The *Garcia* decision: Is good faith in workers' compensation claims management (still) avoidable?

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*The article examines in detail the decision of a Full Court of the NSW Court of Appeal in **CGU Workers Compensation (NSW) Ltd v Garcia** and the earlier decision of Goldring J at first instance in the NSW District Court. The plaintiff's claim was for damages arising out of an alleged breach of a duty in failing to administer his workers' compensation claim in good faith. The plaintiff was successful in the District Court, however on appeal the Full Court comprehensively overturned the decision and held that it would not recognise a duty of good faith in relation to the administration of workers' compensation claims and in any event the facts did not disclose the breach of any such duty. This article compares the decision at first instance with the Court of Appeal decision and reflects on the potential for any similar future claims.*

Introduction

In this article we consider the decision of *Garcia v CGU Workers Compensation Pty Ltd*.[1] This first instance decision of the District Court of New South Wales in 2006 found that an insurer had breached its duty to manage the worker's claim in good faith, and awarded the worker damages for economic and non-economic loss, for injuries consequent upon the insurer's poor claims management, and punitive damages for recklessly increasing the harm to the worker. Importantly, at the time of writing the NSW Court of Appeal in *CGU Workers Compensation (NSW) Ltd v Garcia*[2] overturned the decision, holding that in fact the duty to act in good faith should not be recognised in Australian tort law, and that in any event the insurer had not been in breach of any putative duty to the worker in the management of the workers' compensation claim. The refusal of the Court of Appeal to recognise this novel development in tort law, or to find an implied contractual term to act in good faith as between the worker and the insurer, prompts an examination of some of the key issues in workers' compensation systems in Australia.

This article considers the legal aspects of the decisions in the *Garcia* matter. We note, among other things, that *Garcia*'s case highlights that the work-relatedness test of causation has the capacity to turn some workers' claims into nightmares of forensic proof.[3] Lippel has observed that in relation to the issue of causation a range of concerns arise:

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1 (2006) 3 DCLR (NSW) 135.

2 (2007) 14 ANZ Ins Cas 61-746; [2007] NSWCA 193; BC200706429.

3 J F Keeler, 'Social insurance, disability, and personal injury; a retrospective view' (1994) 44(3) *Uni of Toronto L Jnl* 275 at 321.

> By systematically contesting claims where some scientific controversy may be exploited, consultancies convince employers that they will obtain a double benefit; they win many of the cases in court, given the imbalance of means of the worker and those of the employer; and even if they lose, the known policy of giving the claimant a hard time serves as a serious disincentive to claim compensation by other workers who are injured.[4]

In relation to his claim, Mr Garcia had no difficulty in establishing that he was a person entitled to coverage under the relevant legislation, but his injury problems were greatly exacerbated by the decision-making practices of his employer's insurer, aimed at excluding him from the scheme on the basis that his injury was not work-related; it was this decision and his consequent decline in health which led to his subsequent tort action against the insurer.

Mr Garcia's story

Prior to 1999 Mr Garcia was in good health. A number of pre-employment medical reviews confirmed this. In June 1999, aged 35, Mr Garcia commenced employment with Transfield Worley as a fitter and turner. At this time he was financially comfortable, with little debt and was in the process of purchasing a house. On 2 August 1999 he was tightening bolts with a ring spanner when he wrenched his left arm and shoulder. He suffered immediate pain but continued to work that day and the following few days before the pain in the left shoulder and arm became more severe. He ceased work on 5 August 1999 after consulting a general practitioner. On 10 August he made a workers' compensation claim at his workplace. The employer completed the necessary paperwork as part of the claims procedure, but expressed concern in relation to the claim on the grounds that the worker had apparently not reported the injury until a few days after the event. Garcia returned to work on light duties on 12 August 1999.

HIH, the employer's insurer, received various papers in relation to the claim on or about 17 August, and as a result organised a medical review of Mr Garcia. HIH advised Mr Garcia that his claim was pending until further information was received. Investigators were instructed to obtain a statement from the worker. The investigators also obtained statements from witnesses who confirmed Mr Garcia's statement of events. Thereafter, multiple medical reviews took place, in the first instance confirming an injury to the left arm and shoulder and subsequently implicating the cervical spine. On 21 September HIH wrote to the worker advising him that they were awaiting further medical reports. Medical reviews and reporting continued throughout September. On 8 October HIH *accepted liability* for the claim. On the same day Garcia's employment with Transfield Worley was terminated. Throughout October 1999 he underwent a range of tests and examinations to his neck, shoulder and arm. A disc rupture had been confirmed at the C6/7 level of the cervical spine. Despite clear medical evidence and acceptance of liability, HIH

4 K Lippel, 'Compensation for musculoskeletal disorders in Quebec: systemic discrimination against women workers?' (2003) 33(2) *International Jnl of Health Services* 253 at 256. See also T G Ison, 'Recognition of occupational disease in workers' compensation', Paper for the Conference on the Recognition and Prevention of Occupational Disease — Canadian Centre for Occupational Health and Safety, March 2005, who concludes in a similar fashion.

continued to use the surveillance instigated in August. Further, despite medical evidence that substantiated the worker's claims, he was continually referred for alternative medical opinions. On 24 December 1999, Dr Lloyd Hughes, who had reviewed all the medical evidence at the request of the insurers, wrote a report to HIH to the effect that the worker's condition was not work-related and that there was no sign of work injury. Incredibly, Hughes' report was not provided to the worker's solicitor until 18 January 2001. It was accepted at trial that the examination of Garcia by Dr Hughes only took about one or two minutes.

On 7 January 2000, HIH reviewed its file and denied Garcia's claim, apparently relying on Hughes' medico-legal report that interpreted a range of scans and tests to show no abnormality in the worker's neck or shoulder, despite medical opinion from at least five other medical practitioners confirming otherwise. During the five months from August 1999 to January 2000, Mr Garcia had been in pain and the recommended medical advice was that he be considered for operative treatment to the cervical spine. As Mr Garcia's claim was now denied, his workers' compensation payments ceased and he lost any entitlement to ongoing medical care. Mr Garcia's lawyers commenced proceedings in the Workers Compensation Resolution Service in January 2000. On receipt of the papers, HIH maintained denial of the claim and again failed to disclose Dr Hughes' report dated 24 December 1999. On 9 March 2000, at a conciliation of the dispute, the conciliator recommended that HIH reinstate Mr Garcia's payments. As this was only a recommendation, the worker's lawyers commenced proceedings to obtain an order for reinstatement of payments. During these proceedings the Hughes report was not made available to the worker's solicitors, although the regulations under the Workplace and Injury Management Act 1998 (NSW) obliged the insurers to disclose the report. Further medical reviews took place throughout 2000 pending the resolution of the claim by a court. HIH, through its solicitors, continued to deny liability. On 21 July 2000 another recommendation was made for HIH to review its decision, by a conciliator who by this time had a copy of the Hughes report. The solicitors representing HIH then claimed legal professional privilege on the report. In August and September 2000 the solicitors for HIH approached Garcia's solicitors with an offer to settle the claim by way of a lump sum. The matter was set down for hearing on 4 April 2001. On that day the claim was settled by payment of a lump sum of $20,430.93, which included payments for impairment, pain and suffering.

During the litigation process outlined above, Garcia developed depression. Significantly, so far as future litigation was concerned, he did not have access to medical payments from the insurer and operative treatment was delayed. The depression and continued pain in the neck and shoulder compounded each other.

Thus between August 1999 and July 2001 Carlos Garcia ran the full gamut of the workers' compensation system. He was subjected to multiple medical reviews, surveillance by investigators, denial of his claim and litigation before his claim was finalised. He exited the workers' compensation scheme with serious physical and mental injuries and little over $20,000. Following the finalisation of his claim, Mr Garcia brought an action in the NSW District

Court for damages against the insurer HIH for a breach of the insurer's duty of good faith to him in the management of his claim. At the time of judgment, HIH had, in now notorious circumstances, gone into liquidation and its liability had been assumed by the defendant in those proceedings, CGU Workers Compensation Pty Ltd. The question of the defendant's, CGU Workers Compensation Pty Ltd, liability is not dealt with in detail by the District Court. Goldring J notes that the defendant admitted that it was liable to fulfill the relevant obligations of the company that was the workers compensation insurer of the plaintiff's employer.[5] He noted that CGU Workers Compensation Pty Ltd was a surrogate of the employer's insurer (HIH) and that the defendant (CGU) admitted it was the legal successor of HIH. The Court of Appeal did not address this point at all. It is the action against CGU as surrogate for HIH and as its legal successor that is now considered.

The judgment at first instance in the *Garcia* case

In July 2006 Garcia was awarded $421,957.50 in damages and economic loss after Justice Goldring found that the insurer had a duty to act in good faith towards him, and that the insurer had breached that duty. In relation to these events and others Goldring J found:

> as a result of HIH's wrongful acts and omissions, the plaintiff has developed a severe and permanent mental illness. He is constantly depressed and anxious. He will require psychiatric attention for a considerable period, if not for the rest of his life. His ability to lead a normal life, including relations with his children and sexual relations with his wife, was totally destroyed for a period and is still significantly affected. . . .[6]

Goldring J found that the action of the insurer in ceasing the weekly payments of income maintenance was:

> malicious, reprehensible and done in total disregard of the plaintiff's rights and of his health . . . He was made to feel as if he was a malingerer. He felt he was stigmatized socially. He was made to feel embarrassed and ashamed.[7]

As a consequence of finding that Garcia's condition was made worse by the actions of the insurer, Goldring J awarded general damages of $90,000. This sum was calculated with regard to the loss of opportunity suffered by Garcia in being unable to improve his physical health by surgery, which should have taken place within months of the accident and which, by reason of the delay, compounded the depressive condition. Goldring J ordered the insurer to pay $155,000 for past and future loss of earnings, approximately $100,000 for past and future domestic care, and $26,690 for out of pocket expenses. Given the insurer's reckless disregard for the state of Garcia's physical and mental wellbeing, Goldring J awarded punitive damages:

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5 (2006) 3 DCLR (NSW) 135 at [3].
6 Ibid, at [182].
7 Ibid, at [199].

> In this case I consider that an appropriate award of punitive damages, *to denounce the insurer's wrongdoing, and to indicate to other insurers, by way of general deterrence, that such behaviour will not go unheeded by the courts*, is $50,000.[8]

In summary, over the period of two years after his injury, Mr Garcia went from someone with a relatively serious injury, but with a good prognosis for recovery, to a severely disabled person in his late 30s, with a greatly diminished prospect of work. The judgment found that much of this deterioration was caused by the insurer's claims management decision-making.

The findings and the reasoning at first instance and on appeal are examined below, in two parts: the duty to act in good faith, and the actions which Goldring J found caused the breach of the duty.[9]

Is there a duty to act in good faith by an insurer towards an injured worker?

Goldring J posed the first key question to be decided thus:

> whether a workers compensation insurer owes any duty to workers employed by its insured, and in particular, whether that includes a duty, which can be described as a duty to act in good faith.[10]

He held there was such a duty.[11] Goldring J's judgment includes an extensive survey of the authorities. No previous workers' compensation case in Australia has proceeded to trial on this point. Some early decisions relating to interlocutory or interim judgments have held that it is open for a court to find a duty of the insurer not to act in bad faith. In Australia, to this time, courts have been reluctant to entertain such a proposition and, as can be seen below, the Court of Appeal took a different view to the authorities.[12]

Goldring J noted that duty of care arises out of a combination of statutory obligations to process a claim in accordance with law, and the general contractual duty to act in good faith which arises from a special relationship of the insurer and the worker, which imposes some, but not all, of the obligations arising under a contract upon the insurer. Clearly a worker is someone who will be affected by whatever decisions an insurer makes.

Goldring J drew a distinction between the tortious duty of care and the duty

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8 Ibid, at [200] (emphasis added). The award of punitive damages is unusual and not lightly approached.

9 For a discussion of *Garcia* in the context of the duty to act in good faith for superannuation decision-makers, see A Stewart, 'Good faith in superannuation: where does it end?' (2007) 35(3) *Aust Business Law Jnl* 204.

10 (2006) 3 DCLR (NSW) 135 at [1].

11 The implication of *duty* implies responsibility for action beyond simply legal compliance of paperwork and process towards the active interest in promotion of health and wellbeing for injured workers.

12 For a discussion of previous decisions, see J Peterson, 'The Duty of Good Faith in Insurance Relationships: The Decision in *Gibson v Parkers District Hospital*' (1994) 24 *VUWLR* 189; P Handford, 'A Good Faith Tort?' (1993) 1 *Tort L Rev* 87; P Handford, 'Victoria Puts No Faith In Good Faith Tort' (1996) *Tort L Rev* 21 and R Cameron, 'Non contractual duty of utmost good faith considered in the Supreme Court' (1992) *Commercial Law Quarterly* 11.

to act in good faith and explained this in detail.[13] He drew first from the judgment of Badgery-Parker J in *Gibson v Parkes District Hospital*[14] where it was first held (obiter) that the insurer owed the worker a duty to act in good faith. That case proceeded from a detailed analysis of Australian and US authorities on the issue of the duty to act in good faith. Badgery-Parker J held that the duty to act in good faith was a tortious claim which could be applied in Australia. He said the tort arises where the nature of the relationship was brought about by the contract, as distinct from the terms of the contract itself.[15] This relationship would arise where such a degree of proximity or closeness existed, such as where the insurer is directly responsible for the processing of the worker's claim and thereby responsible for ongoing medical care and financial support. Goldring J noted that these views have now been supported by a number of Australian High Court and Supreme Court judgments. Goldring J described the duty as mutual.[16] He also considered that Carlos Garcia was particularly vulnerable to the effects of any wrongful denial of liability.

At this point we interpose the decision of the NSW Court of Appeal, which unanimously overturned the decision by Goldring J. The Court of Appeal found that the authorities did not support the existence of a tortious duty of good faith.[17] If such a tort was to exist, the Court of Appeal held that the tort must be consistent with the terms or policies of the statutory and contractual frameworks governing the parties.[18] The Court of Appeal held that it was inconsistent with the recognised principles of contract law to award exemplary damages and that there was only qualified support for damages for disappointment and distress and injured feelings.[19] The Court of Appeal held that for policy reasons it was inappropriate to develop a novel tort in this regard. Those policy reasons related to the fact that the statutory workers' compensation scheme already prescribed the rights and obligations of the parties, and a tort which provided for damages over and above this scheme did not fit with this framework.[20] Specifically in relation to the implied contractual duty to act in good faith, the Court of Appeal declined to imply such a term as this was not necessary to give efficacy to the contract of insurance.[21]

The Court of Appeal decision, particularly the leading judgment of the President, needs further examination of its underlying assumptions. The first issue for examination is the proposition that the authorities do not support the establishment of a new tort. It may not be enough to say that there were clearly sufficient authorities for Goldring J to make his apparently bold leap forward; however, it is certainly clear that Goldring J did not act without a thorough consideration of the embryonic developments of the tort. What seems to be of concern is that while the President rejected the development of a new tort

13 (2006) 3 DCLR (NSW) 135 at [30]–[39].
14 (1991) 26 NSWLR 9.
15 (2006) 3 DCLR (NSW) 135 at [34].
16 Ibid, at [37].
17 Ibid, at [57] and [110].
18 Ibid, at [64].
19 Ibid, at [72]–[77].
20 Ibid, at [79]–[87].
21 Ibid, at [131]–[143].

based on a broad discussion of the need for caution in the creation of new rights, his thesis also seems to turn on matters relating to the law of contract. In his discussion of the tort duty to act in good faith, the President swerved into the limitations of contract law to award certain forms of damages as a means of declining to find a tortious duty to act in good faith. With respect, this detour was off course. Tort law has long recognised all the heads of damages awarded by Goldring J, and the reference to the limitations of contractual damages seems spurious.

Secondly, the reasons for declining to establish a novel tort based on its asymmetry with the statutory scheme are dependent on a particular, and we would argue narrow if not incorrect, interpretation of the policy and provisions of the legislation. As was noted by the Court of Appeal, the nature and design of workers' compensation schemes has changed over the last three decades. Most jurisdictions in Australia have made changes to the relationship between workers' compensation and the right to common law damages. Interestingly, most jurisdictions retain the right of workers to pursue damages claims, although the right to pursue damages may be limited by particular thresholds and damages may be capped. It is not necessarily inconsistent with the statutory schemes to provide an alternative right to damages.[22]

The second limb of the Court of Appeal argument that the duty to act in good faith was inconsistent with the statutory scheme was grounded in their interpretation of the rights and obligations currently existing under the NSW Act. As in most states, the legislature has specifically enacted provisions so as to put in place timelines for the completion of various tasks. It is not inconsistent with the scheme of the Act to hold that there is a duty to investigate and resolve a claim in a timely manner. In fact, the trend towards alternative dispute resolution, which was referred to by the Court of Appeal, was implemented for just this purpose. A contractual and tortious duty of care is recognised to exist between the employer and insurer. That duty of care includes proper administration of claims by an insurer on behalf of the employer. In this sense, proper administration of claims must include compliance with all statutory obligations and extends to minimising, where possible, claim costs to the employer. In Australian schemes, the processing and management of claims are generally undertaken by an insurer.[23]

No contractual relationship exists between the employer's workers' compensation insurer and the worker, and thus, under contract law, a worker cannot generally insist that the claim be processed expeditiously, or in accordance with fairness and reasonableness, unless there are statutory

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22 There are numerous examples of the right to damages being circumscribed by workers' compensation legislation in Australia, see, eg, the Workers Compensation and Injury Management Act 1981 (WA).

23 The exception to this is where the employer is a self-insurer, in which case the claim is handled directly by the employer. In any event, often the relationship between the injured worker and immediate line manager or supervisor is lost and substituted by a new relationship between the worker and insurance claims manager. There are both similar and different problems for workers in this relationship. They are beyond the scope of this article.

provisions with which an insurer must comply.[24] In most states and territories within Australia there are minimum statutory obligations to determine claims within specified time limits.[25] Outside those provisions, the onus is on the worker to issue some form of proceedings to compel the primary decision-maker (often the insurance claims officer) to determine the claim, or reconsider the decision. Where an insurer acts in such a manner that the worker's claim is not properly processed or where the claim is denied, then the worker must bring the matter to hearing to seek some form of orders against the insurer. In cases where the worker succeeds, orders for arrears of weekly and other payments can be made. In most cases orders for costs can also be made — although some jurisdictions require the parties to bear their own costs other than in exceptional circumstances. Again, more recently, perhaps in recognition that workers can be severely adversely affected by delays, many jurisdictions have included provisions which allow workers to claim interest on delayed payments.[26] Additionally, the clear trend in all jurisdictions in relation to workers' compensation matters has been the requirement of early and ongoing disclosure of medical reports and other information among the parties to the dispute. Finding that this was part of the duty to act in good faith in fact seems consistent with the intention of the legislation.

The Court of Appeal finding that there could be no implied contractual term to act in good faith appears to be on stronger ground, given the authorities require that contractual terms only be implied, when case is being made that the contract cannot operate efficiently without such a term. However, a fair reading of the judgment of Goldring J suggests that no great weight was put on the implied contractual term argument and the key element relates to the tortious duty.

Was there a breach of duty?

Having decided that a duty can exist as between an insurer and an injured worker, ie, a duty to act in good faith, Goldring J considered the evidence as to whether the duty had been breached by the insurer in relation to its actions towards Mr Garcia. He decided there had been such a breach and set out eight reasons for his decision.[27] In summary they were:

1. The insurer was predisposed, if not prejudiced against the worker, and behaved 'contrary to all reasonable standards'.
2. In relation to the medical reports, the insurer decided to deny the claim against the great bulk of medical evidence. It had ignored

24 The extent to which the contractual employment relationship between a worker and an employer who is self-insured for workers' compensation would impose this obligation is worthy of further examination.

25 For example, s 53(4) of the Workers Rehabilitation and Compensation Act 1986 (SA). Expedition is required, along with an endeavour to determine a claim within 10 business days from receipt. A similar timeline applies in Western Australia.

26 Such a provision has been incorporated in the SA legislation from its inception, ie, s 47 of the Workers' Rehabilitation and Compensation Act 1986 (SA). In some cases the delay may be so gross and the effect on the worker so significant that the usual statutory interest remedies are insufficient to address the disadvantage to the worker (eg, intervening financial and/or personal crises due to a long period without income payments).

27 (2006) 3 DCLR (NSW) 135 at [39]–[42].

medical evidence in the worker's favour, and not disclosed other important reports to the worker's lawyers. 'It was looking for a pretext upon which not to pay the plaintiff's claim.'[28]

3. The insurer preferred one particular medico-legal report opinion in relation to the incident causing the worker's injury over every other medical opinion.
4. The insurer had no reasonable basis to prefer this opinion.
5. When the insurer had received medical opinion contrary to their preferred opinion, they had failed to review their decision to cease weekly payments.
6. The insurer contested the complaint about the cessation of weekly payments when it was clear that maintaining the decision to cease them was bound to fail in the Compensation Commission.
7. Contrary to its obligation to do so, the insurer did not obtain medical reports, nor liaise with the worker's treating doctors.
8. The new insurer's review of the decision in April 2001 (which meant a recommencement of weekly payments), demonstrated that HIH had been 'unreasonable, if not malicious and dishonest' in its action to cease payments. As CGU were the legal successor of HIH its review of the file did not effect any liability which might has been fixed as against HIH, though it might be argued that this action reduced the potential for increased damages.

Goldring J also records that the continued use of surveillance against Mr Garcia may have also been evidence of bad faith, but it was not necessary for Goldring J to decide this given the preponderance of evidence showing the lack of good faith already noted.[29] Interestingly, while it was not necessary for the Court of Appeal to decide this point, the court went on to hold that there was no evidence of a breach of duty in any event. Some may regard the reasons given by the Court of Appeal on this aspect as unconvincing. The Court of Appeal held that the insurer was entitled to test the credibility of the history upon which the medical reports favourable to the worker depended. However, there is nothing in the judgment of Goldring J that suggests that the worker's credibility was in issue. Although it might be argued that causation of the injury was the key point of focus this arguably was a medical matter not (in this case) dependent on the worker's account of how his injury arose. This

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28 Ibid, at [40].

29 Although this point was not decided, some commentators would argue that the filming of an injured worker is tantamount to acknowledging that the insurer considers the claim to be, at least in some respects, at best without merit and at worst fraudulent. Based on this argument if an insurer instigates surveillance as a matter of policy and without any evidence of bad faith by the worker, it follows that the surveillance is an act of bad faith on behalf of the employer/insurer. On the other hand, insurers would argue that they have developed best practice approaches to case management which require consideration of a range of triggers which present themselves in the course of a claim. Where those triggers appear, the claims manager is obliged to fully investigate the claim. One means by which this is done is through an investigator who may utilise film surveillance. It is likely that the Court of Appeal would be more prepared to accept the latter argument. As to the adverse affects of the use of surveillance, see K Lippel, 'Legal and social issues raised by the private policing of injured workers', 2003, at <http://www.ciws.ca/private-policing-lippel.pdf> (accessed 25 September 2007).

might be a fine line to draw. Clearly there are instances where a worker's report of injury needs to be heavily investigated as the acceptance of the worker's history has a large bearing on the medical reports obtained. Garcia's case does not appear to have been such a case. Extending the logic of the Court of Appeal might lead to the assumption that the credibility of all workers must be in doubt whenever a claim to compensation is made. That would be an unfortunate result, which no doubt the Court of Appeal would not intend. Interestingly, no direct comment is made by the Court of Appeal in relation to the insurer's continued failure to disclose medical reports to the applicant's lawyers.

In fact, a reading of the evidence in the judgments in *Garcia* relating to the medical reports does not disclose that the worker's credibility was in issue — the issue seems to be one of differing medical assessment. What seems to have happened in this case is that the insurer simply set about obtaining alternative medical advice. The Court of Appeal's comments in relation to the worker's credibility might be construed as giving a green light to the insurer to behave in an oppressive manner. Obtaining medical opinion of itself is, of course, not oppressive, but multiple referral of workers for opinions has now been recognised in a number of jurisdictions as warranting legislative intervention to prevent doctor-shopping.[30] In addition, the comments that in their view no breach of duty had arisen (if such a duty had been recognised) might be interpreted as an attempt to deny the worker any further right of appeal.

Not evident from the judgment are the reasons for HIH's actions. Goldring J held that his findings of fact demonstrated prejudice, dishonesty, denial of natural justice, poor management practice, unreasonable and biased decision-making and breaches of statutory duty, but the Court of Appeal did not agree with this inference. It may be argued that the behaviour of the insurer arose from the extraordinary commercial circumstances in HIH at the time of the *Garcia* claim[31] and are not typical of insurer claims management practice. The particular combination of actions which Goldring J held had breached good faith in *Garcia* may be atypical of claims management practice, but the pattern of decision-making clearly is not. Mr Garcia experienced a degree of damage to his person, his health, his family and his finances that appear to be extraordinary. But many anti-therapeutic outcomes from the workers' compensation system are a common experience for claimants, albeit seldom due to the combination of insurer activities as shown in *Garcia*. The fact that these practices might be endemic within the workers' compensation system seems to have been a factor for the Court of Appeal. The Court of Appeal noted that:

> Insurers are not charitable institutions, but neither are they mints. Insolvency of an insurer can be catastrophic . . . The unheralded introduction of new types of liability will . . . lead in the longer term to higher premiums. When there are voluntary

30 See, eg, r 91 of the Workers Compensation (DRD) Rules 2005 (WA) which restricts the worker from being referred to no more than three specialists

31 It is a notorious fact that HIH was in severe crisis at around the time of his claim.

> participants in a scheme, such as insurers, a judicially manufactured liability may impact upon the capacity to meet ordinary claims as well as deter others from entering the scheme as insurers.[32]

While these comments are clearly true, arguably this line of reasoning is irrelevant as it touches on the insurer's capacity to pay rather than its actions in managing the claim. Although consideration of the plaintiff's circumstances are relevant for the assessment of damages, the courts have always resisted consideration of the defendant's circumstances when determining liability. That said, the Court of Appeal raises an important point in relation to workers' compensation insurance, namely, the recent propensity of insurers to collapse and in so doing create a burden on the community. There is also some analogy with the comments made on the capacity of insurers to pay with the recent attitude of the High Court in relation to the liability which should be attached to public authorities. In a number of cases the High Court has held the public authority is under no duty of care in relation to decisions which involve or are dictated by financial, economic, social or political factors or constraints.[33]

It is also implicit in these comments that the behaviour of the kind adopted by HIH might be common enough to give rise to a flood of claims. The end result for Mr Garcia is that, despite the behaviour of the insurer in his case, there was no remedy outside of the statutory scheme. In the broader context, the Court of Appeal appears to have accepted that the behaviour of the insurer was to some extent dictated by financial, economic, social or political factors or constraints. That said, the alternative view might be that the Court of Appeal missed an opportunity to bring an insurer to account for poor claims management procedures.[34]

Reflections and conclusions

Writing in 1992 Cameron warned insurers of the likely repercussions of the court holding that an insurer had a duty to act in good faith to an injured worker who claimed compensation or damages. He said:

> It remains to be seen whether a trial judge finds that Mrs Gibson was owed the duty she alleges and whether, if such a duty exists, the facts alleged prove a breach of it.
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> However if a judge does so hold insurers will be exposed to a potential liability which will probably be disproportionately costly compared with any savings made

32 (2007) 14 ANZ Ins Cas 61-746; [2007] NSWCA 193; BC200706429 at [81] per Mason P.

33 See *Sutherland Shire Council v Heyman* (1985) 157 CLR 424 at 468–9; 60 ALR 1.

34 The discussion above does not imply that all injured workers have the same responses to poor claims management practices. Nor does it imply that all workers suffer the same way from practices that have anti-therapeutic outcomes for some. A study of injured workers' experience of rehabilitation and return to work puts forward a typology of workers: disempowered, empowered and those seeking revenge: L M Guy and S D Short, 'Rehabilitation of workers with musculoskeletal injury and chronic pain' (2005) 14(1) *Health and Sociology Review* 77–83. The study is striking for the uniform dissatisfaction injured workers had with the process, and that they all sought to get out of it. The lower socio-economic workers that dominated the disempowered group were stuck with the system, the empowered group had sufficient personal resources to get out in their own way and do their own rehabilitation (sometimes after years), and the 'revenge' group had moved to seeking justice for what they see is adding insult to injury in returning to work that caused their injury.

> by the offending conduct. Whether such a duty is appropriate to be introduced by judicial legislation is another question . . .[35]

Cameron was referring to the successful interlocutory application by Mrs Gibson to amend her statement of claim for damages against a workers' compensation insurer to add a cause of action for a breach of duty of good faith. Her claim never went to court. In noting the success of Mrs Gibson, Peterson urged acceptance of the duty in New Zealand. He noted that the decision in *Gibson v Parkes District Hospital* was a response to concerns which arose of the New South Wales Compensation Scheme at the time. Peterson observed that the scheme left the claimant particularly vulnerable to pecuniary loss if the claim was delayed or denied. Of the decision in Gibson he asserted:

> The defendant's bad faith was also a clear breach of the standard of behaviour required from the exercise of the statutory duty. The decision reflects a perceived need to punish the reprehensible conduct of the defendant insurer and employer who, conscious of that vulnerability, intentionally frustrated the valid claim of the deserving plaintiff.[36]

Gibson was referred to at length by Goldring J at first instance. However, *Gibson* was not followed in a case heard shortly thereafter in Victoria. In *Gimson v Victorian WorkCover Authority*[37] McDonald J declined to recognise a duty to act in good faith in relation to the administration of a workers' compensation claim. Gimson had suffered psychiatric injuries at work, which he claims were aggravated by the maladministration of the defendant's agent in making numerous medical appointments for him. Gimson's statement of claim essentially alleged that the defendants had not acted fairly. This allegation was not accepted as giving rise to a cause of action. Gibson's case was different. She alleged lack of good faith in administration of her payments of compensation. Her claim had been accepted, but the insurer so poorly calculated and remitted her payments that she was placed under financial pressure.

Reflecting on these early cases, the *Gimson* case can be seen as weak on its facts and not the strongest case upon which to assert a duty to act in good faith. *Gibson*'s case appears much stronger and, as noted by Peterson, there were grounds for breach of statutory duty given that the insurer had a statutory duty to properly calculate and promptly pay the applicant/plaintiff. *Garcia*'s case falls somewhere between these two cases on the facts. As in *Gimson*, Garcia's claim was denied, although on the available evidence the claim should have been accepted. The core of Garcia's allegations was that the insurer should have acted on the available medical evidence to accept the claim. To do so against the weight of evidence was a lack of good faith. The Full Supreme Court did not accept this and, in doing so, it appears to have all but closed the door for other plaintiffs to make similar allegations. The Full Court did not confine itself to the facts in *Garcia*, holding that generally no duty arises. As

35 R Cameron, 'Non contractual duty of utmost good faith considered in the Supreme Court' (1992) *Commercial Law Quarterly* 11 at 12.

36 J Peterson, 'The Duty of Good Faith in Insurance Relationships: The Decision in *Gibson v Parkers District Hospital*' (1994) 24 *VUWLR* 189 at 206.

37 [1995] 1 VR 209.

noted above, at least some of the reasons for the Full Court declining to accept such a duty can be traced to policy reasons, which related to restricting the liability of insurers so as to prevent them from opting out of the workers' compensation market. The other ground seems to be that the Full Court did not want to limit the insurer's right to decline a claim for fear that it might fall foul of any duty to act in good faith. Making the case for a breach of duty to act in good faith will certainly be harder following *Garcia*, although it is well to remember that each state and territory scheme has slightly different rules governing the behaviour of insurers. Increasingly the rules and regulations of compensation schemes have required the parties to proceedings to give full and frank disclosure of documents and information, restrict the number of medical appointments which can be made for a worker, require an insurer/employer to investigate and decide a claim within time limits and make payments of compensation in a timely manner. For the future it is unlikely we will see a plaintiff bring a claim solely on the grounds of breach of good faith. It is more likely that plaintiffs would include such an allegation only where there are other uncontroversial causes of action. Further, it is likely that when plaintiffs have the courage to continue with such a claim, the argument will need to be tailored to fit into a claim for breach of statutory duty rather than breach of good faith.