

SOUTH AFRICA / JUDGMENT

De Lange v Ombudsman for the Long Term Insurance and Others (919/2011) [2012] ZAECPHC 45 (26 June 2012)

[2012] ZAECPHC 45

COURT

Eastern Cape High Court, Port Elizabeth

BEFORE

Chetty

CASE / FILE NUMBER

919/2011

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REPORTABLE

IN THE HIGH COURT OF SOUTH AFRICA

(EASTERN CAPE, PORT ELIZABETH)

Case No: 919/2011

In the matter between:

MONICA DE LANGE

.....Applicant

And

THE OMBUDSMAN FOR LONG-TERM

INSURANCEFirst

Respondent

THE APPEAL TRIBUNAL OF THE

OMBUDSMAN FOR

LONG-TERM INSURANCE

.....Second

Respondent

MOMENTUM GROUP LIMITED

.....Third

Respondent

Coram: Chetty, J

Heard: 31 May 2012

Delivered: 26 June 2012

Summary: Judicial

Review -

Of decision of Ombudsman for long term insurance – Appeal

Tribunal – Promotion of Administrative Justice Act –

Whether applicable – Whether an organ of state – decision

not an administrative act – Common Law review –

Application dismissed

JUDGMENT

Chetty, J

Introduction

[1] The office of the Ombudsman for Long-term Insurance was established on 1 January 1985. Its principal function is to mediate in disputes arising between subscribing members of the industry and their respective policy holders. Ex facie its constitution, subscribing members are defined as “Those Members of the Long-Term insurance industry who, from time to time, are Subscribing Members to the Rules of the Ombudsman for Long-Term Insurance”. Policy holders are defined as “The holders of policies of whatever nature issued by the Subscribing Members”. The Rules regulating the relationship between the parties inter se are published annually, and of relevance to the present application are those in force as from 9 July 2009. To give effect to its mission statement to resolve complaints through “mediation, conciliation, recommendation or determination”, the constitution obligates the ombud to ensure that -

“he acts independently and objectively in advising on any complaint received (referred to as the complaint handling process) and takes no instructions from anybody regarding the exercise of his authority.

the Subscribing Members of the industry act with fairness and with due regard to both the letter and spirit of the contract between the parties and render an efficient service to those with whom they contract;

he keeps the scale in balance between the rights of the policyholders on the one hand and the rights of Subscribing Members on the other; and

due weight is accorded to considerations of equity.”

[2] It will be gleaned from the foregoing that the functions of the Ombudsman as adumbrated hereinabove are of a private nature and does not involve the exercise of any public power. It receives and investigates complaints from the public against insurers, period. With that prelude, I turn to the facts of the case.

[3] During June 2009, the applicant lodged a claim with the third respondent under a long term policy of insurance which she held with it for the benefit which the policy provided for in the case of a functional impairment. The claim was predicated upon the provisions of sections 21 and 26 of the policy. It is not in issue that she suffered a loss of hearing in her right ear, a mild sensory-neural loss in her left ear and severe damage to her cranial VIII vestibulocochlear nerve. The third respondent accepted the claim lodged under section 21

and paid her the sum of R237 500.00. It however repudiated the claim formulated in terms of section 26 of the policy. Section 26 provided for a 100% pay-out for “a critical illness - Cranial nerve VIII (vestibulocochlear nerve)” described as “nerve damage with moderately severe equilibrium and/or hearing impairment resulting in the limitation of the daily activities requiring assistance with self-care”.

[4] The applicant could, had she so desired, have instituted an action for indemnification against the third respondent by reason of its repudiation of her claim. Instead she filed a complaint with the first respondent, who, in due course furnished a provisional, and thereafter a final determination, dismissing her complaint. She successfully sought leave to appeal from the first respondent to the designated Appeal Tribunal, the second respondent. Having thus submitted to the jurisdiction of the second respondent, she accepted that the appeal to it was governed by the provisions of the Ombudsman Rules, 6.6 and 6.7 which provide –

“6.6 All issues of a procedural and evidentiary nature shall be determined by the Appeal Tribunal itself.

6.7 The decision of the Appeal Tribunal shall be final and binding:

6.7.1 if the complainant is the appellant, on all the parties concerned;

6.7.2 if the subscribing member is the appellant, on it.”

[5] On 4 November 2010 the second respondent dismissed the applicant’s appeal. Undaunted by this setback, the applicant once more approached the first respondent for a reconsideration of its previous determination, ostensibly in the circumstances contemplated in Ombud Rule 2.2.2. She forwarded a further statement by herself, a document styled “Certification by Audiologist” prepared by an audiologist, Ms Megan Heard and a “communication profile for the hearing impaired” prepared by another audiologist, Ms Melanie Naude. The first respondent duly considered the aforesaid documentation and, in a carefully drafted missive declined to re-open the matter on the basis, inter alia, -

“The further material you contend is new, is not in fact new in the sense required by Rule 2.2.2. Most of it had already been made available between the time you lodged your complaint with my office on 31 October 2009 and when the decision by Judge Melunsky was made on 4 November 2010, and to the extent that the further material may have added additional facts most of it is information that had been known or available to you previously or that you could readily have obtained. Furthermore, some of it is irrelevant to the real questions at issue.”

[6] By notice of motion filed in this court on 29 March 2011 the applicant seeks a judicial review of the decisions of the first and second respondents dismissing her complaint. The relief sought is formulated as –

“i. Reviewing and setting aside the decision of the 1st Respondent dated 20 July 2010 and substituting that decision to read:

‘The Applicant’s complaint is wholly upheld and Momentum Group Limited is ordered to pay the Applicant the functional impairment benefits provided for in section 26 of Momentum Policy Number 205588110.’

In the event that this Honourable Court finding that the decision referred to in prayer

(i) *supra* should stand, the Applicant prays for the following alternative relief:

ii. Reviewing and setting aside the decision of the 2nd Respondent dated 4 November 2010 and substituting it with the following Order:

‘The Applicant’s appeal is substantially upheld and Momentum Group Limited is ordered to pay the Applicant the functional impairment

benefits provided for in section 26 of the Momentum Policy Number 205588110.’

In the event that this Honourable Court finding that the decision referred to in prayer (ii) *supra* should stand, the Applicant prays for the following alternative relief:

iii. Reviewing and setting aside the decision of the 1st Respondent dated 22 February 2011 taken in terms of Rule 2.2.2 of the Rules of the Ombudsman for Long-Term Insurance, and substituting that decision with and Order in the following terms:

‘The Applicant’s claim complies with the provisions of section 26 of her Momentum Policy Number 205588110 and the 3rd Respondent is ordered to pay to the Applicant the functional impairment benefits provided for in section 26 of the said policy.’

iv. Costs of suit against those Respondent(-s) who oppose this application, jointly and severally, the one paying the other to be absolved.”

[7] The relief sought against the first respondent is, upon a proper consideration of the Rules, legally incompetent. Although Rule 2.2.2 obliges the first respondent to reconsider a complaint in the circumstances provided for, it is evident that the envisaged reconsideration must occur prior to any appellate intervention given the express wording of Rule 6.7 that the decision of the Appellate Tribunal is final and binding. Ergo, the first respondent had no jurisdiction whatsoever either to entertain or to consider the further submissions advanced on behalf

of the applicant consequent upon the final determination of the appeal by the second respondent

[8] It is not in dispute that the complete set of documentation concerning the dispute between the applicant and the third respondent served before the second respondent. The third respondent submitted further heads of argument whilst the applicant, in response to a letter addressed to her by the first respondent inviting any further submissions which she considered should be placed before the second respondent, advised that she had none. She nonetheless voiced her dissatisfaction at what she contended were vital omissions from the appeal record. In response, the first respondent, whilst acknowledging that the three letters addressed to it viz, 25, 26 and 27 May 2010 respectively by the applicant had inadvertently

been omitted from the appeal record vouchsafed that they would be forwarded to the second respondent, as indeed they were.

- [9] The issues which fell for determination by the second respondent were succinctly formulated thus –

“In order to arrive at a decision I have to consider three main questions. The first, and perhaps the most difficult, concerns the proper interpretation to be placed on section 26 in the setting of the Functional Impairment Benefits Schedule. The second relates to the question of causation, a matter that arises due to the insured’s pre-existing emotional stress that resulted in her having to be treated by a psychologist. The third question is whether, on the facts before me, Mrs de Lange’s condition can properly be said to fall within the ambit of section 26. I propose to deal with each of these aspects in turn but before doing so I will briefly set out the history of the events leading up to the claim, together with the views expressed by the medical and other experts. There is no need for me to elaborate on these matters, not only because they are well known to the parties but also because they do not, in themselves, give rise to disputed factual issues.”

The second respondent in a well reasoned judgment gave careful consideration to all the relevant facts, submissions and reports, dismissed the appeal and recorded his finding, pursuant to Rule 6.9.2, that the appeal was substantially unsuccessful.

- [10] The review is brought both under the common law and under the Promotion of Administrative Justice Act¹ (PAJA). The common law review is premised upon three main grounds, firstly, the refusal to afford her the opportunity to be heard on the proper interpretation of section 26 of the policy of insurance; secondly, the failure by the second respondent to observe a two phase appellate hearing viz to make a provisional finding and only thereafter on receipt of further submissions, a final determination and thirdly, that the second respondent acted mala fides, had an ulterior motive and failed to apply his mind. The first two grounds can be disposed of shortly. There was no obligation or indeed need for the second respondent to have elicited any further submissions from the applicant. The entire record served before it. The further contention that the appeal process envisages a two phase approach is untenable. The rules make no provision therefore. The review, under the umbrella of PAJA, is premised upon the supposition that the decision reached by the second respondent constituted administrative action, and as such, was reviewable under section 6(2)(c), (action procedurally unfair), section 6(2)(e)(iii) (irrelevant considerations taken into account/relevant considerations not considered), section 6(2)(f)(ii)(cc) (action not rationally connected to the information

before the second respondent) and section 6(2)(h) (unreasonable exercise of power).

- [11] Recourse to PAJA is entirely misplaced. The decision taken by the second respondent did not amount to the exercise of power nor was it given in the performance of a public function - in short it did not constitute administrative action. This conclusion is fortified, as counsel for the second respondent correctly submitted, by the fact that –

membership by any long term insurer of the Long Term Association is entirely voluntary;

policy holders and other complainants who have a complaint about a long term policy issued by a subscribing member are not obliged to utilize the office of the ombud. They are not members of the Long Term Association and not contractually bound to abide by its rules or constitution;

once a decision has been made by the ombud which had the effect of dismissing a complainant's claim, the latter was not obligated to engage in the ombud's appeal process. She was at liberty to institute an action against the third respondent or take whatever other steps she so desired.

Review under the Common Law

[12] The grounds for review under the common law were propounded by Corbett JA in Johannesburg Stock Exchange and Another v Witwatersrand Nigel Ltd and Another² as follows –

“Broadly, in order to establish review grounds it must be shown that the president failed to apply his mind to the relevant issues in accordance with the 'behests of the statute and the tenets of natural justice' (see National Transport Commission and Another v Chetty's Motor Transport (Pty) Ltd 1972

- (3) SA 726 (A) at 735F - G; Johannesburg Local Road Transportation Board and Others v David Morton Transport (Pty) Ltd 1976
 - (1) SA 887 (A) at 895B - C; Theron en Andere v Ring van Wellington van die NG Sendingkerk in Suid-Afrika en Andere 1976
 - (2) SA 1 (A) at 14F - G). Such failure may be shown by proof, inter alia, that the decision was arrived at arbitrarily or capriciously or mala fide or as a result of unwarranted adherence to a fixed principle or in order to further an ulterior or improper purpose; or that the president misconceived the nature of the discretion conferred upon him and took into account irrelevant considerations or ignored relevant ones; or that the decision of the president was so grossly unreasonable as to warrant the inference that he had failed to apply his mind to the matter in the manner aforesaid. (See cases cited above; and Northwest Townships (Pty) Ltd v Administrator, Transvaal, and Another 1975
 - (4) SA 1 (T) at 8D - G; Goldberg and Others v Minister of Prisons and Others (supra at 48D - H); Suliman and Others v Minister of Community Development 1981
 - (1) SA 1108 (A) at 1123A.) Some of these grounds tend to overlap.”
- [13] The second respondent, in a meticulously drafted and reasoned judgment had regard to the entire body of evidential material placed before it. It considered and evaluated all the evidence, including the medical reports, in wrestling with the proper interpretation of clause 26. It commenced the exercise by first rejecting the third respondent's contention that the insurer's intention embodied in the definition in section 26 was to cover “nerve damage with moderately severe equilibrium (impairment) with or without hearing impairment, resulting in the limitation of all daily activities requiring assistance with self-

care” before stating –

“As the Ombudsman pointed out in a letter to Momentum on 17 June 2010, the relevant section covers nerve damage with moderate severe equilibrium and/or hearing impairment. Whatever the insurer’s intention might have been, it cannot override the words actually used. In my view,

therefore, the section envisages:

moderately-severe equilibrium impairment; or

moderately-severe hearing impairment; or

a combination of (a) and (b).

Whether the insured relies upon (a), (b) or (c), however, she will also have to establish that the impairment results in

‘the limitation of all daily activities requiring assistance with self-care’,

subject to my suggested interpretation. Hidden within this phrase is a latent ambiguity: for it is almost impossible to image how a moderately-severe hearing impairment could reasonably result in a limitation of all daily activities. In this regard I agree with the Ombudsman’s view, set out in the final determination, that

‘. . . it is difficult to see how this provision can provide any cover at all, because deafness, even if it were total and in both ears, could hardly give rise to a limitation of all daily activities’

[14] It then embarked upon an analysis of case law in point expounding the principles of construction in policies of insurance of similar ilk and posed the question “How then, should section 26 be construed” before providing the following answer -

“[11] One way might be to ignore the word “alle” completely but it seems to me that it is not necessary to resort to such a drastic remedy, at least insofar as the Afrikaans version is concerned. It would be sufficient to give proper effect to the obvious intention of the parties by replacing the expression “alle daaglikse” with a single word “alledaagse”, meaning “everyday”. What would then be covered by the section would be a limitation of the insured’s everyday activities. A construction along these lines would also give effect to the two rules of construction which ordinarily benefit the insured, viz the contra proferentem rule and the rule that the assured should be favoured (see Kliptown Clothing case at 108B-C)”

[15] It then considered the question of causation and undertook a thorough evaluation of the applicant’s condition with specific regard to the effect of the damage to her eighth cranial nerve with reference to the provisions of section 26 and the facts before concluding,

“[25] But however that may be, I am far from being satisfied that Mrs de Lange’s hearing impairment has resulted in the limitation of her everyday activities to such an extent that she requires assistance with self-care. On the contrary what evidence there is indicates with relative certainty that, in general, she has the ability to care for her own everyday needs without medical, professional or other assistance. In my opinion, therefore, Momentum was entitled to repudiate her claim under section 26.”

The foregoing reproduction of the second respondent’s reasons for dismissing the appeal demonstrate quite unequivocally that there is no basis for the applicant’s complaint that the second respondent failed to take into account relevant considerations and gave undue weight to irrelevant ones or that the decision arrived at was arbitrary or capricious. The third, and only remaining common law ground for review, is fallacious and the application accordingly falls to be dismissed.

[16] Although the second respondent did not oppose the application and abides the decision of this court, it nonetheless filed an affidavit in which the deponent refutes the allegations leveled against him by the applicant. It is unnecessary for purposes of this judgment to consider the affidavit in any detail for ex facie the judgment, the accusations leveled against the second respondent are spurious and without foundation. Neither the second respondent’s approach nor reasoning is open to attack.

[17] The general rule is that costs follow the result. The third respondent has however sought a punitive costs order against the applicant by reason of her unwarranted attack upon the integrity of the first and second respondent. Whilst it is indeed so that her letters and affidavits contain gratuitous comment, I am unpersuaded that either the first or second respondents are particularly affronted thereby. In the result the following order will issue –

The application is dismissed with costs.

D. CHETTY

JUDGE OF THE HIGH COURT

Obo the Applicant: In Person (Tel: 072 713 3418)

Obo the 3rd Respondent: Adv A.R.G Mundell S.C instructed by Goldberg & De Villiers, 13 Bird Street, Central, Port Elizabeth, Tel (041) 501 9806, Ref: C Jonker

1Act No, 3 of 2000

2 1988

(3) SA 132 (A) at 152A-E

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