Commission of New South Wales (Third Defendant)

Representation:

Counsel:

J Gumbert and D Kim (Plaintiff)
B McManamey and D Epstein (First Defendant)

Solicitors:

Moray & Agnew (Plaintiff)
Lexington Law Group Pty Ltd (First Defendant)

File Number(s): 2025/00146657

Publication restriction: Nil

JUDGMENT

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This Judgment involves a judicial review of decisions made by a Medical Assessor and President's Delegate under the Motor Accident Injuries Act 2017 (NSW) (the MAI Act).

The plaintiff is AAI Limited trading as AAMI (the insurer). It is represented by J Gumbert and D Kim of counsel. The first defendant is Andrew Patsalis (the claimant). He is represented by B McManamey and D Epstein of counsel. The second defendant is Atsumi Fukui (the Medical Assessor), the medical assessor appointed by the President of the Personal Injury Commission of New South Wales (the Commission) under s 33 of the Personal Injury Commission Act 2020 (NSW) (the Personal Injury Commission Act). The third defendant is the President of the Commission. The second and third defendants have filed submitting appearances.

The parties relied on a joint court book consisting of 2 volumes marked as exhibit A1 and A2 respectively.

Extension of time to file the Summons

The insurer sought an extension of time to file the summons. The claimant did not oppose the extension of time being granted. The delay in filing was not significant. In these circumstances, I grant an extension of time to file the summons.

Background

On 25 October 2021, the claimant was injured in a motor vehicle accident (the accident) where his motor vehicle was rear ended when he was stopped in traffic at Roseberry in Sydney, New South Wales.

There was a medical dispute between the claimant and the insurer as to the medical assessment matter set out in sch 2 cl 2(a) of the MAI Act, namely “the degree of permanent impairment of the injured person that has resulted from the injury caused by the motor accident (including whether the degree of permanent impairment is greater than a particular percentage [10%])”.

On 6 June 2022, the matter was referred to the Commission by the claimant under s 7.20 of the MAI Act for assessment of that medical dispute. The claimant claimed that he sustained a number of injuries as a result of the accident including psychological injury including Major Depression and Post Traumatic Stress Disorder (PTSD).

On 12 May 2023, the insurer put on a reply to the claimant’s application together with a statement of issues.

On 15 January 2024, the insurer conceded that the claimant’s whole person impairment (WPI) exceeded 10% on psychiatric grounds, having regard to a report of Dr Kaplan dated 28 November 2023, who assessed his WPI at 18%.

On 21 June 2024, after the insurer was in receipt of further information, it issued a decision declining to concede that the claimant’s WPI exceeds 10% on either a physical or psychiatric basis.

The summons

On 15 April 2025, the insurer filed a summons seeking:

An order in the nature of certiorari or, alternatively, a declaration setting aside or declaring invalid the decision made by the Medical Assessor, in her capacity as a medical assessor appointed pursuant to section 33(1)(b) of the Personal Injury Commission Act, namely, the certificate and decision dated 28 October 2024, purportedly made pursuant to s 7.23 (1) of the MAI Act (the Medical Assessor’s Decision).

An order in the nature of certiorari or, alternatively, a declaration setting aside or declaring invalid the decision of the Delegate of the President of the Commission (the Delegate), dated 16 January 2025, made purportedly pursuant to s 7.26 of the MAI Act, dismissing the plaintiff’s application for review of the Medical Assessor’s Decision (the Delegate’s decision).

An order in the nature of mandamus, remitting the matter the subject of the Medical Assessor's Decision to the third defendant for determination by a different medical assessor and/or (with respect to the relief sought in subsection 2) for re-determination by the President pursuant to section 7.26 of the MAI Act, according to law.

The insurer relied upon 10 grounds of judicial review. Grounds 1 to 6 relate to the Medical Assessor's decisions and grounds 7 to 10 relate to the Delegate's decisions. So far as the Medical Assessor is concerned, these grounds of judicial review are interrelated. I shall deal with the grounds of judicial review in sequential order in this judgment.

The grounds of judicial review in relation to the Medical Assessor's Decision are as follows:

Ground 1: The insurer had made a substantial and clearly articulated argument based on established facts. The Medical Assessor failed to respond to the substance of the insurer's argument. This was a constructive failure to exercise jurisdiction and a denial of procedural fairness. (failure to respond to a clearly articulated argument) The substance of the insurer's argument included the following:

The claimant had a concurrent workers compensation claim in which he made reports and provided history that were inconsistent with the reports he made in his Compulsory Third Party (CTP) claim;

The claimant's medical records were inconsistent with significant aspects of the claimant's reporting in his CTP claim.

Ground 2: The Medical Assessor was required to provide reasons for her decision, pursuant to s 7.23(7) of the MAI Act. The Medical Assessor failed to expose her actual path of reasoning for diagnosis, findings on causation, and assessment of impairment. The failure to provide reasons that expose the actual path of reasoning on the medical question referred is an error of law on the face of the record. (failure to give reasons)

Ground 3: Pursuant to s 7.21 of the MAI Act, the assessment was required to be made in accordance with the Motor Accident Guidelines version 9.2 (the Guidelines). The Guidelines required the Medical Assessor to review and evaluate all available evidence (cll 6.17 - 6.18). The Medical Assessor failed to evaluate the evidence and failed to comply with the Guidelines in this respect. This was a constructive failure to exercise jurisdiction. (constructive failure to exercise jurisdiction)

Ground 4: Clause 6.41 of the Guidelines required the Medical Assessor to bring to the claimant's attention to inconsistencies between the Medical Assessor's clinical findings, and information obtained through medical records, and to give claimant an opportunity to respond to the inconsistencies, in order to ensure accuracy and procedural fairness. The Medical Assessor failed to comply with these clauses and thereby constructively failed to exercise her jurisdiction and failed to afford the insurer procedural fairness. (procedural fairness)

Ground 5: Further and separately to the statutory obligation set out in Ground 4, the Medical Assessor had a common law duty to afford procedural fairness to the parties. The duty to afford procedural fairness required the Medical Assessor to take all necessary steps to ensure a fair assessment. Having regard to the significant inconsistencies between the claimant's reporting to the Medical Assessor, and his previous reporting as recorded in the material before the Medical Assessor, there was a duty for the Medical Assessor to attempt to explore and if possible resolve the inconsistencies. The Medical Assessor failed to do this, and thereby failed to afford the insurer procedural fairness. (also procedural fairness)

Ground 6: The Guidelines relevantly provide that impairment must be attributable to a psychiatric diagnosis recognised by the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), which is currently DSM-5. The Medical Assessor found that the claimant met the DSM-5 diagnosis for Post Traumatic Stress Disorder (PTSD). However, the Medical Assessor failed to address that the criteria for the diagnosis requires "actual or threatened death, serious injury..." and accepted that the criteria were satisfied on the basis of the claimant's perception of the accident rather than also considering the objective nature of the accident. Failing to properly apply the DSM-5 criteria was a constructive failure to exercise jurisdiction. (also constructive failure to exercise jurisdiction)

The following grounds of judicial review relate to the Delegate's decision. If the Medical Assessor's Decision is found to be lawful, grounds 7 and 8 immediately fall away.

Ground 7: The Delegate's decision is invalid because it relies for its validity on the statutory precondition of a medical assessment decision. On the basis that the decision of the Medical Assessor is void due to legal error, the decision of the Delegate is also void.

Ground 8: Before the Delegate, the insurer had submitted that the Medical Assessor had erred in a similar manner to that described above. Due to the fact that the decision was afflicted by legal error in the ways described in judicial grounds 1 to 4 in this Judgment, the Delegate erred in failing to find that those errors were present. The Delegate's decision is illogical and irrational and not based on findings or inferences or fact supported by logical grounds.

Ground 9: The Delegate exceeded his statutory function by determining the application on the basis of a view as to the substance of the grounds raised rather than applying the correct test which was whether there was reasonable cause to suspect that the medical assessment was incorrect in a material respect.

Ground 10: The Delegate asked himself the wrong question and applied the wrong test in relation to the question of whether the Medical Assessor had failed to adequately consider the material and provide sufficient reasons, failed to respond to the insurer's argument, and incorrectly applied the DSM-5 criteria for PTSD. Rather than asking whether there was reasonable cause to suspect that the assessment was incorrect in a material respect, the Delegate explained how the Medical Assessor had justified her assessment.

The insurer submitted that by reason of any or all of these grounds, the decisions of the Medical Assessor's decision and the Delegate invalid and should be set aside.

The relevant statutory framework

I shall briefly set out the relevant statutory framework established by the MAI Act.

The State Insurance Regulatory Authority (SIRA) is charged with the administration of the compulsory third-party insurance scheme established by the MAI Act. Section 1.3 of the MAI Act outlines its objects:

1.3 Objects of Act

- (1) This Act establishes a new scheme of compulsory third-party insurance and provision of benefits and support relating to the death of or injury to persons as a consequence of motor accidents.
- (2) For that purpose, the objects of this Act are as follows —
 - (a) to encourage early and appropriate treatment and care to achieve optimum recovery of persons from injuries sustained in motor accidents and to maximise their return to work or other activities,
 - (b) to provide early and ongoing financial support for persons injured in motor accidents,
 - ...
 - (d) to keep premiums for third-party policies affordable by ensuring that profits achieved by insurers do not exceed the amount that is sufficient to underwrite the relevant risk and by limiting benefits payable for soft tissue injuries and psychological or psychiatric injuries that are not recognised psychiatric illnesses,
 - ...
 - (g) to encourage the early resolution of motor accident claims and the quick, cost effective and just resolution of disputes,
 - ...

4.11 No damages for non-economic loss unless permanent impairment greater than impairment threshold

No damages for non-economic loss may be awarded in respect of injury unless the degree of permanent impairment of the injured person as a result of the injury caused by a motor accident is greater than 10%.

4.12 Assessment of permanent impairment required if dispute over impairment threshold

- (1) If there is a dispute about whether the degree of permanent impairment of an injured person is sufficient for an award of damages for non-economic loss, damages may not be awarded unless the degree of permanent impairment has been assessed by a medical assessor under Division 7.5.

Note.

The assessment of the medical assessor is conclusive in proceedings before a court or the Commission—see section 7.23. Section 7.20 authorises a court, the Commission or party to a dispute, to refer the dispute about the degree of permanent impairment to the Commission for assessment by a medical assessor.

- (2) This section does not prevent—
 - (a) the degree of impairment from being re-assessed under Division 7.5, or
 - (b) a claim from being settled at any time.

...

7.17 Definitions

...

"medical assessment" means an assessment of a medical assessment matter under this Division.

"medical dispute" means—

- (a) a dispute between a claimant and an insurer about a medical assessment matter, or
- (b) an issue arising about a medical assessment matter in proceedings before a court for damages or in connection with the assessment of a claim by the Commission.

...

7.21 Assessment of degree of permanent impairment

- (1) The assessment of the degree of permanent impairment of an injured person for the purposes of this Act is to be made in accordance with the Motor Accident Guidelines. The assessed degree of permanent impairment is to be expressed as a percentage.
- (2) Impairments that result from more than one injury arising out of the same motor accident are to be assessed together to assess the degree of permanent impairment of the injured person.
- (3) In assessing the degree of permanent impairment, regard must not be had to any psychiatric or psychological injury, impairment or symptoms, unless the assessment of the degree of permanent impairment is made solely with respect to the result of a psychiatric or psychological injury.

- (4) A medical assessor may decline to make an assessment of the degree of permanent impairment of an injured person until the assessor is satisfied that the impairment caused by the injury has become permanent.

...

7.23 Status of medical assessments

- (1) The medical assessor or assessors to whom a medical dispute is referred is or are to give a certificate as to the matters referred for assessment.
- (2) The certificate is, in any court proceedings or in any proceedings in connection with a merit review under Division 7.4 or a claims assessment under Division 7.6—
- (a) prima facie evidence of any matter certified as to the degree of impairment of earning capacity of the injured person as a result of the injury concerned, and
- (b) conclusive evidence of any other matter certified.

...

- (7) A certificate is to set out the reasons for any finding by the medical assessor or assessors as to any matter certified in the certificate in respect of which the certificate is conclusive evidence.

...

SCHEDULE 2 – Matters for the purposes of Part 7

2 Medical assessment matters

The following matters are declared to be medical assessment matters for the purposes of Part 7—

- (a) the degree of permanent impairment of the injured person that has resulted from the injury caused by the motor accident (including whether the degree of permanent impairment is greater than a particular percentage),
- (b) whether any treatment and care provided or to be provided to the injured person is reasonable and necessary in the circumstances or relates to the injury caused by the motor accident for the purposes of section 3.24 (Entitlement to statutory benefits for treatment and care),
- ...
- (d) the degree of impairment of the earning capacity of the injured person that has resulted from the injury caused by the motor accident,
- (e) whether the injury caused by the motor accident is a threshold injury for the purposes of the Act.

Section 18 of the Personal Injury Commission Act reads:

18 Delegations by the President and Division Heads

- (1) The President may—
 - (a) delegate to a Division Head of a Commission Division or other member any of the functions of the President (other than this power of delegation), or
 - (b) delegate to a registrar or any other member of staff of the Commission any of the functions of the President (other than this power of delegation) specified by a Division Schedule for a Commission Division or prescribed by the Commission rules.

...

- (2) Despite subsection (1), the President may delegate a function of the President under section 92 of the Motor Accidents Compensation Act 1999 or section 7.34 of the Motor Accident Injuries Act 2017 only to the Division Head of the Motor Accidents Division.

- (3) The Division Head of a Commission Division may—
 - (a) delegate to another Division member any of the functions of the Division Head (other than this power of delegation), or
 - (b) delegate to a registrar or any other member of staff of the Commission any of the functions of the Division Head (other than this power of delegation) specified by the Division Schedule for the Division or prescribed by the Commission rules.

...

The functions exercised by the Delegate arise in the context of the medical assessment scheme established by the MIA Act. Section 7.26 of that Act provides:

7.26 Review of medical assessment by review panel

- (1) A claimant or an insurer may apply to the President to refer a medical assessment under this Division by a single medical assessor to a review panel for review.
- (2) An application for the referral of a medical assessment to a review panel may be made only on the grounds that the assessment was incorrect in a material respect.
- (3) A medical assessment may not be referred for review under this section on more than one occasion.

- (4) If a medical assessment under this Division is based on the assessments of 2 or more single medical assessors (resulting in a combined certificate as to the total degree of permanent impairment) (a combined certificate assessment), the combined certificate assessment cannot be the subject of review under this section except by way of the review of any of the assessments of the single medical assessors on which the combined certificate assessment is based.
- (5) The President is to arrange for the medical assessment to be referred to a review panel, but only if the President is satisfied that there is reasonable cause to suspect that the medical assessment was incorrect in a material respect having regard to the particulars set out in the application.

...

An application for review is therefore made by the President, but in practice is determined in the first instance by a delegate pursuant to s 18 of the Personal Injury Commission Act.

The Guidelines relevantly provide:

Evaluation of impairment

6.17 The medical assessor must evaluate the available evidence and be satisfied that any impairment:

- (a) is an impairment arising from an injury caused by the accident, and
- (b) is an impairment as defined in clause 6.9 (above).

6.18 An assessment of the degree of permanent impairment involves three stages:

- (a) a review and evaluation of all the available evidence including:

medical evidence (doctors' hospitals' and other health practitioners' notes, records and reports)

medico-legal reports

diagnostic findings

other relevant evidence

- (b) an interview and a clinical examination, wherever possible, to obtain the information specified in these Guidelines and the AMA4 Guides necessary to determine the percentage impairment
- (c) the preparation of a certificate using the methods specified in these Guidelines that determines the percentage of permanent impairment, including the calculations and reasoning on which the determination is based. The applicable parts of these Guidelines and the AMA4 Guides should be referenced.

Permanent impairment

...

6.21 The evaluation should only consider the impairment as it is at the time of the assessment.

...

Pre-existing impairment

6.31 The evaluation of the permanent impairment may be complicated by the presence of an impairment in the same region that existed before the relevant motor accident. If there is objective evidence of a pre-existing symptomatic permanent impairment in the same region at the time of the accident, then its value must be calculated and subtracted from the current WPI value. If there is no objective evidence of the pre-existing symptomatic permanent impairment, then its possible presence should be ignored.

...

Consistency

...

6.41 Where there are inconsistencies between the medical assessor's clinical findings and information obtained through medical records and/or observations of non-clinical activities, the inconsistencies must be brought to the injured person's attention; for example, inconsistency demonstrated between range of shoulder motion when undressing and range of active shoulder movement during the physical examination. The injured person must have an opportunity to confirm the history and/or respond to the inconsistent observations to ensure accuracy and procedural fairness.

Assessment of mental and behavioural disorders

6.213 The impairment must be attributable to a psychiatric diagnosis recognised by the current edition of the Diagnostic & Statistical Manual of Mental Disorders (DSMs) or the current edition of the International Statistical Classification of Diseases & Related Health Problems (ICD). The impairment evaluation report must specify the diagnostic criteria on which the diagnosis is based.

...

The insurer's submissions to the Medical Assessor

On 3 July 2024, the insurer made the detailed submissions to the Medical Assessor. The insurer's grounds of judicial review are based on these submissions. They are lengthy, but they need to be reproduced so that they can be analysed. The submissions are as follows:

"Background of dispute in the Commission

[10] The insurer has now obtained material that is relevant to the assessment of both the claimant's alleged physical and psychiatric injuries. Based on this new material, the insurer has revoked their concession in respect to permanent impairment, issuing a new decision on 21 June 2024 declining to concede the threshold for both physical and psychiatric injuries.

...

Issues in Dispute

[12] The insurer submits that there is now a dispute about:

- (a) Whether the subject accident caused the alleged injuries
- (b) Whether the alleged injuries result in a permanent impairment greater than 10%.

...

[16] The insurer has become aware that the claimant pursued a claim for workers compensation from EML arising from a workplace (psychiatric) injury said to have been the result of workplace bullying and harassment in the course of the claimant's employment with Woolworths in 2012.

[17] The claimant commenced lodged the workers compensation claim form on 17 February 2022, and commenced his claim for weekly payments in the Personal Injury Commission on 21 July 2023, that is, after the subject accident.

[18] The workers compensation claim was not disclosed to the insurer's qualified medical experts.

...

[Dr Dinnen's reports are reproduced in full later in this judgment as they form the foundation of some of the insurer's grounds of judicial review.]

[21] In support of the claimant's subject motor accident claim, the claimant has relied on reports of Dr Dinnen dated 23 February 2023 and 10 April 2024.

[22] In his report of 23 February 2023, Dr Dinnen did not provide an assessment of the claimant's permanent impairment arising from the subject motor accident. However, there is another report of Dr Dinnen of the same date that was prepared in respect to a workers compensation claim that the claimant was pursuing.

[23] In the report of Dr Dinnen dated 23 February 2023 that related to the workers compensation claim, he assessed the claimant's psychiatric injury resulting from the claimant's workplace injury as giving rise to a 21% permanent impairment. Specifically:

He noted the history of a diagnosis of schizophrenia in 2005 and recorded that the claimant said the claimant had improved after treatment at Bankstown Community Health and did not require any further medications.

He diagnosed chronic paranoid schizophrenia, which had been aggravated by the employment in 2012.

He reported that, in spite of ongoing treatment, the claimant was still getting a lot of hallucinations and paranoid thoughts.

In this report, Dr Dinnen noted that the claimant used to attend gym regularly until 2012 but had not done so since and that the claimant had no social life.

[24] In Dr Dinnen's other report of 23 February 2023 relating to the claimant's motor accident claim (the 'motor accident report'):

The report starts the same as his other report, but then Dr Dinnen omits the two paragraphs on page 3 under the heading 'Second episode of psychiatric illness' that refer to the claimant's experience of bullying in the claimant's workplace.

On page 4 there are additional sections under the headings 'Motor vehicle accident, 20 October 2021' which refer to the subject accident and 'Subsequent Psychiatric Condition' which detail the symptoms of depression and PTSD that the claimant had reportedly experienced since the subject motor accident. These two sections do not feature at all in the other report of the same date.

Dr Dinnen still described the claimant as having a lot of hallucinations and paranoid thoughts which was noted to be predominant and constant. He noted that the claimant had described that the schizophrenia had been significantly worse after the subject accident.

He considered the claimant's symptoms to be consistent with the diagnosis of chronic paranoid schizophrenia complicated by the development of PTSD and depressive disorder following the subject motor accident.

[25] The workers compensation file also included reports of Dr Clarke, psychiatrist qualified for the workers compensation insurer, dated 10 May 2022 and 8 August 2023 (the latter being after receipt of various clinical records which she had previously not had access to) and the insurer notes the following:

In the earlier (2022) report, Dr Clarke recorded that the claimant had said that about six months earlier the claimant developed what the claimant termed 'depression' without a clear trigger, although it was around the time the claimant had reconnected briefly with the claimant's daughter.

She recorded that the claimant had reported that the claimant had suffered from symptoms of schizophrenia continuously since 2012, only ever achieving partial remission with treatment.

In the later (2023) report, Dr Clarke noted that in her earlier report she had reported the claimant's assertion that the claimant had experienced an episode of schizophrenia in 2005 with a full remission after brief treatment and return to full function until the workplace bullying resulted in a relapse of his symptoms. However, she now noted that the contemporaneous clinical documentation disputed this history and the claimant had in fact had a much more severe and enduring pre-existing condition, which she detailed.

She identified that in 2012 it had been found that there had been an error in the administration of the claimant's medication from June 2012 to October 2012, which she considered had been responsible for the exacerbation of the claimant's symptoms at that time.

She recorded from her examination on 3 August 2023 that the claimant disclosed ongoing persecutory delusions, and intermittent auditory hallucinations.

She noted that it was evident the claimant had not sustained employment for more than a few months for approximately a decade prior to the claimant's employment in 2012 and had not worked at all since then. She considered that in the context of the claimant's chronic psychotic symptoms, a return to the workforce is unlikely.

It remained her opinion that the claimant had a DSM-5 diagnosis of schizophrenia, multiple episodes, partly in remission. In her view, the evidence established that the experiences with the claimant's employer in 2012 were incidental to the condition and did not have a significant impact on it. She considered that the claimant had pre-existing chronic and enduring schizophrenia and had not suffered a work injury.

[26] There is no reference in the reports of Dr Clarke to the subject motor accident, which notably had occurred only about six months prior to her first examination and report.

[27] The insurer had previously relied on reports of Dr Kaplan, psychiatrist, dated 7 March 2023, 15 December 2023, and 10 January 2024 who had assessed a 20% permanent impairment from psychiatric injury, reduced to 18% to take account of the preexisting condition. It is noted that:

Dr Kaplan recorded the history that the claimant had been involved in a motor vehicle accident on 25 October 2021, when the claimant was stopped in traffic and the claimant's vehicle was rear-ended.

Dr Kaplan recorded that prior to the accident, the claimant would go out often and the claimant's schizophrenia was under good control. The claimant reportedly did not have any symptoms (delusions or hallucinations) but felt that this condition had worsened, adding to problems with pain and depression.

Dr Kaplan considered that the claimant's condition was consistent with a diagnosis of:

Pain disorder, subsumed under Somatic Symptom Disorder, however, in his later report of 15 December 2023 he said the pain disorder diagnosis could not be maintained (noting that the claimant's chronic pain was chiefly from his shoulder and the claimant was not having any other treatment besides minimal analgesia).

Major Depressive Disorder

Post-traumatic Stress Disorder (or Adjustment Disorder with anxiety and some driving phobia); in his later report of 15 December 2023, Dr Kaplan said that he was not convinced that the claimant had PTSD as a primary diagnosis, but only as an alternative diagnosis to Chronic Adjustment Disorder with depression and anxiety

Schizophrenia, paranoid type (in remission).

The conditions, with the exception of schizophrenia, arose from the subject accident.

Dr Kaplan assessed a 20% WPI, reduced to 18% after deduction for the pre-existing psychiatric condition.

[28] The insurer notes that the history relied on by Dr Kaplan that the claimant's schizophrenia was under good control prior to the subject accident, and that the claimant would go out often prior to the subject accident. This is inconsistent with the history taken by Dr Clarke and Dr Dinnen. In particular, for example, they had recorded that the claimant's symptoms of schizophrenia had continued and worsened since the 2012 workplace injury. Specifically, both Dr Dinnen and Dr Clarke (in February 2023 and August 2023) recorded that the claimant was still experiencing paranoia, delusions, and hallucinations, whereas Dr Kaplan reported in March 2023 that the claimant was not suffering from delusions or hallucinations. Dr Kaplan recorded that the claimant was asked about the claimant's psychotic symptoms arising from schizophrenia and had said that since going on Rexulti after 2012 these symptoms had been completely absent, specifically hallucinations, delusions, or ideations. This cannot be reconciled with the symptoms recorded by Dr Dinnen and Dr Clarke at around the same time.

[29] The insurer has also considered the report of Dr Dinnen dated 10 April 2024. In this report: He referred to his earlier diagnosis of chronic paranoid schizophrenia prior to the accident, and that his had been complicated by the development of PTSD and depressive symptoms since the subject accident. He then said that 'at this interview I decided to conduct a formal assessment according to the criteria set for these three conditions.

He then recorded the symptoms and considered that the diagnosis of PTSD is satisfied

and related to the subject accident. He also recorded the symptoms of major depressive disorder which he said are attributable to the subject accident as well.

Dr Dinnen noted that there were reportedly no hallucinations or delusions.

Dr Dinnen assessed a 22% WPI arising from the PTSD and depressive disorder, with no deduction for pre-existing condition.

[30] The insurer considers that the report of Dr Dinnen on 10 April 2024 cannot be reconciled with his report of 23 February 2023 provided in the context of the claimant's workers compensation claim and in which he assessed a 21% WPI arising from his diagnosis of chronic paranoid schizophrenia.

...

[32] The insurer also notes that the clinical records from the claimant's treating GP, Dr Wong, include:

Entries pre-accident that refer to feeling lethargic and not motivated. In 2017 there were notes 'feels depressed'.

The first entry post-accident consultation note was on 22 February 2022, about three months after the subject accident. This entry refers to the workplace bullying accident in July 2012 and resultant relapse in schizophrenia. There is no reference to the subject motor accident.

The entry on 21 March 2022 states the claimant was 'still feeling stressed' and then the next entry on 25 March 2022 refers to the 'diagnosis of schizophrenia ... in remission by 2008, started working in 2011 ... then went to work at Woolworths in March 2012. Was bullied ... in July at work and his condition relapsed...'

The entry on 28 April 2022 records 'still feeling depressed ... needs referral to ...'. The entries continue with references to still being depressed and not able to work.

On 29 September 2022, the record notes 'still feeling depressed and agitated about the bullying at work in 2012.'

[33] The insurer has also considered the clinical records of the claimant's pre-accident treating psychiatrist, Dr Saker, whom the claimant was seeing for treatment of the claimant's psychiatric issues up to the date of the subject accident. Specifically, the following entries are noted:

On 20 August 2019 Dr Saker assessed the claimant, noting the claimant's presenting problems included that the claimant was continuing to experience hallucinations and paranoia and did not leave the house much, frequently felt low and had problems with concentration and irritability. He recorded the diagnosis as schizophrenia, paranoid subtype, with a K10 score of 38 (indicating severe anxiety I depression).

On 3 February 2021 Dr Saker assessed the claimant again, recording a K10 score of 38 (indicating severe anxiety I depression).

On 2 August 2021 Dr Saker assessed the claimant again noting the claimant had paranoid thought content and in his view was suffering from schizophrenia paranoid subtype and adjustment disorder with anxious mood secondary to a death threat from the claimant's ex-wife.

After the accident, Dr Saker assessed the claimant again on 30 March 2022 and noted the history of the subject accident, leading to the development of major depressive disorder and PTSD.

- [34] The insurer is cognisant that the post-accident record by Dr Saker on 30 March 2022 is not consistent with the post-accident recorded by Dr Wong on 22 February 2022, Dr Saker's entry referring to the subject motor accident whereas Dr Wong's entry referring to the claimant's workplace bullying accident in July 2012 and associated relapse of schizophrenia.
- [35] The insurer has also had regard to the report from Mr Wiggins, the claimant's treating clinical psychologist to Dr Wong dated 11 April 2022 in which he referred to a counselling session that day with the claimant having reported a 2012 work injury and that the claimant had been withdrawn, isolated, feeling depressed and anxious and being diagnosed with schizophrenia in 2012. There were suicidal ideations. There was no mention in Mr Wiggins report of the subject motor accident.
- [36] The insurer has also had regard to the statements from the claimant's workers compensation records, in particular in the claimant's statement of 11 July 2023, the claimant detailed the claimant's employment and health history and said that after suffering a schizophrenic episode in 2005, the claimant was treated with injections for two to three months and then felt much better, the claimant improved and did not require any further medication for this condition. The claimant described the harassment at work (in 2012) and said that the claimant had become unwell, suffering hallucinations and paranoia, and commenced on treatment again about two months after ceasing work, and remained on that regime since. Despite the treatment, the claimant said that he continued to have a lot of hallucinations and paranoid ideations.
- [37] The insurer has also had regard to the circumstances of the accident and minimal damage as depicted in the photographs of the claimant's vehicle (see below). The insurer submits that the subject accident does not meet the criterion A for a DSM-V diagnosis of PTSD, namely, it was not of such a nature to have exposed the claimant to an actual or threatened risk of serious injury.

...

- [43] The insurer also has the records of Dr Wong and significantly these records include:

Entries from 2013 to 2020 referring to pain in the neck, back, and right shoulder, for which the claimant was being prescribed Targin.

There are entries on 20 August 2020 and 3 December 2020 (i.e. before the subject accident on 25 October 2021) and the next entry is not until 22 February 2022 (i.e. after the subject accident).

The first entry post-accident on 22 February 2022 refers to the workplace bullying accident in July 2012 and resultant relapse in schizophrenia but makes no reference to the subject accident.

...

- [50] The insurer submits that there are credit issues highlighted above in respect to his pursuit of a claim for a psychiatric injury in respect to his alleged 2012 workplace injury that is grossly inconsistent with his pursuit claim for a psychiatric injury in respect to the subject accident. There are also inaccuracies in respect to the continuation of his physical symptoms in the cervical and lumbar spine following the earlier motor accident. These issues have rendered the opinions expressed by various experts to be of limited utility.
- [51] The insurer submits that whether the issues go to the claimant's credit or the accuracy of his recollection, the assessor would treat any self-reporting with some caution and instead prefer the evidence contained in contemporaneous records where they are available, or at least where they are not contradicted with other contemporaneous records.
- [52] The insurer disputes that the subject accident caused any injury to the claimant's cervical spine, lumbar spine or left shoulder or any psychiatric injury.
- [53] The insurer does not concede that any injuries caused by the subject accident resulted in permanent impairment that is greater than 10%." (references omitted)

It is fair to say that the claimant's psychiatric condition is complex. At this early stage in the Judgment, I drew attention to the statement of Basten JA in *Mason v Demasi* [2009] NSWCA 227 (Demasi) said at [2]:

"[2] First, the trial judge was invited to discount the appellant's oral testimony on the basis of accounts given to various health professionals, which appeared inconsistent either with each other, or with her oral testimony, or both. The difficulties attending this kind of exercise should be well-understood; as explained in the *Container Terminals Australia Ltd v Huseyin* [2008] NSWCA 320 at [8], such apparent inconsistencies may, and often should, be approached with caution ...".

Such caution is appropriate in the case of a person like the claimant who has had such protracted struggle with psychiatric conditions.

Dr Dinnen's reports

On 15 February 2023, Dr Dinnen, a consultant psychiatrist first interviewed and examined the claimant in relation to his workers' compensation claim and his motor vehicle incident for the purpose of creating medico-legal reports.

In all, Dr Dinnen wrote five medico-legal reports:

first workers compensation report dated 23 February 2023;

second workers compensation report addressing WPI dated 23 February 2023;
first motor accident report (the subject of this judicial review) dated 23 February 2023;
third workers compensation report dated 13 September 2023; and
second motor accident report dated 10 April 2024.

On 15 February 2023, Dr Dinnen interviewed the claimant before he prepared the reports dated 23 February 2023.

Dr Dinnen – Workers Compensation Reports

The workers compensation reports relate to the claimant's claim for workers compensation arising from bullying the claimant experienced at Woolworths in 2012 (nearly a decade prior to the motor accident claim) that aggravated pre-existing schizophrenia.

Dr Dinnen referred to the claimant's bullying claim in 2012 and his previous motor accident in April 2003 (this motor accident in 2003 plays no role in the current claim).

On 23 February 2023 (after the motor incident) had occurred, Dr Dinnen wrote the first workers compensation report. It recorded:

"First Episode of Psychiatric Illness:

In giving this chronology, the patient told me that he developed an acute episode of schizophrenia in 2005. When I asked him to describe his symptoms, he told me he would sit in front of the television and think it was speaking to him. He eschewed treatment. He was isolated in solitary confinement for quite some time.

...

Second Episode of Psychiatric Illness:

The patient told me he worked at the warehouse at Yennora for five or six months [in 2012] but was then subjected to harassment and bullying. In response to enquiry, he told me there were usually one-hundred-and-fifty people on a shift.

...

Current Symptoms

In spite of ongoing treatment, the patient told me he still gets a lot of hallucinations. "I think I see mice at the corner of my eye, people staring at the window." Paranoid thoughts include feeling that people are talking about him. These symptoms are predominant and constant.

A little later in the interview, when I asked how he spends his time, he told me that he spends it "pacing". He will drive once or twice a week to do the shopping.

...

Review of Documentation

1. Dr Sydney Oen, Psychiatrist, 3 August 2019

This certificate advises the patient had been under his care since 2017 and had admissions to two acute psychiatric units in 2005 and 2011. "He was diagnosed with chronic paranoid schizophrenia at these times and has been on maintenance antipsychotic medication since then. His symptoms include intermittent auditory hallucinations and paranoid ideation. He is also troubled by ongoing restlessness, which may be a side effect of his medication regime."

He had been on a disability support pension since 2012. There was no likelihood of any further improvement in his condition. It was unlikely he would ever be gainfully employed in a capacity for which he was reasonably qualified, because of his education, experience or training.

2. Dr Stuart Saker, Psychiatrist, 20 August 2019

This is a similar certificate to the one noted above from Dr Oen.

3. Statement of Worker, dated 31 March 2022

This statement was taken by an insurance investigator and is of several pages and eight-six numbered paragraphs.

He describes his casual employment from March 2012 (paragraphs 25-38), including an unsuccessful application for permanency. He describes being bullied from early-June 2012 (39-42) and his report of that situation (43-44). He describes an incident in July 2012, where a number of permanent employees had "a number of unsafe and reckless acts towards me on their machines" (45-52). This was his last shift at Woolworths Yennora. He was contacted by the workplace when he did not attend and had reported the reason (54-59).

In his statement, the patient describes how his condition had deteriorated following the workplace bullying and how he had required ongoing treatment (66-75). He had hoped his condition would improve but it progressively worsened and he has had suicidal thoughts (74-75).

The patient describes the ongoing effects of this injury (80-85).

4. WorkCover Certificate of Capacity

In this Certificate dated 26 May 2022, Dr K Y Wong of Condell Park certified the patient unfit for work as a result of "bullying at work, resulting in relapse of schizophrenia". The date of injury is given as July 2012.

There are a number of other Certificates of Capacity of a similar nature, dated February and April 2022. The one in April provides a diagnosis of "Schizophrenia. Major depression."

5. Letter from Howard C Wiggins. Psychologist. 11 April 2022

This is directed to Dr Wong and advises the patient had his first counselling session that day. "He reported a work injury 2012, feeling that his colleagues and managers bullied, swore at him and threatened him."

The symptoms described include social withdrawal, depression and suicidal ideas.

Comment:

The documentation is consistent with and corroborates the account which the patient gave at interview.

With Regard to Your Specific Enquiry:

1. Your diagnosis.

Paranoid schizophrenia.

2. Whether exposure to events at Woolworths from March to 22 July 2012 have aggravated, exacerbated and accelerated his preexisting schizophrenia.

Yes.

3. If so, were the employment events or exposure to events the main contributing factor to any such aggravation, exacerbation and acceleration of the underlying schizophrenia or any other psychiatric diagnosis you have made?

Yes.

4. In your opinion and based on our client's history has there been any such aggravation, exacerbation and acceleration or has it been ongoing since 22 July 2012?

The condition has been ongoing since 22 July 2012.

5. Your prognosis.

The patient's condition is likely to continue at its current level of incapacity and symptoms.

6. Your opinion as to our client's capacity for work since 23 July 2012.

He has had no capacity for work since that time.

7. If not for any employment-caused aggravation, exacerbation and acceleration of the underlying schizophrenia in July 2012, is it likely that our client would have continued with work as a storeman and forklift driver with controlled schizophrenia, noting his medical history prior to July 2012?

In my experience, many patients with chronic schizophrenia are able to hold down jobs of this nature, or in factory work, where the work environment is supportive and comfortable for them. The patient's account is that he did continue to work from the first episode in 2005 until 2012. If the workplace at Woolworths in Yennora had been favourable, I would expect him to have continued to work there.

8. Please provide your account of [whole person impairment] in respect of psychiatric injury.
See separate report.”

On 23 February 2023, Dr Dinnen wrote the second workers compensation report that focussed on the criteria to assess the claimant’s whole person impairment. He records as follows:

“Assessment of Impairment - WorkCover Guidelines:

Diagnosis

Chronic paranoid schizophrenia.

Permanent impairment

The conditions are likely to persist at their current levels. He has reached maximum medical improvement.

Effects of Treatment

He is receiving ongoing treatment. Two percent should be added to the assessment to adjust for this ongoing benefit.

Co-morbidity

None.

Pre-existing Impairment

None, prior to 2011/2012.

Table 11.1 Self-care and Personal Hygiene

The patient is able to manage to care for himself in the four-bedroom family home but admits that he has some difficulty coping. He commented that his "hygiene has gone down the drain" and he is not eating well. He tends to stay in the home, other than for going shopping on occasion. See main report. Class 2.

Table 11.2 Social and Recreational Activities

Social activities are nonexistent, because of his illness. Class 3.

Table 11.3 Travel

He is able to travel, to a limited extent, to do some shopping but for the most part prefers to stay at home. Class 2.

Table 11.4 Social Functioning

Close relationships are impaired by his chronic illness. Class 3.

Table 11.5 Concentration. Persistence and Pace

Cognitive function is impaired because of his schizophrenic illness. Class 2.

Table 11.6 Employability

He is unfit for work. Class 5.

The median class score is 3. The aggregate score is 17.

The percentage of whole body permanent impairment is 21% (19% plus 2% for treatment effect)."

On 13 September 2023, Dr Dinnen wrote the third workers compensation report. It was written in response to a report of Dr Clarke dated 8 August 2025. Dr Dinnen confirmed that his opinion as given in his reports dated 23 February 2023 remain unchanged.

It is fair to say that the medico-legal reports in relation to the 2012 Woolworths incident were first written in 2022 (10 years after the incident).

Dr Dinnen – Motor Incident reports

On 23 February 2023, Dr Dinnen wrote the first motor incident report, relating to the incident that occurred on 25 October 2021. He reported:

"First Episode of Psychiatric Illness:

In giving his chronology, the patient told me that he developed an acute episode of schizophrenia in 2005. When I asked him to describe his symptoms, he told me he would sit in front of the television and think it was speaking to him. He eschewed treatment. He was isolated in solitary [confinement] for quite some time.

...

Second Episode of Psychiatric Illness:

The patient told me he [in 2012] worked at the warehouse at Yennora for five or six months but was then subjected to harassment and bullying. In response to enquiry, he told me there were usually one-hundred-and-fifty people on a shift.

...

Motor Vehicle Accident, 20 [25] October 2021:

The patient told me he was driving home from the City at night, after spending time at the casino where had visited a friend. He was in Rozelle, at the major intersection with Victoria Road, after coming off the Anzac Bridge. He was in the left-hand lane. He was stationary in the traffic. His car was hit from behind. He was not pushed into the car in front, however.

...

Subsequent Psychiatric Condition:

The patient told me that he has suffered from depression since the [current incident] accident and has been diagnosed with post-traumatic stress disorder. He told me he had not been depressed previously and was always optimistic and positive.

Since the accident, suicidal thoughts have bothered him. He feels worthless. He has no self-esteem. He has thoughts of hanging himself.

When I asked the reason, the patient told me it is because he cannot do the things he used to do. For example, he had a hobby business as an egg seller, through his sister at Falls Creek. For a year before his accident, he was able to sell the eggs door to door, earning about \$280 per week. He commented that he has always loved animals. Other activities which he is no longer able to enjoy include related hobbies, such as golf and tennis, although he has not engaged in those for many years.

What plays on his mind is that he is no longer able to lift. He is restricted physically. He has constant pain and that makes him feel worthless.

He has also developed insomnia.

In spite of ongoing treatment, the patient told me he still gets a lot of hallucinations. "I think I see mice at the corner of my eye, people staring at the window." Paranoid thoughts include feeling that people are talking about him. These symptoms are predominant and constant.

A little later in the interview, when I asked how he spends his time, he told me that he spends it "pacing". He will drive once or twice a week to do the shopping.

The patient told me he started under the care of Dr Saker in 2014. Three months after he started to see him, he was diagnosed with depression. He was referred to Psychologist Charmaine Moubarak, whom he saw for over a year, usually once a month.

Dr Saker has treated him with medication for his insomnia and he also takes Minipress. Current medication is Rexulti 2 mg daily. He has taken that for about three or four years. He had previously gained a lot of weight, up to 96 kg, while Zyprexa.

With regard to his schizophrenia, which has been present on an ongoing basis since 2012, the patient told me it was significantly worse after the motor vehicle accident.

With regard to the symptoms of post-traumatic stress disorder, the patient told me he gets nightmares and flashbacks. These occur three or four times a week. Nothing as significant as this accident had ever happened to him before.

He cannot sleep and wakes up in a sweat. He startles easily.

He told me he gets frustrated and he finds it very easy to become irritated.

He neglects his self-care. His appetite is gone and he has lost a lot of weight.

He tries not to drive. He prefers to only drive his car to the shops when there is no traffic and it feels safe. When he drives, he is troubled by thoughts of the accident.

The sound of a car horn startles him.

He is reminded of the screech of the tyres and the bang at the time of the accident.

The patient told me he started smoking cigarettes after the accident and now smokes about thirty-five cigarettes daily, because of his depression.

Review of Documentation:

I was provided with documents from Dr Saker's file. Records of the initial assessment in 2014 describe the patient as having ongoing symptoms and treatment. They noted a car accident in April 2013, when "his back, neck, right arm and right shoulder were injured". He was noted to have a reactive affect. He had no formal thought disorder and had no abnormal thought content. His condition was assessed as being in partial remission, with ongoing treatment.

Copies of correspondence to the local doctor date from November 2014 and record ongoing symptoms and management.

On 27 May 2016, Dr Stuart Saker wrote to Dr Wong of Condell Park that the patient had been "pacing frequently" and medication was to be reduced.

An assessment on 20 August 2019, noted the patient had continued to experience visual hallucinations and had ongoing paranoia that someone would cut his ankles with a razor. He was now taking brexpiprazole (Rexulti) 2 mg daily.

I note a letter on 27 May 2022 addressed to Dr Lina Aljuma of Yagoona, with a copy to AAMI, advising that the patient has "treatment-resistant PTSD, MDD on a background of longer term schizophrenia".

In a letter dated 26 August 2022, Dr Saker advises the patient was "struggling with depression and PTSD. He has nightmares and is afraid when driving that he will be hit from behind. He is living by himself. He cannot sleep at night. He is seeking his psychologist, Charmaine. He had a car crash on 24 October 2021 and his PTSD has been bad since."

The last letter of 28 October 2022 advises the patient had decided against TMS and noted that he "has pre-existing schizophrenia and PTSD and MDD from his motor accident."

Opinion:

The records from the treating psychiatrist are consistent with the account which the patient gave at interview. The history obtained at interview, together with the ongoing symptoms as described by the patient are also consistent with Dr Saker's diagnosis of chronic paranoid schizophrenia, complicated by the development of post-traumatic stress disorder and depressive symptoms following the motor vehicle accident of October 2021."

On 10 April 2024, Dr Dinnen wrote the second motor accident report. It records the following:

"Motor vehicle accident, 25 October 2021:

He was in a 2012 Camry with a towbar and was stationary in Rozelle when the accident occurred. He had come from dinner with a friend. It was about 7:00pm or 7:30pm and it was dark. He had just come off the Anzac Bridge towards the main intersection with Victoria Road. He was hit by another sedan. He was thrown forward. He was wearing a seat belt. He remained in the car for five or 10 minutes. He had pain in his left shoulder, neck and back.

He got out of the car and exchanged details with the other driver and took photographs of the cars. He drove to a side street and sat in his car for two or three hours. "I was in shock and in pain." He then drove home.

Psychiatric consequences:

He recalled becoming very depressed and very down about three weeks after the accident. "I was not wanting to do anything. I was not wanting to get out of bed."

The immediate consequence of the accident was that he was no longer able to maintain his business selling eggs and looking after the chickens. Within one to three days after the accident "I was in pain and unable to run the business". He had to euthanase the 200 chickens over the next three weeks, by killing them himself.

Ongoing symptoms of depression have persisted. "I am still very very depressed. I have suicidal thoughts. I haven't got over it."

In regard to a specific question he acknowledged that having to kill the chickens had affected him deeply. He told me he loves animals and the chickens were easy to care for. He feels guilty about that.

He has ongoing nightmares about the accident.

His confidence when driving has been adversely affected. He is able to drive but when he is stationary he is on guard and apprehensive about having another accident. He was able to return to driving about two to three weeks after the accident.

He gets very anxious.

He tends to relive the accident.

He does not feel like cooking meals for himself. "I don't feel like it. I'm too depressed."

Some days he cannot get out of bed because he is too depressed and has bad thoughts and feels suicidal.

He will leave the house once or twice a week to get basic requirements such as bread and milk, or to go for a coffee. If he encounters someone he knows he will say hello but will not socialise. "I'm not in the frame of mind to socialise. I feel down."

Anxiety is heightened by stress such as having to attend today's appointment. He is always conscious of having access to a toilet if he is out of the house.

His relationship broke down after the accident. He had been together with Rachel for about two-and-a-half years. She was 39 and lived in Berala with her parents. They had met through friends and would meet up five or six times a week but were not living together. The sexual relationship was adequate. After the accident however he could not be bothered going out. He was too frightened. He broke the relationship off.

He had two admissions to Toronto Private Hospital. The first was from 10 to 29 September 2023 and the second from 4 to 18 December 2023. The admissions were because he was having suicidal thoughts. He had benefit from attending classes in mindfulness, communication and behaviour while in hospital and medication was changed with the addition of zolpidem.

He has had a payment as a result of the physical injury suffered in the accident. He told me these were assessed by Dr Peter Conrad with 16% permanent impairment resulting from the left shoulder (6%), the neck (5%) and the back (5%). He gets domestic help for six hours a week and yard maintenance once a week through the insurance company.

Diagnostic considerations:

Clinically, when I examined this patient in February 2023 and reviewed the documentation as then provided I was of the view that the patient had chronic paranoid schizophrenia, prior to the accident and that had been complicated by the development of post-traumatic stress disorder and depressive symptoms following the motor vehicle accident of October 2021.

At this interview I decided to conduct a formal assessment according to the criteria set for these three psychiatric conditions in DSM5.

Post-traumatic stress disorder diagnosis - coded at 309.81:

...

The diagnosis of PTSD is satisfied with regard to the motor vehicle accident of October 2021.

Major depressive disorder, DSM-5, coded at 296.22:

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (eg feels sad, empty, hopeless) or observation made by others (eg appears tearful).

These symptoms are present.

2. Markedly diminished interest or pleasure in all or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).

These symptoms are also present.

3. Significant weight loss when not dieting or weight gain (eg a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.

He has lost 10kg in weight. He does not eat well and has lost appetite.

4. Insomnia or hypersomnia nearly every day.

These symptoms are present.

6. Fatigue or loss of energy nearly every day.

He suffers fatigue.

7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

He has feelings of worthlessness and guilt.

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

Concentration is reduced with problems with decision-making as he is very impulsive and is troubled by self-doubt.

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

These symptoms are recurrent.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

Schizophrenia coded at 295.90 in DSM5:

A. Two (or more) of the following, each present for a significant portion of time during a one-month period (or less if successfully treated). At least one of these must be (1), (2) or (3):

1. Delusions

No.

2. Hallucinations

No.

3. Disorganised speech (eg frequent derailment or incoherence)

No.

4. Grossly disorganised or catatonic behaviour

No.

Negative symptoms (ie diminished emotional expression or avolition)

No - he has depression instead.

He has no ongoing intrusive symptoms of schizophrenia.

Assessment of impairment - GARP V:

This is for a major depressive disorder and post-traumatic stress disorder, conditions consequent to the accident of 24 October 2021.

Assessment of impairment, Motor Accident Authority Guidelines, AMA 4:

...

The median score is 3. The aggregate is 17 and percentage of whole person permanent impairment is 22% (19% plus 3% for treatment effect).

Review of documentation:

A letter to the insurer from psychologist Charmaine Moubarak of Bankstown dated 27 June 2022 advised in brief that the patient had been attending for treatment. "[The claimant] has a pre-existing schizophrenia diagnosis, where the MVA had triggered PTSD and MDD symptomatology. She also saw a note from Dr Stuart Saker, psychiatrist of Toronto of 22 March 2024 noting that the patient's "schizophrenia was largely in remission prior to his motor vehicle accident of 25/10/2021. Following the MVA he was unable to attend to his chickens anymore and lost his main source of income". He was noted at interview to have flat affect, and to be of low mood with negative thought content. Further management was advised.

A. letter from Toronto Private Hospital to the insurer of 15 March 2024 advised the patient had attended 20 sessions of a depression management group programme but "continues to present with anxiety and depressive symptoms". Further treatment was recommended.

Ms. Moubarak provided a more detailed report dated 15 August 2022 directed to the referring doctor. The patient had been seen on four occasions at that point. She noted that Dr Saker had diagnosed him suffering from major depressive disorder and post-traumatic stress disorder following the accident. Her report describes ongoing symptoms in detail, with the criteria for major depressive disorder and post-traumatic stress disorder set out and symptoms present satisfying those diagnoses.

A report from psychiatrist Dr Robert Kaplan of 7 March 2023 was directed to the insurer. He diagnosed the patient as suffering from pain disorder, major depressive disorder and in remission schizophrenia paranoid type. His condition was not considered to have stabilized, so no assessment of impairment was carried out. However, in a further report of 10 December 2023 Dr Kaplan assessed permanent impairment due to these conditions at 19%.

List of questions submitted by patient:

1. Have there been any periods of hospitalisation and/or surgical procedures carried out following the accident?

Admitted to Toronto Private Hospital for post-traumatic stress disorder, major depression, anxiety, suicidal ideation. Dates: 10 September 2023 to 29 September 2023 and 4 December 2023 to 18 December 2023.

2. Obtain a detailed pre-accident medical history

As above.

3. Obtain a detailed post-accident medical history (for any subsequent injuries or medical conditions)

As above.

4. What current symptoms is the patient reporting? Are there are [a]ny associated disabilities which would be due to these symptoms?

As above.

5. Your clinical and functional findings on examination

As above.

6. Provide an assessment of the available medical reports

Noted - see previous report also.

7. Is the patient's current condition consistent with the alleged injuries and disabilities?

Yes.

8. Your diagnosis in relation to the injuries and disabilities sustained in the accident.

Major depressive disorder and post-traumatic stress disorder.

9. In your opinion have the patient's injuries stabilised to be considered sufficiently recovered? For those injuries that you believe have not stabilised, please provide an appropriate timeframe for stabilisation, if possible

Yes.

10. Your opinion as to the reasonableness and necessity of treatment received following the accident

He received full treatment as described above from local doctor, psychologist and psychiatrist.

11. Your opinion as to the reasonableness and necessity [of] future treatment and your comments as to duration and costs of any such treatment

Ongoing treatment in this maimer is desirable. Costs of \$3,000 to \$5,000 per year not counting hospital treatment.

12. In your opinion, are the alleged injuries and disabilities the direct result of this motor vehicle accident or are they the result of a prior or subsequent injury or disability, or pre-existing, or some other reason

Direct result of the MVA.

13. Where applicable, please provide your opinion of the patient's ability to resume their pre-accident home duties

Limited. See above.

14. Where applicable, for what period, if any, would they have been unable to undertake their pre-accident home duties? To what extent [was] this inability, if any, due to the accident?

Presumably since the accident.

15. If the client is still unable to resume pre-accident home duties/domestic assistance, please comment on the patient's ability to return to home duties/domestic assistance and the extent to which this is due to the accident

He is receiving assistance for work as noted above.

16. Your assessment of whole person impairment in accordance with the AMA "Guide to the Evaluation of Permanent Impairment" (4th edition) and the Motor Accident Guidelines (effective from 1 December 2017)

22%.

17. Degree of whole person impairment (WPI) of injuries that are permanent.

22%

18. Determination regarding the degree of whole person impairment of the injured person as a result of the injuries

As above.

19. Your opinion of the patient's ability to resume their pre-accident employment

Unfit permanently.

20. For what period, if any, would the patient have been unable to undertake their pre-accident employment? To what extent was this inability, if any, due to the accident?

Since the MVA, due to it.

21. For what period, if any, would the patient have been required to undertake suitable duties and/or hours? To what extent was this need, if any, due to the accident?

Not applicable.

22. If the patient is still unable to resume pre-accident employment please comment on the patient's ability to return to work on suitable duties/hours, or in alternative employment

Unfit for any employment."

The Medical Assessor's Decision dated 28 October 2024

On 3 October 2024, the claimant was assessed by the Medical Assessor, a psychiatrist, in relation to his psychiatric injuries.

On 28 October 2024, the Medical Assessor issued a certificate certifying that PTSD and Major Depressive Disorder caused by the motor vehicle accident gave rise to 23% WPI. The Medical Assessor acknowledged receipt of submissions from the insurer and the claimant. Her reasons for his decision are as follows:

"History

8. Psychosocial history and pre-accident history

...

In 2005 he suffered acute psychosis and had a psychiatric admission for ten days. He was diagnosed with Schizophrenia. He stated that he was on medication for four months and did not have psychiatric follow up. His mother also suffered from Schizophrenia. He remained well until he suffered a relapse of psychosis in 2011 and had another psychiatric admission. He stated that he returned to work after his first psychotic episode in 2005 and worked as a handyman till 2011 when he suffered a relapse of Schizophrenia. He then went to work in a distribution centre for Woolworths from February to July 2012. He left work at Woolworths distribution centre because he experienced bullying and harassment. He submitted a workers compensation claim in relation to the incident in 2012 with a claim for exacerbation of Schizophrenia. He stated that the workers compensation claim is currently under appeal.

[The claimant] was placed on depot antipsychotic medication following his psychiatric admission in 2011 until 2014. He has been on oral antipsychotic medication Rexulti (brexpiprazole) and has been seeing a psychiatrist privately. He saw psychiatrist Dr Oen and subsequently Dr Saker who remains his treating psychiatrist. He reported that his mental state remained stable, and he led a "normal life" until the subject motor accident in 2021. He stated that his previous psychiatric history only related to his psychotic symptoms, and he did not previously suffer from Major

Depressive Disorder even if he had depressive symptoms related to his psychosis from time to time.

Since 2013 he worked as a handyman doing odd jobs such as gardening and painting for family and friends. He had chickens at home and started selling fresh eggs and was trying to build up his egg selling business prior to the subject motor accident. During 2018 and 2019 he also worked as a carer for his mother providing 24-hour care for her. He was responsible for showering, cooking, cleaning, home maintenance, administering medication and taking her to appointments. He stated that his mother had Schizophrenia and heart disease.

...

Prior to the subject motor accident [the claimant] reported attending the gym and enjoying going fishing, rock and roll dancing and riding his exercise bike. He went to church fellowship every Saturday night where he maintained a social network. He reported having two close friends.

...

10. History of symptoms and treatment following the motor accident

...

He reported that he started to feel down about a week after the motor accident. He stopped driving because he was "scared to drive". He had flashbacks about the collision impact and nightmares started. He suffered broken sleep and lost interest and motivation. He did not drive because of anxiety and avoided the accident site. He described post-trauma symptoms characterised by nightmares about the accident and flashbacks and said that he relives the accident when he is stationary in his car. He has avoided talking about the accident as it distresses him and recalling the accident triggers more anxiety and agitation. His self-care deteriorated and he did not cook and ate less and lost over 20 kilograms in weight since the subject motor accident especially over the last seven to eight months. He was irritable and angry and easily frustrated which led to a breakup of his long-term relationship four months after the subject motor accident. He stated that he was not himself. He stopped socialising and has been socially isolated.

He has been provided a support worker to assist him with driving and housework and the support worker started driving him to see his psychiatrist, Dr Saker on the Central Coast. He reported being hypervigilant and nervous as a passenger in a car. He stopped all work including his handyman work and in selling eggs and his chicken had to be put down. He stopped going anywhere and his support worker takes him to appointments and for some shopping. He felt worthless. He has not been caring for himself such as not showering unless prompted or brushing his teeth.

...

12. Current symptoms

He continues to experience ongoing pain in his neck, back and shoulder.

He stated that he has not had any psychotic symptoms since they have been in remission on treatment with antipsychotic medication. He reported depressed mood, anergia, amotivation and anhedonia. His sleep is poor, and he does not derive any enjoyment. He is socially isolated. He is irritable and has had fleeting suicidal ideation. He continues to experience anxiety when in a car especially in traffic, nightmares and flashbacks. He reported that his symptoms have remained much the same without improvement.

...

CLINICAL EXAMINATION

14. Mental state examination

[The claimant] presented as unkempt and was malodorous. His grey beard was overgrown, and his hair was untidy. He was pleasant and cooperative. His mood was flat and depressed, and his affect was restricted. He was distressed about his current mental health. There was no formal thought disorder. He denied psychotic symptoms such as delusions and hallucinations. He would not elaborate on his suicidal thoughts but admitted to experiencing suicidal ideation and stated that he does not want to live. He had good memory and was able to give a clear history and maintained focus through the assessment.

15. Current functioning

He neglects his self-care and does not shower unless prompted. He does not brush his teeth. He stopped cooking and cleaning his house and receives ten hours a week of personal and domestic support from a support worker from the insurance company. The support worker helps with driving him, cooking and domestic tasks. He rarely leaves the house and stopped socialising. He avoids initiating contact with friends but has occasional contact with a friend of 40 years who contacts him. He has not visited his sister for over nine months. He does not engage in activities other than watching television, occasionally reading the Bible and using the Internet on his mobile phone. Support worker takes him to appointments and for some shopping.

16. Comments on consistency

Mr Patsalis' account of the accident and his symptoms were generally consistent with those reported during other psychiatric assessments. He has a longstanding psychiatric illness namely Schizophrenia and a number of incidents such as workers compensation and previous motor vehicle accident for which he has attended psychiatric assessments. I note there are different opinions and documentation of symptoms by different psychiatrists and psychologists. However, I did not find any major inconsistencies in his reporting.

REVIEW OF DOCUMENTATION

17. Summary of relevant documentation

I note a certificate by Assessor Samson Roberts dated 2 October 2014 in relation to [the claimant's] motor vehicle accident in April 2013. Dr Roberts determined that there was no psychiatric diagnosis related to the motor vehicle accident. (The insurer incorrectly notes that Dr Roberts' certificate relating to the 2013 accident documents that had assessed agoraphobic anxiety/depression/PTSD).

Treating psychiatrist since 2014, Dr Saker reports on 13 December 2022 significant decline in his function following his 2021 accident.

Dr Saker in his report dated 14 June 2022 addressed to NSW CTP claims notes that [the claimant] suffers from Major Depressive Disorder and Posttraumatic Stress Disorder related to his accident on 25 October 2021.

[The claimant] was seen by three different psychiatrists in 2023 for reports. They included three reports from Dr Kaplan dated 7 March 2023, 15 December 2023 and 10 January 2024 noting diagnosis of Post traumatic Stress Disorder and Major Depressive Disorder; Dr Dinnen on two occasions related to the motor vehicle accident on 23 February 2023 and 10 April 2024 who considered that [the claimant] had chronic Schizophrenia complicated by the development of PTSD, depressive disorder following the subject motor accident; Dr Clark assessed him for reports dated 10 May 2022 and 4 August 2023 and 24 November 2023 for assessment for the workers compensation claim with a finding of no impairment from work-related injury.

General practitioner, Dr Lina Aljumha notes [the claimant] had depressive symptoms in early 2024.

Report of Dr Sydney Oen dated 14 July 2024 Dr Oen was [the claimant's] previous treating psychiatrist from 2017 to 2020. He diagnosed chronic paranoid Schizophrenia in remission during the period that he looked after [the claimant] and states that there was no other psychiatric diagnosis.

Discharge summary from Toronto Private Hospital where [the claimant] was admitted under his psychiatrist, Dr Saker from 11 December 2023 to 22 December 2023 notes diagnoses of Schizophrenia, PTSD and Major Depressive Disorder.

Dr Saker reports on 17 July 2024 that [the claimant] developed new symptoms of insomnia, anxiety and PTSD following the subject motor accident whereas he has had Schizophrenia and depression before and that he has suffered worsening of depression following the subject motor accident.

DETERMINATIONS

18. Diagnosis and reasons

[The claimant] has a longstanding psychiatric history with a diagnosis of Schizophrenia in 2005 and had two psychiatric admissions for psychosis in 2005 and 2011. He did not have any further psychiatric admissions until after the subject motor accident and was well managed on antipsychotic medications.

He was involved in a minor motor vehicle accident in April 2013 but did not suffer a psychiatric injury as a result of that accident. He was assessed by Dr Samson Roberts for that motor accident claim who determined that there was no psychological injury related to the motor accident in April 2013. [The claimant] confirmed that he did not experience any mental health symptoms related to that accident and stated that the claim was submitted by lawyers.

He was working until 2012 when he left employment at Woolworths warehouse and submitted a workers compensation claim in relation to bullying and harassment ten years later in 2022 after advice from a solicitor. He stated that the claim was for exacerbation of Schizophrenia. [The claimant] denied having suffered from depression or having been prescribed antidepressant medication prior to the subject motor accident.

Based on [the claimant's] history and on mental state examination, it is my opinion that he developed Major Depressive Disorder and Posttraumatic Stress Disorder (PTSD) following the subject motor accident. Although his vehicle was not significantly damaged during the subject motor accident [the claimant] stated that his towbar took the brunt of the impact thus not damaging the body of his car and he felt that he was quite shocked and disoriented and felt that it was potentially a life-threatening accident. Therefore, his perception of the accident fulfils Criterion A for a DSM-5 diagnosis of PTSD. He fulfils Criterion B by intrusion symptoms including nightmares and flashbacks. He experiences intense or prolonged psychological distress from exposure to internal or external cues that symbolise or represent an aspect of the traumatic events in that he avoids talking about the accident and recalling the accident causes him distress with marked anxiety. His condition fulfils Criterion C in that he has avoided driving and avoids the accident site. He avoids distressing memories, thoughts or feelings about the accident by avoiding talking to people about the accident. He has had negative alterations in cognitions with negative beliefs about himself, fear, anger, loss of interest in significant activities and feeling detached from others. He has not been able to experience positive emotions thus fulfilling Criterion D. He fulfils Criterion E in that he has had alterations in arousal and reactivity associated with irritable mood, anger, hypervigilance, exaggerated startle response and sleep disturbance as well as problems with concentration. The duration of disturbance has been more than one month thus fulfilling Criterion F. His condition causes clinically significant distress and impairment in social, occupational and other important areas of functioning thus fulfilling Criterion G. His condition is not attributable to the physiological effects of a substance or another medical condition.

[The claimant] also suffers from Major Depressive Disorder. He reported onset of significant depressive mood following the subject motor accident with depressed mood, irritability, anhedonia, anergia, amotivation, feelings of worthlessness, significant weight loss, insomnia, and suicidal ideation including suicide attempts. He therefore fulfils a DSM-5 diagnostic criteria of Major Depressive Disorder.

19. Causation and reasons

[The claimant] did not have a prior history of Post traumatic Stress Disorder. Whilst the presence of depressive symptoms prior to the subject motor accident is unclear, his history does not indicate presence of Major Depressive Disorder prior to the subject motor accident, and he stated that he had not been prescribed antidepressant medication prior to the subject motor accident. Therefore, it is my opinion that both his depressive disorder and PTSD are causally related to the subject motor accident.

Summary of injuries referred by the parties

20. The following injuries WERE caused by the motor accident:

Posttraumatic Stress Disorder

Major Depressive Disorder”

The Medical Assessor assessed 28% current WPI and 5% pre-existing impairment, resulting in a total of 23% WPI caused by the motor accident.

The review of the Medical Assessor’s Decision by the Delegate

On 21 November 2024, the insurer applied for review of the Medical Assessor’s decision, pursuant to s 7.26 of the MAI Act.

On 16 January 2025, the Delegate, Kenneth Ho, dismissed the insurer’s application for review of the Medical Assessor’s Decision. I will again refer to the Delegate’s decision later in this Judgment when considering judicial grounds 7 to 10.

The Delegate’s reasons for his decision are as follows:

“REASONS

Failure to adequately consider the relevant material and provide sufficient reasons

8. The insurer refers to portions of the medical assessor's certificate wherein the medical assessor has taken and reported on the claimant's history.

9. The insurer submits that medical evidence in the medical assessment proceedings before Medical Assessor [...] contain history which was different to that history reported by the medical assessor, and that a proper consideration of the inconsistent history would "warrant significantly more analysis and comment than those contained in the [medical] assessor's certificate."
10. The insurer points to inconsistent reporting of work history, social history, and medical history.
11. Medical Assessor [...] obtained a history from the claimant and of the claimant, including of his work history, social history, and work history.
12. The medical assessor identified that "[the claimant] has a longstanding psychiatric history with a diagnosis of Schizophrenia in 2005 and had two psychiatric admissions for psychosis in 2005 and 2011."
13. The medical assessor addressed the claimant's history of Schizophrenia throughout her certificate and found that: "He did not have any further psychiatric admissions until after the subject motor accident and was well managed on antipsychotic medications."
14. Medical Assessor [...] reported that the claimant " ... stated that his previous psychiatric history only related to his psychotic symptoms, and he did not previously suffer from Major Depressive Disorder even if he had depressive symptoms related to his psychosis from time to time."
15. The medical assessor considered the relevant documents before her including the documents referred to by the insurer, including the reports of Dr Saker, Dr Kaplan, Dr Clarke, and Dr Dinnen.
16. In relation to consistency, Medical Assessor [...] found the following:

"[The claimant's] account of the accident and his symptoms were generally consistent with those reported during other psychiatric assessments. He has a longstanding psychiatric illness namely Schizophrenia and a number of incidents such as workers compensation and previous motor vehicle accident for which he has attended psychiatric assessments. I note there are different opinions and documentation of symptoms by different psychiatrists and psychologists. However, I did not find any major inconsistencies in his reporting."
17. It is evident that the medical assessor was aware of and considered the submission made with respect to the different medical opinions and inconsistencies. Medical Assessor [...] did not find any major inconsistencies in his reporting.

18. It was recognised by the majority in *Minister for Immigration & Ethnic Affairs v Wu Shan Liang* [1996] HCA 6 at [31], that " ... the reasons of an administrative decision-maker are meant to inform and not to be scrutinised upon over-zealous judicial review by seeking to discern whether some inadequacy may be gleaned from the way in which the reasons are expressed."
19. At subheading 17 of the certificate, Medical Assessor [...] provided a summary of the relevant documentation. The medical assessor noted the claimant's longstanding schizophrenia and mental health issues.
20. At subheading 19, Medical Assessor [...] reported the following:

"[The claimant] did not have a prior history of Post traumatic Stress Disorder. Whilst the presence of depressive symptoms prior to the subject motor accident is unclear, his history does not indicate presence of Major Depressive Disorder prior to the subject motor accident, and he stated that he had not been prescribed antidepressant medication prior to the subject motor accident. Therefore, it is my opinion that both his depressive disorder and PTSD are causally related to the subject motor accident."
21. In *Insurance Australia Ltd v Marsh* [2022] NSWCA 31, Basten JA (Macfarlan JA agreeing) held at [11] that "... the function of a medical assessor is to form his or her own opinion on the medical question in dispute; it is not to choose between competing opinions, nor to assess the correctness of such opinions. As the High Court concluded, with respect to a medical panel: "The function is in every case to form and to give its own opinion on the medical question referred to it by applying its own medical experience and its own medical expertise."
22. A Medical Assessor is required to set out in the statement of reasons the "actual path of reasoning" by which the Medical Assessor arrived at the opinion that he or she formed. They are under no obligation to explain why it did not reach an opinion it did not form, even if that different opinion is shown by material before it to have been formed by someone else. *Wingfoot Australia Partners Pty Ltd v Kocak* [2013] HCA 43
23. Medical Assessor [...] provided an adequate path of reasons for the findings which were made. The medical formed her own opinion after a consideration of the relevant documents before her.
24. I am not satisfied that there is a reasonable cause to suspect that the medical assessment is incorrect in a material respect based on the insurer's submission that the medical assessor failed to adequately consider the relevant material and provide sufficient reasons.

Error in respect to criterion A for a DSM-5 diagnosis of PTSD

25. The insurer submits that the medical assessment contains an error with respect to a finding made to the diagnostic criteria for posttraumatic stress disorder, specifically criterion A.

26. The insurer submits that "the reference to the claimant's perception of the accident as being sufficient to fulfil criterion A represents a mis-application of the DSM-5.
27. The insurer makes the following further submissions:

"38. It is the insurer's submission that the mere fact that a person feels 'shock and disorientated' following an accident is not sufficient to make the accident a criterion A event. Nor is the subjective feeling of the claimant that the accident was a potentially life-threatening accident sufficient to fulfil the criterion when the objective circumstances do not meet the requirement for actual or threatened death or serious injury.
39. The insurer submits there is a 'baseline' level of objective events that can fulfil criterion A and that, although minds may differ as to where that baseline is, such baseline is the realm of the psychiatrist in exercising their clinical expertise and judgement, not the claimant in their subjective perception or recollection."
28. Medical Assessor [...] relevantly found at subheading 18 the following:

"Although his vehicle was not significantly damaged during the subject motor accident [the claimant] stated that his towbar took the brunt of the impact thus not damaging the body of his car and he felt that he was quite shocked and disorientated and felt that it was potentially a life-threatening accident. Therefore, his perception of the accident fulfils Criterion A for a DSM-5 diagnosis of PTSD."
29. Criterion A will be satisfied if there is exposure to threatened death or serious injury. The medical assessor found that the claimant felt it was "potentially a life-threatening accident."
30. Accordingly, Medical Assessor [...] found that criterion A was satisfied.
31. The claimant refers to *Gonzalez v Allianz Australia Insurance Ltd* [2016] NSWSC 1549. At [52] Beech-Jones J held in part that:

"... it suffices to state that from the beginning to the end of the medical assessment whether or not a claimant satisfied the criteria for a recognisable psychiatric disorder and should be diagnosed as suffering from any such disorder was a matter of clinical judgment, exclusively for a medically qualified assessor to undertake. Most significantly it was solely a question of fact for the Assessor. This is especially the case for any assessment as to whether a particular event was sufficiently traumatic enough to have caused PTSD."
32. Medical Assessor [...] found that the claimant satisfied the diagnostic criteria for a diagnosis of PTSD. The medical assessor provided her reasons for making this finding as set out in the certificate.
33. The medical assessor set out a history of the motor accident at subheading 9 and references the nature of the motor accident in her reasoning.
34. The medical assessor exercised her clinical experience and clinical judgment and considered the relevant history and documents before her.

35. I am not satisfied that there is a reasonable cause to suspect that the medical assessment is incorrect in a material respect based on the insurer's submission that the medical assessment contains an error with respect to the consideration of criterion A in relation to a diagnosis of posttraumatic stress disorder in accordance with the DSM-5-TR.

DETERMINATION

36. I have considered the particulars set out in the claimant's application both separately and together, and I am not satisfied that there is a reasonable cause to suspect that the medical assessment is incorrect in a material respect.
37. The application will not be referred to a Review Panel."

Application by the insurer for the decision to be remade

On 5 February 2025, the insurer applied for the decision to be re-made pursuant to Minister for Immigration and Multicultural Affairs v Bhardwaj (2002) 209 CLR 597; [2002] HCA 11 ("the Bhardwaj application"). On 28 March 2025, the Delegate declined to re-make the decision. There is no challenge to this decision so I need not refer to this decision again.

The Law

The authorities which follow are those raised by the parties.

In Minister for Immigration & Ethnic Affairs v Wu Shan Liang (1996) 185 CLR 259; [1996] HCA 6 (Wu Shan Liang), Brennan CJ, Toohey, McHugh and Gummow JJ said at [30]: "The reasons for the decision under review are not to be construed minutely and finely with an eye keenly attuned to the perception of error". The Delegate referred to this authority in his reasons.

In Wingfoot Australia Partners Pty Limited v Kocak (2013) 252 CLR 480; [2013] HCA 43 (Wingfoot), the High Court said at [47]:

"[47]... It goes too far, however to conceive of the function of the Panel as being either to decide a dispute or to make up its mind by reference to competing contentions or competing medical opinions. The function of a Medical Panel is neither arbitral nor adjudicative: it is neither to choose between competing arguments nor to opine on the correctness of other opinions on that medical question. The function is in every case to form and to give its own opinion on the medical question referred to it by applying its own medical experience and its own medical expertise."

Both parties cited Dranichnikov v Minister for Immigration and Multicultural Affairs (2003) 77 ALJR 1088; [2003] HCA 26 (Dranichnikov) where Gummow and Callinan JJ held at [24] and Kirby J held at [81] and [88].

"[24] To fail to respond to a substantial, clearly articulated argument relying upon established facts was at least to fail to accord Mr Dranichnikov natural justice. A failure to accord natural justice did not provide a statutory basis for a review of a decision of the Tribunal.

...

[81] No express provision appeared in s 476(1) of the Act to afford a ground for judicial review on the footing of a failure of a person, purporting to make a decision, to exercise that person's jurisdiction and power as the Act provided. In a case such as the present, to afford relief, it would be necessary to construe broadly the grounds that appeared in s 476(1) of the Act, perhaps beyond their apparent purpose.

...

[88] Obviously, it is not every mistake in understanding the facts, in applying the law and reasoning to a conclusion that will amount to a constructive failure to exercise jurisdiction. But where, as here, the mistake is essentially definitional and amount to a basic misunderstanding of the case brought by the Applicant, the resulting flaw is so serious as to undermine the lawfulness of the decision in question in a fundamental way.”

...”

The Medical Assessor had a duty to respond to the substance of the insurer’s argument and a failure to do so would be a constructive failure to exercise jurisdiction, and a denial of procedural fairness: *Allianz Australia Insurance Ltd v Cervantes* [2012] NSWCA 244 (Cervantes), per Basten JA at [19]-[20]; *Dranichikov* per Gummow and Callinan JJ at [24] and Kirby J at [81]. It would not suffice to set out competing submissions when there is then no consideration of the substantial and clearly articulated argument: *Zilic v QBE Insurance (Australia) Ltd* [2025] NSWSC 11 (Zilic) at [50]-[51], [55] per McNaughten J.

In *Rodger v De Gelder* (2015) 71 MVR 514; [2015] NSWCA 211 (*Rodger v De Gelder*), the Court of Appeal held that the review panel in that case had failed to respond to a substantial argument raised by the claimant.

In *Insurance Australia Group Ltd t/as NRMA Insurance v Keen* [2021] NSWCA 287 (Keen) at [38] – [42], it was emphasised that the role of a medical assessor is quite different to the role of a Court, and that Wingfoot at [47] makes it clear that the role of the panel is not to decide disputes or make up its mind by reference to competing contentions. However, the Medical Assessor had a duty to afford procedural fairness (per Wingfoot at [47]), and the Court has many times confirmed that the duty includes a duty to respond to a substantial and clearly articulated argument based on established facts.

As noted above, that was stated unanimously by the Court of Appeal in *Rodger v De Gelder* (that specifically considered Wingfoot and was not said to have been decided incorrectly in Keen) and has been re-stated many times since (e.g. *Oeding-Erdel v Allianz Australia Insurance Limited* [2021] NSWSC 1264, and *Lederer v Insurance Australia Limited trading as NRMA Insurance* [2022] NSWSC 322 (Lederer)).

In *Insurance Australia Limited t/as NRMA Insurance v Momand* [2024] NSWSC 1529 (Momand), Price AJ referred to a number of authorities and then said at [87]:

“[87] None of these cases suggest that when a substantial and clearly articulated argument is advanced, the medical assessor is not bound to consider the argument.”

Judicial review grounds 1 and 2

The insurer has dealt with judicial review grounds 1 and 2 together. I will do the same.

The insurer’s submissions (ground 1)

The Medical Assessor failed to respond to the substance of the insurer’s argument. She did not engage with the substance of the argument regarding the substantial inconsistencies in reporting at all. The Medical Assessor failed to respond to the submission that the evidence showed that the claimant was reporting that the nature and cause of his impairment was related to the motor accident, for the purposes of the motor accident claim, but reporting that the nature and cause of his impairment was related to the 2012 work injury, for the purposes of his workers compensation claim.

The report of Dr Dinnen that was prepared for the workers compensation insurer, which recorded substantially different symptoms said to arise from the work injury in 2012, and assessed WPI arising from the work injury at 21%, was not even mentioned by the Medical Assessor. The claimant’s self-reporting was accepted even when fundamentally at odds with the other evidence, as outlined above. The Medical Assessor did not explain how the evidence that the claimant currently had very substantial impairment arising from the pre-existing and unrelated psychiatric condition factored into her decision-making process regarding current impairment.

To say that there were no major inconsistencies in reporting, in the face of such significant inconsistencies, was no response to the argument that was made. Even if the claimant’s pre-accident records suggested his schizophrenic condition was well managed prior to the accident (as suggested by Dr Oen), that issue went only to the extent of preexisting impairment. The Medical Assessor was required to assess the current condition (cl 6.21 of the Guidelines) including assessing the cause of the current diagnoses and impairment, before considering a deduction for pre-existing impairment (cl 6.31). The claimant had made statements and reported to doctors, in his workers compensation claim, that his pre-existing condition of schizophrenia, aggravated by his work injury and not by the motor accident, was now substantially affecting him and was a cause of major impairment. The Medical Assessor failed to deal with these issues.

The insurer had identified that the claimant reported that he had not worked and had no social life since 2012, and that this was inconsistent with his reporting in his motor accident claim. These were matters that were critical to the assessment under the Psychiatric Impairment Rating Scale in the Guidelines (specifically to three of the six classes – social and recreational activities, social functioning and adaptation). The Medical Assessor simply accepted the claimant’s self-reporting as to his pre- and post-accident functioning and did not respond to the argument regarding the inconsistencies.

In Momand, Price AJA stated at [89]-[92]:

“[89] In the present case, there was more than one conclusion open to the medical assessor. He was required to consider the plaintiff’s argument that the motor vehicle accident was minor and the diagnosis of PTSD was not consistent with Criterion A in DSM-5 as the defendant had not been exposed to actual or threatened death or serious injury by directly experiencing the traumatic event of a severe motor vehicle accident. This was a fundamental consideration before a diagnosis of PTSD could be made.

[90] The medical assessor was required to set out the actual path of reasoning by which he arrived at his conclusion that the defendant’s diagnosis of PTSD “was caused by the subject MVA as it was a significant accident where [the defendant] was exposed to death” (see [30] above).

[91] The medical assessor was obliged to give some explanation as to why he accepted from the defendant that he was impacted from the rear at a speed of 80 km/h, which resulted in his head being smashed into the window (see [29] above) in preference to the plaintiff’s argument. The defendant’s account did not sit happily with the minor damage to both vehicles.

[92] The medical assessor’s reasons for issuing the MAC neither provide his actual path of reasoning nor any explanation as to why he accepted what had been said by the defendant. It was not sufficient for the medical assessor to simply refer to the McIntosh Report as being included in the list of documents central to his submission. The inadequacy of the medical assessor’s reasons demonstrate that the medical assessor failed to give a proper and genuine consideration to the plaintiff’s argument.”

The insurer here made an argument almost identical to that in Momand regarding the accident being of insufficient severity to satisfy the criteria for PTSD. The Medical Assessor was required to give proper and genuine consideration to the plaintiff’s argument and respond to it. She failed to do so. The failure to respond to the substance of the insurer’s argument was a constructive failure to exercise jurisdiction and a denial of procedural fairness.

The insurer referred to Insurance Australia Limited t/as NRMA Insurance v Warren [2019] NSWSC 1126, where I stated at [68]:

“[68] The question for this Court is whether or not the assessor’s reference to ‘the documentation provided’ constitutes a response to the insurer’s argument that Mr Warren’s cervical spine injury, at least in part, pre-dated the subject accident. It is my view that it does not. Although the medical assessor’s reasons refer to the reports of Mr Warren’s treating practitioners after the accident, the medical assessor has failed to engage with the arguments advanced by the insurer that Mr Warren had a documented history of prior injury to the cervical spine. This was a substantial argument based upon evidence and was material the assessor’s determination. This failure to respond is a failure to accord procedural fairness and constitutes a constructive failure to exercise jurisdiction and an error of law.”

The insurer submitted that in the present case, the Medical Assessor's reference to documentation provided does not constitute a response to the insurer's argument.

The claimant's submissions (ground 1)

In its submissions to the Medical Assessor the insurer stated in paras [50] and [51]:

"[50] The Insurer submits that there are credit issues highlighted above in respect to his pursuit of a claim for psychiatric injury in respect to his alleged 2012 workplace injury that is grossly inconsistent with his pursuit (sic) claim for psychiatric injury in respect to the subject accident. There are also inaccuracies in respect to the continuation of his physical symptoms in the cervical and lumbar spine following the earlier motor accident. These issues have rendered the opinions expressed by various experts to be of limited utility.

[51] The Insurer submits that whether the issues go to the Claimant's credit or the accuracy of his recollection, the Assessor should treat any self-reporting with some caution instead prefer the evidence contained in contemporaneous records where they are available, or at least where they are not contradicted with other contemporaneous records."

The claimant submitted that this is in fact what the Medical Assessor did. The history she obtained accorded with contemporaneous records. In her Decision, she noted that:

In 2005 the claimant suffered acute psychosis and had 10 days psychiatric admission.

After 4 months medication he was well and worked as a handyman until 2011 when he had a relapse.

He worked for Woolworths from February to July 2012 where due to bullying he suffered an exacerbation of schizophrenia.

Since 2013 he worked as a handyman doing odd jobs such as gardening and painting and selling eggs.

He was placed on anti-psychotic medication from 2011 to 2014.

He claimed his mental state was stable and he led a "normal life" until the subject accident in 2021.

His previous motor vehicle accident in April 2013 did not result in any change in his mental state.

The claimant submitted that the history the Medical Assessor obtained is corroborated by contemporaneous records namely:

Clinical records Bankstown Medical Health Records as to the claimant's admission in 2005 and 2011.

Clinical records of Dr Wong.

Clinical records of Dr Saker.

Report Dr Sydney Oen.

Bankstown Family Practice records Dr Chan.

Clinical records Dr Aljhuma.

The insurer's submissions to the Medical Assessor did not ask her to reconcile conflicting records, nor form any particular view with respect to the records, but to consider and refer to the contemporaneous material in resolving the matter.

The claimant submitted that Momand involved a case where the plaintiff was diagnosed with a psychiatric condition in circumstances where there was a dispute as to the severity of the impact of the collision. Ultimately it was found that (based on the evidence of a traffic reconstruction engineer) the plaintiff's speed was much lower than what he claimed and that the Medical Assessor had disregarded this vital evidence which included evidence of damage to the vehicles, the safety features of the plaintiff's vehicle and the lack of physical injuries by the plaintiff.

While the claimant conceded that there are significant inconsistencies between the two reports of Dr Dinnen dated 21 February 2023, he submitted that the Medical Assessor based her decision on the contemporaneous medical material rather than Dr Dinnen's reports.

The Medical Assessor did consider the claimant's prior psychiatric condition in assessing his impairment and made a deduction of 5%. Dr Dinnen in his report dated 10 April 2024 regarding the motor vehicle accident does take a history of the workplace injury at Woolworths in 2012 and that he worked after his injury at Woolworths. Dr Dinnen was fully appraised of the effects of the work injury as he had considered it in his prior report dated 23 February 2023.

What the insurer put to the Medical Assessor in its submissions was not "a substantial clearly articulated argument" relying on established facts, but rather inconsistencies in one report, namely that of Dr Dinnen in his report dated 20 October 2023. The Medical Assessor based her decision on contemporaneous medical records and the history given to her by the claimant. The Medical Assessor provided a path of reasoning which sufficiently demonstrated the route taken to coming to her finding and decision.

The Medical Assessor considered the substance of the submissions. She expressly stated that she reviewed and considered the material before her including the submissions made by the insurer.

The Medical Assessor also considered the question of the consistency of the claimant's account. She formed the view that it was generally consistent with those reported during other psychiatric assessments. She expressly referred to the different opinions and documentation of symptoms by different psychiatrists but did not find any major inconsistencies. That finding is sufficient to have disposed of the submission based upon the argument that there was inconsistency in reporting to Dr Dinnen.

In any event the submission had no true merit. Dr Dinnen had assessed the claimant both in respect of the claimed work injury and the injury from the motor vehicle accident. He found in his report dated 23 February 2023 that the work injury was an aggravation of chronic schizophrenia. The motor vehicle accident had caused PTSD and major depressive disorder. It is the claimed inconsistent reporting to Dr Dinnen that formed the basis for the insurer's submissions.

The Medical Assessor returned to the question of the other medical opinions referred to earlier in the claimant's submissions. The Medical Assessor discussed and considered the medical material provided to her. While she says that Dr Oen confirmed the pre-existing chronic paranoid schizophrenia was in remission from 2017 to 2021, she refers to the reports of Dr Dinnen dated 23 February 2023 and 10 April 2024. She says that the reports are related to the motor vehicle accident it is apparent that the report dated 23 February 2023 was obtained in support of the claim for the work-related injury. It is related to the motor vehicle accident in that it informs the opinion contained in the later report to the effect that the motor vehicle accident caused a psychological injury that was different to the pre-existing chronic schizophrenia. In his report of 10 April 2024 Dr Dinnen refers to the earlier report and says that the 2 reports should be read in conjunction.

The determination at [18] of the Medical Assessor's Decision refers to the various matters including that the work claim was for aggravation of schizophrenia and that there were no depressive symptoms prior to the motor vehicle accident.

The insurer's submissions in reply (ground 1)

The utility of the submissions in reply is to clarify issues. The claimant submitted that that the history obtained by the Medical Assessor accords with contemporaneous records. Even if some of the history taken by the Medical Assessor is consistent with some contemporaneous records, it does not address the insurer's argument regarding the inconsistent reporting by the claimant. The Medical Assessor failed to respond to the submission that the evidence showed that the claimant was reporting that the nature and cause of his impairment was related to the motor accident, for the purposes of the motor accident claim, but simultaneously and conflictingly reporting that the nature and cause of his impairment was related to the 2012 work injury, for the purposes of his workers compensation claim.

The claimant in his submissions sets out a list of evidence that is said to be consistent with the history obtained by the Medical Assessor, but it is not clear which parts of the evidence are said to be consistent. In fact, the evidence that the claimant relies upon is inconsistent with the history obtained by the Medical Assessor in significant respects. For instance, Dr Saker recorded on 20 August 2019 that the claimant had last worked in 2011. On 3 February 2021, Dr Saker recorded that the claimant was paranoid and leaving the house much less and he was socially withdrawn. This does not support the claimant's submission that these records are consistent with the history obtained by the Medical Assessor, noting that the claimant told the Medical Assessor that since 2013 he had worked as a handyman and selling fresh eggs and that he was

trying to build up his business prior to the accident and that prior to the accident he maintained a social network. These matters pertaining to the claimant's pre-accident functioning were critically important to the assessment of several categories of impairment in the Psychiatric Impairment Rating Scale in the Guidelines.

The inconsistencies in the two reports of Dr Dinnen were not the sole basis for the insurer's argument. There were numerous other inconsistencies, as outlined in the insurer's submissions, including reports to Dr Clarke, the early post-accident records of Dr Wong referring to workplace issues rather than the motor accident, the pre-accident records of Dr Saker that showed significant pre-accident symptoms, and the claimant's own statement in his workers compensation claim.

The claimant conceded that there are "significant inconsistencies" between the two reports of Dr Dinnen but suggests that the Medical Assessor did not rely on these reports and instead based her decision on contemporaneous material. Somewhat inconsistently, the claimant also accepts that the Medical Assessor based her assessment on the history given by the claimant. That identifies the problem. The self-reporting by the claimant was inconsistent, both in between the differing versions he had given to various doctors and with the contemporaneous evidence in significant respects.

It does not suffice to set out competing submissions when there is then no consideration of or response to the substantial clearly articulated argument: Zilic at [50]-[51], [55] (McNaughten J).

The claimant submitted that the Medical Assessor lawfully disposed of the argument relating to inconsistent reporting to Dr Dinnen by finding that the claimant's reports had been "generally consistent". This does not respond to the substance of the argument at all, given that in one report Dr Dinnen had assessed current WPI at 21% due to the work injury but in another report assessed current WPI arising from the motor accident at 22% with no deduction for any pre-existing condition. A finding that these two reports are consistent is not only non-responsive to the argument but is incoherent (which goes to the reasons ground – Ground 2).

The Medical Assessor was required to assess the claimant's current condition (cl 6.21 of the Guidelines) including assessing the cause of the current diagnoses and all current impairment, before considering a deduction for pre-existing impairment (cl 6.31) and if necessary subsequent impairment (cl 6.34). The process was recently described by Garling J in *Buestami v Allianz Australia Finance Ltd* [2025] NSWSC 465 (Buestami) at [23]-[27].

The Medical Assessor must assess all current impairment and only after that has occurred is there a consideration of whether some of that impairment must be deducted as being pre-existing or subsequent to the motor accident. It is not lawful to simply exclude part of current impairment from the assessment (for instance, if there are two conditions presenting, and only one is caused by the subject motor accident, the Medical Assessor cannot just assess one condition and disregard impairment caused by the other). An error of this kind was addressed by Garling J in *Buestami* as follows at [29]-[31]:

“[29] First, contrary to the obligation in cl 1.21 of the Guidelines, the Review Panel at no time determined the extent of the whole person impairment as it existed at the time of their assessment. Secondly, at no time, as required by cl 1.34 of the Guidelines, did the Review Panel determine the whole person impairment relating to the subsequent event, namely, the unrelated event of a dog bite; nor did it then undertake a calculation which reflected the obligations in the Guidelines...”

- [30] Rather, in a convoluted way, contrary to that provided in the Guidelines, the Review Panel sought to “set aside”, to use its terms, any impairment related to the subsequent dog bite event because the Review Panel concluded that the adjustment disorder which it diagnosed as relating to that event was wholly unrelated to the motor vehicle accident.
- [31] Accordingly, the result produced by the Review Panel was not an assessment which accorded with either of the requirements of the Guidelines. It clearly mistook its obligation, and it has produced a Certificate which does not reflect the jurisdiction which it is obliged to exercise. It is erroneous at law, and it constitutes a failure to properly exercise its jurisdiction.”

This explains why the claimant’s submission is misconceived when it suggests that it was acceptable for Dr Dinnen to prepare two separate assessments of current impairment based on two conditions arising from different causes, which (it must be inferred) required him to “set aside” the impairment caused by one condition when assessing the other. The Guidelines do not permit that approach. If the work injury (aggravation of schizophrenia) currently gave rise to 21% WPI, it necessitated consideration of a deduction under either the pre-existing impairment or subsequent impairment clauses (if it was impairment that had evolved postaccident due to an unrelated condition). It could not be disregarded.

Ultimately, there were numerous inconsistencies in the insurer’s reporting and the evidence in many important respects, as set out in the claimant’s submissions. The Medical Assessor did not give proper and genuine consideration to the insurer’s argument, nor respond to it, as was required.

These submissions are considered together with those in judicial ground 2.

The insurer’s submissions (ground 2)

The Medical Assessor was required by section 7.23(7) of the MAI Act to provide reasons for her decision which explain “the actual path of reasoning in sufficient detail to enable the Court to see whether the opinion does or does not involve error of law”: Wingfoot at [55].

The scope of the medical question referred to the panel is a question of fact in each case, dependant on the actual dispute between the parties. The nature of the reasons required depends on the scope of the dispute. In Insurance Australia Limited trading as NRMA Insurance v Brown (2019) 89 MVR 508; [2019] NSWSC 1236 Button J said at [72]:

“[72] What are adequate reasons must be seen in many contexts, and must almost always be judged in accordance with the matters that have been placed in dispute by the parties before that decision-maker.”

While reasons may be sufficient if a gap in the reasons can be filled by necessary inference, gaps in the reasons cannot be filled by an assumption that the decision was made according to law: *Zahed v IAG Limited t/as NRMA Insurance* (2016) 75 MVR 1; [2016] NSWCA 55 at [6]. In *Della Bruna v Health Care Complaints Commission* [2025] NSWCA 105 the Court of Appeal said at [15]-[16]:

“[15] Consistently with approaching the task in a sensible and balanced way, a beneficial approach to reasons does not demand that any ambiguity be resolved in favour of the decisionmaker: see SZCBT v Minister for Immigration and Multicultural Affairs [2007] FCA 9 at [26] (Stone J); approved eg Communications, Electrical, Electronic, Energy, Information, Postal, Plumbing and Allied Services Union v Abigroup Contractors Pty Ltd [2013] FCAFC 148 at [190]; Allianz Australia Insurance Ltd v Rutland [2015] NSWCA 328; (2015) 73 MVR 211 at [26]; Minister for Home Affairs v Ogawa (2019) 269 FCR 536; [2019] FCAFC 98 at [116].

[16] The Court’s review of the reasons of a decision-maker should not proceed in a manner inclined to finding error. But that does not mean the Court must strive to read the reasons in such a way as to avoid the conclusion of error. For example, it is not for the Court to fill gaps in reasons by speculating about what further unarticulated considerations, if any, lie behind what the decision-maker said. The Court’s duty is to read the reasons fairly and as a whole, making due allowance (where relevant) for the fact that the authors are not lawyers accustomed to writing in a legal manner.”

The Medical Assessor failed to expose her actual path of reasoning for the diagnosis, findings on causation, and assessment of impairment.

As to diagnosis, the Medical Assessor failed to explain why the criteria for PTSD were satisfied, in circumstances where the insurer relied on evidence that criterion A for the diagnosis under the DSM-5 was not met. This is further addressed in ground 6.

As to causation, the Medical Assessor failed to explain why the claimant’s current symptoms and impairment were caused by the motor accident, in circumstances where he had significant symptoms prior to the accident as outlined in the insurer’s submissions, and where he was recorded (both in his own statement and by other doctors) as complaining that his post-accident symptoms related to other causes.

When assessing impairment, the Medical Assessor failed to explain why she accepted the claimant’s self-reporting of pre- and post-accident impairment when it was inconsistent with the evidence before the Medical Assessor.

The failure to provide reasons that expose the actual path of reasoning on the medical question referred is an error of law on the face of the record.

The claimant’s submissions (ground 2)

The claimant submitted that the Medical Assessor did provide reasons exposing the actual path of reasoning on the medical question, namely that:

The Medical Assessor obtained the claimant's history.

The Medical Assessor recorded that the history she obtained was corroborated by contemporaneous records.

The Medical Assessor based her decision on the contemporaneous medical material rather than Dr Dinnen's reports.

The Medical Assessor took into account the claimant's existing psychiatric condition in assessing his impairment and made a deduction of 5%.

In *Bradley v IAG t/as NRMA Insurance Limited* [2020] NSWSC 792, Ierace J said at [55]:

"[55] The parties accept that this standard is qualified by the circumstances delineated in *Campbelltown City Council v Vegan* [2006] NSWCA 284. In that case Basten JA (Handley and McColl JJA agreeing) said:

"[121] Where it is necessary for the Panel to make findings of primary fact, in order to reach a particular conclusion as to the existence, nature and extent of any physical impairment, it may be expected that the findings of material facts will be set out in its reasons. Where facts are in dispute, it may be necessary to refer to evidence or other material on which findings are based, but the extent to which this is necessary will vary from case to case. More importantly where more than one conclusion is open, it will be necessary for the Panel to give some explanation of its preference for one conclusion over another...

[122] On the other hand, to fulfil a minimum legal standard, the reasons need not be extensive or provide detailed explanation of the criteria applied by a medical specialist in reaching a professional judgment: see *Soulemезis v Dudley (Holdings) Pty Limited* (1987) 10 NSWLR 247 (at 273-274) (Mahoney JA) and (at 281-282) (McHugh JA). At least, that will be so where the medical science is not controversial: if it is, a more expansive explanation may be required."

In *Cervantes*, Basten JA said at [22]:

"[22] The second point is that neither *Dranichnikov* nor *Miah* went so far as to imply an obligation to consider every piece of evidence presented. Further, to refer to a report, but not to a particular passage in the report, may indicate an implicit preference for some other material which (in the absence of any no evidence ground) must be accepted as existing to support a particular conclusion. Such a course cannot constitute a failure to take into account a relevant consideration nor a failure to respond to a substantial argument: *Minister for Immigration and Citizenship v SZJSS* [2010] HCA 48 at [35]."

By taking a detailed history of the claimant's psychiatric condition from 2005 to date and from relying on contemporaneous documents the Medical Assessor did provide a path of reasoning for her decision.

The Medical Assessor also considered the opinions of all qualified psychiatrists and noted there were different opinions.

By accepting that the claimant suffered PTSD after the accident in the face of some contrary evidence, this does not constitute a failure to take into account a relevant consideration.

The Medical Assessor set out the matters taken into account. She considered the medical material and explained what she thought was relevant from that material.

The path of reasoning is fully set out. The claimant had a pre-existing schizophrenia but developed depressive symptoms which justified the diagnoses of post traumatic stress disorder and major depressive disorder as a result of the motor vehicle accident. This conclusion is consistent with the opinions of Dr Dinnen and Dr Kaplan. There was no medical opinion to the contrary.

In the circumstances the Medical Assessor has complied with the obligation to give reasons.

The insurer's submissions in reply that are somewhat repetitive. They do not add an issue of substance.

Resolution

Failure to respond to clearly articulated argument (ground 1)

The claimant's psychiatric condition is far from straightforward. It is complex. It was common ground between the medical specialists that the claimant had pre-existing schizophrenia that varied in severity from time to time. The 2012 incident exacerbated his schizophrenia.

I accept that when a Medical Assessor set out the documents that they have considered, it can be just a formulative list but that is not sufficient. The Medical Assessor is obliged to go further to articulate how the relevant documents were analysed. The reasoning may be brief but succinct.

The various doctors' reports largely contained similar diagnoses. The Medical Assessor set out the documentation she reviewed, and in particular noted that that Drs Kaplan, Dinnen and Saker each diagnosed major depressive disorder and post-traumatic stress disorder as a result of the accident. The claimant's general practitioner, Dr Aljumha also noted depressive symptoms in early 2024.

I am of the opinion that the Medical Assessor did sufficiently address and articulate how she analysed the relevant documents. She set out the inconsistencies between the medical reports as raised by the insurer. She noted that the claimant's account was "generally consistent with those reported during other psychiatric assessments" and said "I note there are different opinions and documentation of symptoms by different psychiatrists and psychologists. However, I did not find any major inconsistencies in [the claimant's] reporting."

As a psychiatrist, the Medical Assessor had direct experience with note writing and the capacity, in the normal course of affairs, for different medical reports to be in variance with one another. Her primary obligation was to make an independent determination of the claimant's medical condition.

On proper construction of her statutory duty, she was obliged to consider a clearly formulated argument. Meanwhile, she was not obliged to accept any such argument. It was open to her with the benefit of her medical knowledge and experience to reject the argument on the basis that the identified inconsistencies in the medical reports were of little import or significance. This is consistent with the view expressed by the Court of Appeal in *Demasi*.

The Medical Assessor acknowledged inconsistencies that she viewed as relevant. She understood the insurer's argument. She considered those inconsistencies together with what was recorded in other psychiatric reports.

The Medical Assessor set out the claimant's pre- and post-accident history, based on both the claimant's reporting and medical documentation, including reports of the claimant's treating psychiatrists from before the motor accident. The Medical Assessor noted that prior to the accident, the claimant lived a "normal life", was able to care for himself and maintained interests and relationships. He also worked as a handyman, had chickens at home and an egg-selling business and was a full-time carer for his mother. She analysed the claimant's reports and medical documentation after the accident.

She noted that since the accident, the claimant neglected self-care and domestic tasks and almost entirely withdrew from interests and relationships. Following the accident, he ceased all work and had to put down his chickens.

The Medical Assessor also noted that while the claimant's history with respect to depressive symptoms prior to the accident was unclear, she said that she was of the opinion that the history does not indicate major depressive disorder prior to the accident.

The Medical Assessor's obligation does not extend to consider every piece of evidence presented but rather in a sensible and balanced way to approach the task. In my view, the Medical Assessor properly addressed the substantially and clearly articulated arguments raised by the insurer. There is no constructive failure to exercise jurisdiction. Nor was there a denial of procedural fairness.

Failure to give reasons (ground 2)

The Medical Assessor set out all the documentation she relied upon and provided a history based on that documentation and on the claimant's reporting.

The Medical Assessor provided reasons for each criterion for a diagnosis of PTSD. With respect to criterion A, she explained:

“Although his vehicle was not significantly damaged during the subject motor accident [the claimant] stated that his towbar took the brunt of the impact thus not damaging the body of his car and he felt that he was quite shocked and disoriented and felt that it was potentially a life threatening accident. Therefore his perception of the accident fulfils criteria A for a DSM-5 diagnosis of PTSD.”

The insurer challenged the Medical Assessor’s decision as to her findings in relation to criterion A as to whether or not the claimant satisfied criterion A on diagnosing PTSD. This submission is also repeated in judicial ground 6. I will deal with it here. The finding that is quoted in the above paragraph is a finding that she was entitled to make. It’s based on Medical Assessor’s function to form and give her own opinion on a medical question by applying her own medical experience and expertise. I make further comments on this topic in my determination of grounds 9 and 10 below.

As to causation, the Medical Assessor concluded that PTSD and major depressive disorder were caused by the accident based on his history as referred to and set out earlier in this Judgment.

As to impairment, the Medical Assessor explained that she accepted the claimant’s reporting as it was generally consistent with prior reports, as set out above.

While it is odd that Dr Dinnen’s reports in relation to the 2012 work incident and the motor vehicle accident were prepared at the same time, he did refer to the prior work incident in his motor vehicle accident reports. The Medical Assessor treated Dr Dinnen’s report as being one in a number of other psychiatric reports that she had. The Medical Assessor recorded that the history she obtained was corroborated by contemporaneous records. The Medical Assessor based her decision on the contemporaneous medical material rather than solely Dr Dinnen’s reports. The Medical Assessor took into account the claimant’s existing psychiatric condition in assessing his impairment and made a deduction of 5%.

It is my view that the Medical Assessor did respond to the substance of the insurer’s argument. Further, the Medical Assessor afforded the parties procedural fairness. If the insurer was of the view that it was blindsided by the reports provided by Dr Dinnen, it could have sought an adjournment to obtain further psychiatric reports. The Medical Assessor also exposed her actual path of reasoning for diagnoses, findings in causation and assessment of damages. The Medical Assessor provided proper and sufficient reasons for her decision. There was no denial of procedural fairness.

Both judicial review grounds 1 and 2 fail.

Judicial review ground 3

This ground is somewhat repetitive.

The insurer's submissions

Pursuant to s 7.21 of the MAI Act, the assessment was required to be made in accordance with the Guidelines, which required the Medical Assessor to review and evaluate all available evidence (cll 6.17-6.18). As set out above, the Guidelines have statutory force, and it was held in *Boyce v Allianz Australia Insurance Ltd* [2018] NSWCA 22 (*Boyce v Allianz*) that a failure to carry out the assessment in accordance with the Guidelines may constitute a constructive failure to exercise jurisdiction: *Boyce v Allianz*, per Basten JA at [41], [44], Macfarlan JA agreeing.

Clauses 6.17 – 6.18 of the Guidelines required the Medical Assessor to review and evaluate the evidence before her. Here, as in *Boyce v Allianz*, the relevant Guidelines are in mandatory terms: “the medical assessor must evaluate all the available evidence...” In *Lederer Brereton* JA said at [37]:

“The obligation to “evaluate” all the available evidence involves no less, and possibly more, than the obligation to “consider” certain matters, which requires that the assessor intellectually engage with and evaluate that evidence.”

In *Abdal v Insurance Australia Limited t/as NRMA Insurance* [2025] NSWSC 478, Wright J said at [101], [104] and [105]:

“[101] Under cl 6.18(a), the first stage includes not only conducting a “review” of all the available evidence but also making an “evaluation” of that evidence including, expressly, medico-legal reports. Thus, a medical assessor’s functions in relation to medical legal reports is both to review and to evaluate them. This function is presumably limited to those medico-legal reports (or other evidence) that are directly relevant to the medical dispute in question.

...

[104] Under cl 6.18(a) of the MA Guidelines, however, the medical assessor was to “evaluate” those reports, in addition to noting or reviewing them.

[105] Evaluation, on its ordinary meaning, involves considering carefully and forming a view as to the worth of what is being evaluated. In the case of medico-legal opinions, their evaluation would naturally involve assessing the cogency of the opinions.”

In this case, it is not necessary to go so far as may be suggested by *Abdal*, to find that the Medical Assessor was required to assess the cogency of the opinions in the medical reports and/or to explain why her own assessment differed. However, the Medical Assessor was required to consider and intellectually engage with the evidence. That lower obligation was not met here, with respect to important evidence, as outlined above.

The Medical Assessor failed to evaluate the evidence and failed to comply with the Guidelines in this respect. This was a constructive failure to exercise jurisdiction.

The claimant's submissions

This ground consists of an assertion that the Medical Assessor did not engage with the evidence. The insurer's submission does not identify any evidence that was relevant and not considered.

The claimant submitted that in those circumstances it is difficult to respond, however the claimant relies on his submissions on judicial review ground 1 above.

The insurer's submissions in reply

The claimant's submissions suggest that the insurer has not identified any evidence that was relevant and not considered. However, the insurer's submissions comprehensively set out the evidence relied upon by the insurer to support its substantial and clearly articulated argument and that was not addressed by the Medical Assessor, in the submissions supporting Ground 1. With respect to Ground 3, the insurer's submissions referred to the failure to consider and intellectually engage with the evidence outlined above therein.

Resolution

This ground of review is similar to judicial review ground 1. As explained earlier, the Medical Assessor set out all of the medical evidence relied upon. She noted inconsistencies and made her own findings based on the medical evidence and on the claimant's reporting. The Medical Assessor complied with the Guidelines. This ground of judicial review fails.

Judicial review grounds 4 and 5

I shall deal with grounds 4 and 5 together.

The insurer's submissions

Clause 6.41 of the Guidelines provides:

6.41 Where there are inconsistencies between the medical assessor's clinical findings and information obtained through medical records and/or observations of non-clinical activities, the inconsistencies must be brought to the injured person's attention; for example, inconsistency demonstrated between range of shoulder motion when undressing and range of active shoulder movement during the physical examination. The injured person must have an opportunity to confirm the history and/or respond to the inconsistent observations to ensure accuracy and procedural fairness.

The requirement to afford procedural fairness also exists at common law. The Medical Assessor was required to take any and all necessary steps to ensure a fair assessment. In *Frost v Kourouche* [2014] NSWCA 39, the Court of Appeal said at [41]:

“[41] Ultimately, the question of the content of the obligation to accord procedural fairness is one of practical justice. Gleeson CJ said that ‘Whether one talks in terms of procedural fairness or natural justice, the concern of the law is to avoid practical injustice’: Re Minister for Immigration and Multicultural and Indigenous Affairs; Ex parte Lam [2003] HCA 6; 214 CLR 1 at [37]. In connection with the Act, in McKee at [8], Allsop P said that ‘procedural fairness would require any and all necessary steps to ensure a fair hearing’.”

Having regard to the significant inconsistencies between the claimant’s reporting to the Medical Assessor, and his previous reporting as recorded in the material before the Medical Assessor, there was a duty on the Medical Assessor to attempt to explore and if possible, resolve the inconsistencies. In *Dominice v Insurance Australia Limited* (2017) 81 MVR 249; [2017] NSWCA 171 (Dominice), Simpson JA (with Emmett AJA agreeing) referred to an earlier incarnation of clause 6.41 contained in previous Guidelines and said at [61] and [70]:

“[61] Clause 1.43 offers a guard against the drawing, unfairly, of conclusions about inconsistencies detected in a claimant’s presentation. It can also, as in the present case, act as a guard against conclusions that may be unfairly drawn in favour of a claimant, against the interests of an insurer, where the conclusions (as here) are unsupported by medical records or history. In order to make a proper assessment, Dr Ashwell needed to investigate the discrepancies between Ms Dominice’s presentation to Dr Kenna 10 months earlier and her presentation to him, as well as the inconsistencies he noted in her presentation to him. It was the drawing of the conclusion, in the face of inconsistent medical records and without exploration or explanation, that caused the proper officer to have the requisite satisfaction that there was reasonable cause to suspect that Dr Ashwell’s assessment was incorrect in a material respect. No error in the primary judge’s conclusion in this respect was established. Ground 1 of the appeal was rejected.

...

[70] The submission placed undue weight upon Dr Ashwell’s conclusion, at the expense of his reasoning process (which was not disclosed in the report). Dr Ashwell noted inconsistencies in presentation. He (apparently) made no attempt to explore them with Ms Dominice. He merely put them aside in stating (not reaching) his conclusion. It was there that cl 1.43 had its part to play. It may very well have been that, had Dr Ashwell engaged Ms Dominice with respect to the inconsistencies, he would not have been able to state the conclusion that he did. That is the potential material error on which the proper officer formed her satisfaction.”

In *Allianz Australia Insurance Limited v Bell* [2025] NSWCA 187 per Price AJA at [111], Payne and Ball JJA agreeing, the Court of Appeal accepted that there may be cases where cl 6.41 applied to clinical assessment of a psychological injury, but not to an inconsistency in a reporting history that has no relevance to the clinical assessment (as was found to be the case there). The inconsistencies in the present matter are plainly of potential relevance to the clinical assessment, as they concerned critical elements of the assessment process, including the assessment of current and pre-existing impairment applying the PIRS. These inconsistencies are the very inconsistencies that fall within cl 6.41 and that needed to be addressed in the manner set out in that clause.

In failing to make any attempt to explore or resolve the inconsistencies between the claimant's reporting in his workers compensation claim and his reporting to the Medical Assessor (and in his motor accident claim), the Medical Assessor failed to comply with cl 6.41 and thereby constructively failed to exercise her jurisdiction and failed to afford the insurer procedural fairness.

The claimant's submissions

Paragraph 6.41 of the Guidelines refers to inconsistency between the clinical findings of the Medical Assessor and information obtained through medical records and/or observations of non-clinical activities.

In this case the Medical Assessor made clinical findings of major depressive disorder and PTSD. It is submitted that her findings were consistent with the contemporaneous records of the insurer's treating Doctors and hospital notes. The finding is also consistent with the opinions expressed by Dr Dinnen and Dr Kaplan.

In Wingfoot, the High Court said at [47]:

"[47] It goes too far, however to conceive of the function of the Panel as being either to decide a dispute or to make up its mind by reference to competing contentions or competing medical opinions. The function of a Medical Panel is neither arbitral nor adjudicative: it is neither to choose between competing arguments nor to opine on the correctness of other opinions on that medical question. The function is in every case to form and to give its own opinion on the medical question referred to it by applying its own medical experience and its own medical expertise."

In Farr v Insurance Australia Limited t/as NRMA Insurance [2014] NSWSC 1435, Adamson J said at [46]:

"[46] Nonetheless, a Medical Assessor's duty is to come to his or her own opinion and take his or her own history, not to analyse every piece of information from every opinion contained in a document with which he was provided: [Wingfoot] at [47]."

Furthermore, it is submitted that the inconsistencies referred to in Dominice were in relation to physical findings on an examination which the Medical Assessor considered not to be consistent. was held in that case that cl 1.43 (now cl 6.41) of the Guidelines applied as the Medical Assessor failed to bring these inconsistencies in presentation to the attention of the claimant for explanation.

It is submitted that in this case there was no inconsistency between the history obtained by the Medical Assessor and contemporaneous medical records. The Medical Assessor had considered the evidence and found as a matter of fact that there was no relevant inconsistency.

In the light of that express finding this ground is in reality a complaint about fact finding and does not disclose an error of law or jurisdictional error.

The insurer's submissions in reply

The claimant's submissions repeat the submission that the Medical Assessor's findings were consistent with Dr Dinnen despite having earlier acknowledged that Dr Dinnen's own findings are inconsistent. It is also said that the findings were consistent with Dr Kaplan, which fails to acknowledge that one of the inconsistencies the insurer complained of was that the claimant had made inconsistent reports to Dr Kaplan compared to the reports he was making in his workers compensation claim.

These grounds are not a complaint about fact finding. They are about the process that led to the fact finding and determinations on the medical question referred. The Medical Assessor was required to afford procedural fairness and was required by the Guidelines to explore and attempt to resolve inconsistencies that were relevant to the assessment being conducted. The failures to do so are errors of law.

Resolution

The Medical Assessor said the following of the claimant's reporting:

"Mr Patsalis' account of the accident and his symptoms were generally consistent with those reported during other psychiatric assessments. He has a longstanding psychiatric illness namely Schizophrenia and a number of incidents such as workers compensation and previous motor vehicle accident for which he has attended psychiatric assessments. I note there are different opinions and documentation of symptoms by different psychiatrists and psychologists. However, I did not find any major inconsistencies in his reporting."

The Medical Assessor was not obliged to analyse every inconsistency. Her decision that claimant suffered PTSD and major depressive disorder was supported by medical experts. So was her decision that prior to the accident, the plaintiff suffered from schizophrenia.

The Medical Assessor was not obliged to consider each statement in the claimant history that was said to be inconsistent. Rather these grounds of judicial review fall within what was said in Wu Shan Liang: "the reasons of an administrative decision-maker are meant to inform and not to be scrutinised upon over-zealous judicial review by seeking to discern whether some inadequacy may be gleaned from the way in which the reasons are expressed."

Both judicial review grounds 4 and 5 fail.

Judicial review ground 6

I have already addressed this ground of judicial review earlier on the topic of whether the diagnosis of PTSD met the criteria set out in DSM-5. For the same reasons, this judicial ground fails.

The result is that all the insurer's grounds of review in relation to the Medical Assessor's decision fail. Therefore, it is not necessary to deal with judicial review grounds 7 to 8 in relation to the Delegate's decision as they directly arise from the Medical Assessor's decision. I have found no error.

Judicial review grounds 9 and 10

However, judicial grounds 9 and 10 challenge the Delegate's decision, and I shall deal with them together.

The principles to be applied in judicial review proceedings challenging the determination of a Delegate are limited to determining whether the opinion has been properly formed according to law: *QBE v Miller* (2013) 67 MVR 322; [2013] NSWCA 442 (*QBE v Miller*) per Basten JA at [36]. The issues are "whether the determination was irrational, illogical and not based on findings or inferences of fact supported by logical grounds" (*Minister for Immigration and Multicultural and Indigenous Affairs v SGLB* (2004) 78 ALJR 992; [2004] HCA 32 at [38] (*Gummow and Hayne JJ*), and applied in *QBE v Miller* at [36]) and whether the opinion was formed by "taking into account irrelevant considerations or otherwise misconstruing the terms of the legislation" (*QBE v Miller*, at [36] citing Latham CJ in *The Queen v Connell; Ex parte Hetton Bellbird Collieries Ltd* (1944) 69 CLR 407 at 432).

In *Mandoukos v Allianz Australia Insurance Ltd* [2024] NSWCA 71, the Court of Appeal said (per Stern JA, Leeming and Kirk JJA agreeing) at [101]:

"[101] The question for the primary judge was whether, under the Act, it was open to the Delegate not to be "satisfied that there [was] reasonable cause to suspect that the medical assessment was incorrect in a material respect having regard to the particulars set out in the application", as provided ins 7.26(5) of the Act. That was not a question which turned on whether or not there was jurisdictional error in the decision of the Medical Assessor. As Basten JA held in Meeuwissen at [23] (Beazley JA and Sackville AJA agreeing) as regards equivalent provisions in the 1999 Act:

"The power under s 63 [of the 1999 Act] is that of a gatekeeper, not a decisionmaker. Where there is reasonable cause to suspect that a significant error has been made, fairness suggests that the review should be allowed to proceed. In other words, the injured party is entitled to a decision reached in accordance with a proper understanding of statutory scheme and the facts: where an important fact has been ignored, the assessment has not been properly undertaken and the statutory right subverted."

This lower standard of reasonable cause to suspect error is satisfied with respect to all of the errors set out above. The decision of the Delegate is only explicable on the basis that the Delegate did not correctly apply the law.

The insurer's submissions (ground 9)

The Delegate exceeded his statutory function by determining the application on the basis of a view as to the substance of the grounds raised rather than applying the correct test which was whether there was reasonable cause to suspect that the medical assessment was incorrect in a material respect. This reveals an error of the kind described in *Oeding-Erdel v Allianz Australia Insurance Limited (Oeding-Erdel)* [2021] NSWSC 1264 at [36]:

"[36] In my view, it is clear from those statements that the proper officer exceeded her statutory function. She clearly determined the application on the basis of a view as to the substance of the grounds raised. That required the exercise of medical expertise she did not possess in order to arrive at conclusions she was not authorised to draw. Her conclusions plainly related to the correctness of the Assessor's decision rather than the question whether there was "reasonable cause to suspect that the medical assessment was incorrect in a material respect."

Instead of considering whether there was reasonable cause to suspect that there may be a material error in the decision by virtue of the insurer's argument, the Delegate purported to determine whether there was, in fact, an error. He erroneously conflated his gatekeeper role with that of a court exercising supervisory jurisdiction in judicial proceedings.

The insurer's submissions (ground 10)

The Delegate asked himself the wrong question and applied the wrong test in relation to the question of whether the Medical Assessor had failed to adequately consider the material and provide sufficient reasons, failed to respond to the insurer's argument, and incorrectly applied the DSM-5 criteria for PTSD. Rather than asking whether there was reasonable cause to suspect that the assessment was incorrect in a material respect, the Delegate explained how the Medical Assessor had justified her assessment.

The claimant's submissions (grounds 9 and 10)

These grounds are the same argument and are responded to together.

The submissions made to the Delegate both refer to the test which is the President being satisfied that there is reasonable cause to suspect that medical assessment was incorrect in a material aspect.

The determination of the Delegate was that he was not satisfied that there is reasonable cause to suspect that the medical assessment was incorrect in a material respect.

The Delegate considered each of the arguments raised and found that he was not satisfied to the relevant degree.

The insurer does not identify any error in the reasoning process. Whilst it is accepted that the Delegate does not determine an appeal if there are grounds to suspect that the medical assessment was incorrect it is an inevitable part of that process to consider what the Medical Assessor did and consider whether there is reasonable cause to suspect an error. If the Delegate

concludes that the Medical Assessor is correct and that the argued grounds do not cause him to suspect that there is reasonable cause to suspect that there is an error then there is no error in rejecting the application.

At paragraph 36 of the Delegate's decision, he found that he was not satisfied there was reasonable cause to suspect that the medical assessment was incorrect in material respect. His reasons disclose that he did not consider that the satisfied him that there was reasonable cause to suspect that the medical assessment was incorrect in a material aspect. A consideration of the other grounds demonstrates that there was no error as submitted by the insurer.

This supports the conclusion that the Delegate did not err.

It also shows that any error could not have been material and in those circumstances the Court would exercise its discretion not to intervene

The insurer's submissions in reply (ground 9 and 10)

The Delegate's decision can only be explained on the basis that he did not correctly apply the law and that he exceeded his role as gatekeeper.

The claimant submitted that any error could not have been material. The test of materiality is low, and the insurer need only demonstrate a realistic possibility that the decision could have been different absent the error/s of law: *LPDT v Minister for Immigration, Citizenship, Migrant Services and Multicultural Affairs* (2024) 280 CLR 321; [2024] HCA 12 at [7]. That threshold is comfortably met in this case, noting that the application for review under s7.26 of the MAI Act did not turn on whether the insurer could prove jurisdictional error, and that it was sufficient that there be reasonable cause to suspect a broader range of errors including (particularly relevantly here) potential errors in understanding of the facts.

The insurer submitted in oral submissions that the Delegate, being not a medical practitioner, was not in a position to determine there was objectively no error in the application of the DSM-5 in finding PTSD, and that this question needed to go to the review panel as it required medical expertise (T27 [40]-[45]).

Resolution

As stated by the Court of Appeal, the principal question for this Court is whether it was open to the Delegate not to be satisfied that there was reasonable cause to suspect that the medical assessment was incorrect in a material respect having regard to the particulars set out in the application: *Mandoukos* at [101]. The further questions are whether the Delegate failed to respond sufficiently to a clearly articulated argument and whether the Delegate failed properly to fulfil their statutory function in asking and answering the wrong question or in stepping beyond their remit by substantially considering her opinions and conclusions.

The essence of the insurer's submission is that the Delegate erred in law by not asking whether or not there was reasonable cause to suspect that the Medical Assessor's Decision was wrong in a material respect, but rather in substance satisfying himself that the Medical Assessor's Decision was correct. This is said to give rise to the error identified by McCallum JA in Oeding-Erdel at [36]. The insurer submitted that '[i]nstead of considering whether there was reasonable cause to suspect that there may be a material error in the decision by virtue of the insurer's argument, the Delegate purported to determine whether there was, in fact, an error'.

For the reasons which follow, I do not accept this argument or the other arguments raised in grounds 9 and 10.

The gist of the claim put to the Delegate was that the Medical Assessor had failed to reconcile the inconsistencies in the claimant's medical records and failed to give them their proper weight. Reviewing the Medical Assessor's reasons, the Delegate was satisfied that the Medical Assessor had noted and understood the argument as to inconsistency.

The Delegate perceived that the Medical Assessor considered the argument as to inconsistency and that she was unpersuaded by it. The Delegate did not consider that the Medical Assessor's failure to expatiate at length about the nature of the inconsistencies and their possible import was reasonable cause to suspect that the Medical Assessor's Decision was incorrect in a material respect. The Delegate correctly identified the principle from Wu Shan Liang that administrative decisions are not to be scrutinised with excessive zeal. The Delegate did not set out the inconsistencies and form a view as to how they should be construed with respect to the claimant's current psychiatric state and its causes. Had he done so, that might have fallen into an error as identified in Oeding-Erdel. He did not do so, and the insurer's argument is not made out.

As to the argument that the Delegate incorrectly construed or applied the DSM-5, it is true that it was not for the Delegate to construe or apply the DSM-5. The Delegate is not a qualified psychiatrist. However, the Delegate did not construe or apply the DSM-5. The Delegate correctly quoted Beech-Jones J in Gonzalez v Allianz Australia Insurance Ltd [2016] NSWSC 1549 at [52] regarding the interpretation and application of the DSM-5:

"... it suffices to state that from the beginning to the end of the medical assessment whether or not a claimant satisfied the criteria for a recognisable psychiatric disorder and should be diagnosed as suffering from any such disorder was a matter of clinical judgment, exclusively for a medically qualified assessor to undertake. Most significantly it was solely a question of fact for the Assessor. This is especially the case for any assessment as to whether a particular event was sufficiently traumatic enough to have caused PTSD."

The determination of whether a person suffers from PTSD (which involved both clinical investigation and interpretation of the DSM-5) is not a question of law. It was a question of fact that fell within the scope of the Medical Assessor's determination.

For these reasons, both the judicial review grounds 9 and 10 with respect to the Delegate's decision fail.

The Result

The result is that the plaintiff's application for judicial review fails. The Summons dated 15 April 2025 is dismissed.

Costs

Costs are discretionary. Normally costs follow the event. The plaintiff is to pay the first defendant's costs.

Orders

The Court orders that:

The Summons dated 15 April 2025 is dismissed.

The plaintiff is to pay the first defendant's costs.

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