LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON JUSTICE AND COMMUNITY SERVICES
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Submission Cover Sheet

Inquiry into Motor Accident Injuries Bill 2018—Exposure Draft and Guide to the Motor Accident Injuries Bill 2018 Exposure Draft

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The Committee Secretary
Standing Committee on Justice and Community Safety
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Dear Secretary

Inquiry into *Motor Accident Injuries Bill 2018*

IAG welcomes the opportunity to provide a submission to the Standing Committee on Justice and Community Safety (the Committee) in response to the exposure draft of the *Motor Accident Injuries Bill 2018* (the Bill). IAG supports the reform of the ACT CTP scheme and looks forward to continuing to work with the ACT Government to deliver the reforms.

The primary concern of IAG following our review of the Bill is the complexity of some claims processes for injured people and to a lesser extent, for insurers. Our specific concerns and feedback are outlined in the following pages.

We have also included a number of recommendations which we consider would simplify and improve the experiences of injured people in making claims and also better meet the objectives of the Citizens' Jury and the ACT CTP scheme.

About IAG

Our purpose is to make your world a safer place, which means we are working to create a safer, stronger and more confident tomorrow for our customers, partners, communities, shareholders and our people throughout Asia Pacific. IAG is the parent company of a general insurance group, with operations in Australia and New Zealand. Our businesses sell insurance under many leading brands, including: NRMA Insurance, CGU, SGIO, SGIC, Swann Insurance and WFI in Australia; NZI, State, AMI and Lumley Insurance in New Zealand.

As one of the largest motor vehicle insurers in the Asia-Pacific, IAG develops, underwrites, sells and manages claims for general insurance products that are sold directly and indirectly to customers and businesses. IAG insures over 3.2 million passenger vehicles in Australia.

IAG has been a provider of CTP insurance in the ACT since 1980 and under the NRMA Insurance brand, was the sole provider of CTP insurance in the ACT for over 30 years. IAG currently underwrites around 164,000 CTP personal insurance policies in in the ACT each year. IAG also provides CTP insurance in New South Wales and South Australia.

1. Entitlement to defined benefits

Foreign nationals

The Bill requires that a foreign national injured in a motor accident in the ACT exhaust their entitlements under any insurance policy (for example, travel insurance) before recovering under the motor accident injuries scheme (see clause 44). Travel insurance policies vary considerably in their terms and the cover they offer. It is likely that an injured person's access to treatment and care and income replacement payments would be delayed by reason of the obligation to attempt recovery against the travel insurance policy and to quantify entitlements under that policy as against those for which they may be eligible under the motor accident injuries scheme. We consider this process likely to cause inconvenience and distress to an injured person thereby diminishing any benefits that may be considered associated with the requirement.

The proposal is also administratively complex for insurers who would need to deal with the foreign national's travel insurer (who has no obligation to share information) to attempt to ascertain where travel insurance liability ceases, and the motor accident injuries liability begins.

Recommendation – Foreign nationals
IAG recommends removing the requirement for foreign nationals to recover against any travel insurance policy.

2. Defined benefits – income replacement

There are various aspects of income replacement benefits processes outlined in the Bill which we consider may be problematic for injured people and insurers in their administration. There are particular clauses in the Bill which we consider will be confusing to injured people and will likely lead to many disputes. Our concerns in relation to the income replacement provisions are set out below.

Gross income

Clause 77(a)(ii)(B) and (C) require a *substantially uniform* and *established pattern* of overtime for overtime to be included as part of an injured person's gross income. These terms are highly subjective thereby open to wide ranging interpretation which may cause disputes in the calculation of gross income while also disadvantaging some injured people and benefiting others.

Recommendation – Meaning of gross income
IAG recommends that the requirements for overtime to constitute part of the injured person's gross income be clearly quantified to avoid disputes and to ensure fair consideration of overtime worked by injured people.

Capable of being in paid work

We consider that the definition of "capable of being in paid work" could be regarded as a stigmatising reference to those falling outside the category and potentially divisive in its operation. For example, an unemployed person who is actively looking for work may not satisfy this definition. This definition would also be unfair to an injured person who has a strong work history but has had health problems which have recently kept them out of the workforce. They may now be able to return to work and be actively seeking employment. However, if they had not worked at least 260 hours in the previous 52 weeks (roughly 7 weeks of full time work), they would not satisfy the definition of "capable of being in paid work".

We are concerned that there would be many people who do not satisfy this definition and thus would not be entitled to receive income replacement benefits. Additionally, we consider that being advised that they are not "capable" of being in paid work would negatively impact these injured people.

Full-time students

We also hold some concern in relation to clause 80(1)(e) of the Bill particularly when this clause is considered in conjunction with the example of "Suzy" included in the Guide to the Bill (page 15). It would seem that if a full-time student has a recent work history, this will override the application of clause 89 and their pre-injury earning capacity (the reference point for measuring their loss) will be determined according to their recent work history, not what they would have received upon completion of their course of study. For example, if Suzy had been one week away from completing her nursing degree, her income replacement benefits would be calculated, for up to five years after the accident, on her casual work as a barista and football referee, not on what she would have earned working full-time as a nurse.

Recommendation – full-time students

We recommend that the income replacement benefits for injured people who were full-time students at the time of the accident be calculated on the basis of any employment during the course of their study.

However, the injured person's income replacement benefits should be calculated on the basis of the earnings the injured person would have received upon being employed on the completion of the course of study from the following dates:

- If the injured person's completion of their study has been delayed as a result of their injuries, from the date the injured person would have completed the course but for their injuries or
- If the injured person completes their course as expected but is not able to commence paid work as expected as a result of their injuries, from the date of completion of the course.

Anticipated return to work

In a number of clauses, the term "anticipated return to work" is used. This term is subjective and open to a variety of interpretations which will likely result in disputes. It suggests that no actual return date is required, only that that the injured person would one day return to work.

No entitlement to income replacement benefits – retirement-aged injured person

Clause 93 of the Bill provides that there is no entitlement to income replacement benefits for injured people who are at retirement age plus 26 weeks. This means that an injured person of this age who was working at the time of the accident receives no income replacement benefits if they are unable to work as a result of their injuries. This is an unjust outcome for injured people who continue to work past retirement age by choice or need.

The *Motor Accident Injuries Act 2017* (NSW) provides for income replacement benefits for injured people who continue to work past retirement age for a period of 12 months after the accident (see section 3.13). This allows the injured person to apply for a pension or make other financial arrangements to fund their future. We consider this approach to be preferred to that outlined in clause 93 of the Bill.

Recommendation – Retirement-aged injured person
We recommend that clause 93 of the Bill be revised to mirror section 3.13 of the *Motor Accident Injuries Act 2017* (NSW). We consider that this revision would produce much fairer outcomes for injured people who are working beyond retirement age.

Amount of income replacement benefits

Clauses 97 and 98 of the Bill provide that the level of income replacements available to an injured person will depend on their pre-injury income:

First entitlement period

- An injured person whose pre-injury income is less than $800 will receive 100% of their pre-injury income
- An injured person whose pre-injury income is over $800 will receive 95% of their pre-injury income

Second entitlement period

- An injured person whose pre-injury income is less than $800 will receive 100% of their pre-injury income
- An injured person whose pre-injury income is equal to or more than $800 but not more than $1,000 will receive 95% of their pre-injury income
- An injured person whose pre-injury income is more than $1,000 will receive 80% of their pre-injury income

We consider that this method of calculating entitlements will result in unjust outcomes where the pre-injury income amounts of injured people may vary by only a few dollars.

Example – John and Mary
John's pre-injury income is $795 so he will receive 100% of his pre-injury income. Mary's pre-injury income is $802. She will receive 95% of her pre-injury income which is $761.90.

Recommendation – amount of income replacement benefits

We recommend that the same rate of benefits be applied to all injured people (say 95%), regardless of their pre-injury income, unless their pre-injury income is below the minimum wage in which case they should receive 100% of their pre-injury income.

3. Defined benefits – treatment and care

Allowable expenses during initial period

The Bill provides that allowable expenses can be claimed and must be paid by an insurer up to 28 days (the initial period) after the lodgement of an application for defined benefits, if the application is lodged within 13 weeks of the motor accident.

The Guide to the Bill provided by the ACT Government provides that (yet to be developed) guidelines:

- will require insurers to pay for an initial medical consultation, and up to two allied health services, provided prior to the injured person making an application for defined benefits (page 13) and
- will likely allow for the automatic approval of up to 4 services from a general practitioner and up to eight allied health services where a doctor's referral has been provided in the first four weeks from the receipt of the application (page 16).

To ensure an injured person's access to early treatment and care is as easy as possible, it should made clear whether the allowable expenses incurred prior to an application for defined benefits being lodged are included in or in addition to the automatic approval available following lodgement of the application.

We also suggest that allowable expenses be further defined to specify the services which are to be considered as allowable expenses and those which are not. For example, we do not consider that investigations such as MRIs and alternative treatments such as natural therapies (which are not evidence-based) be included as allowable expenses.

4. Assessment of whole person impairment

IAG supports the objective assessment of injury and understands it to be an efficient method for the distribution of finite resources. An assessment of an injured person's whole person impairment (WPI) is critical to determine their entitlement (if any) to a defined benefit quality of life payment and if they are not at fault, to determine their entitlement to make a common law damages claim.

Whilst this assessment is of great importance, we are concerned by the overall complexity of this process. Injured people will be required to take in complex information upon which they will be required to make decisions that have potentially significant financial impacts upon them. All of this while they are dealing with the effects of their injuries.

It is also likely that the complexity of the process will cause injured people to seek the assistance of a lawyer, for which no legal costs may be payable by the insurer.

We are particularly concerned by the following aspects of the WPI assessment process:

- The requirement for the injured person to pay an excess to the insurer for the assessment where the insurer considers there is no permanent impairment (clause 136(2)(c)). We consider that this requirement disadvantages those injured people of lesser financial means. We also submit that enforcing this process and collecting/recovering excess amounts would be administratively difficult and expensive, to say nothing of the impact on the relationship between the injured person and insurer.

- The requirement for injured people to select whether they will pursue quality of life benefits for physical or psychological injuries, where they have sustained both (clause 145(1)). We do not consider it reasonable to require injured people to make this election. It is unfair for injured people to be required to make such a determination based on complex medical information which has potentially significant financial impacts. We also consider it to be unjust that both physical and psychological injuries are not assessed when an injured person has suffered both, particularly as these are likely to be the more seriously injured people.

- The Bill currently makes no special provision for children who may prove difficult to assess for WPI within the proposed timelines, and who will suffer losses and have needs that will fall outside the timeframes for defined benefits.

- The tool or methodology to be used in undertaking the WPI assessment has not been specified in the Bill. The Guide to the Bill (at page 16) indicates that the intention is to adopt the Safe Work Australia Guidelines which are based on the American Medical Guidelines 5th Edition with modifications for some body systems. We submit that care is required in modifying the WPI assessment tool to ensure that a tool designed for workers and work place injuries adequately and fairly responds to road trauma injuries and injuries of children and the elderly.

It is also noted that the Bill requires a WPI assessment to occur in all cases, except where the insurer considers there is no permanent impairment and the injured person agrees. There is no provision which allows for agreement of WPI between the parties. This would reduce the overall cost of WPI assessments within the scheme and where possible, remove the need for injured people to undergo potentially unnecessary assessments.

The case study below outlines the complexity and difficulties of the WPI process and allocation of defined benefits.

Case study - Daria

Daria is a carpenter by trade. She left her employer a few months before she had her second child. Her employer was a small business which could not keep her role open while she was on unpaid leave. Given that the cost of child care for two children while she worked would be similar to what Daria could earn, the family decided that it would be better for everyone if Daria took a career break until the oldest of the children started school, in about 2 years.

A few months before Daria was planning to return to work, she was seriously injured, along with her youngest child, in an accident she did not cause. Daria is unable to work indefinitely, and there is a possibility she will never be able to return to work as a carpenter,given the nature and severity of her orthopaedic and psychological injuries.

Daria is eligible to make an application for defined benefits. She is entitled to recover medical expenses and quality of life benefits but not income replacement. Daria will also be eligible to make a motor accident claim.

Despite having lost income during the first year after her accident, Daria will not be able to recover this loss even if she lodges a common law claim for damages.

Daria and her family feel financial pressure as a result of the injuries preventing her return to work. There are also additional costs that are not recoverable. For example, Daria, and perhaps the youngest child will need WPI assessments that need to be paid for by the family. The insurer is only required to pay for the first assessment and Daria is not sure whether the physical or psychological injuries will result in the greatest impairment and which will

provide the greatest financial benefit. Daria elects to have the insurer pay for assessments of her and the youngest child's physical injuries as there will be more than one assessment for each of them as they have injuries to multiple body systems.

Accordingly, Daria will need to pay for a private medical assessment of her psychological injuries and those of her child. She is concerned about these assessments, the assessment process, cost and the timing, particularly for her child.

Two years after the accident, the cost to the family of having Daria out of the workforce is biting hard. Daria is working closely with the insurer on her rehabilitation and is desperate for her injuries to stabilise as she needs to receive her quality of life benefit payment. Daria is aware that by taking the defined benefit payment and not waiting for the damages claim to be resolved she will have to take a lesser amount. However, she needs the money now so feels like she has no choice.

The decisions that the family must make are very difficult for them as they know very little about how injuries are measured, and payments are calculated. The treatment, rehabilitation and care of two family members causes enormous disruption to family life and the addition of the claim and decision-making responsibilities makes life even tougher and recovery slower.

Recommendation – Assessment of whole person impairment

We recommend:

- That where an injured person has sustained both physical and psychological injuries, the insurer be required to meet the cost of assessment of the WPI for both injury types, removing the need for an election on the part of the injured person.
- That the requirement for an excess to be paid where there is a dispute over whether or not there is any WPI be removed.
- That special provision be made for WPI assessments for children
- Parties be permitted to agree the level (or range) of WPI, removing the need for assessment wherever possible

We consider that the recommendations above, if implemented, would go some way to reducing the complexity and difficulty currently associated with the WPI process.

However, we consider that despite any simplification of the WPI assessment process which may occur, there will be a need for a significant investment in the development of information for injured people to assist them in understanding the process of assessment. To further increase understanding and avoid disputes where possible, we also suggest that case studies that demonstrate the level of WPI that common injury types are likely to produce be provided.

5. Quality of Life payments

Scale for payments

The table below sets out the eligibility requirements for quality of life payments and the maximum amounts payable for quality of life benefits.

Fault	Level of injury	Maximum
Not at fault and at fault	< 5% whole person impairment	NIL
	> 5% whole person impairment	$350,000 (defined benefits)
Not at fault	>10% whole person impairment	$500,000 (common law damages)

It is currently proposed that the amount of the quality of life payment to be paid to the injured person is to be determined according to the percentage of their whole person impairment, with a dollar value prescribed for each percentage point between 5% and 100% (for defined benefits) and between 10% and 100% (for common law damages).

Accordingly, there is a clear financial incentive for an injured person to test their WPI assessment score and to "push" for a higher WPI score. There is financial benefit in an increase of 1% in a WPI assessment score. This would create disputes, prolong the finalisation of WPI outcomes and delay the progress of the claim.

IAG proposes that a scale with ranges of WPI rather than a defined amount for individual percentage points be used for the calculation of quality of life payments. We note that this measure was proposed as part of Model D in the Finity paper "*Model Designs Citizens' Jury for ACT CTP Scheme*", which was provided to the Citizens' Jury in their final deliberations (see page 22, section 3.71). Model D was ultimately selected as the model which best reflected the objectives identified by the Citizens' Jury.

We consider that removing percentage point precision would alleviate cost from the scheme and stress from injured people. Further, a range for WPI would better facilitate agreement between the parties, reducing disputes and removing the need for assessments which are costly, take some time and can also be stressful for the injured person.

Recommendation – Quality of life payments
We recommend that the calculation of quality of life benefits be made by reference to WPI ranges (covering multiple percentage points) rather than to individual percentage points. We consider that this would promote ease of administration, reduce the number of assessments required and disputes on assessments.

6. Death benefits

IAG has concerns in relation to the efficiency of the application of scheme funds and administration of death benefit payments. It is noted that financial dependency upon the deceased by the person's spouse (past or present) and/or children is a pre-condition to eligibility for death benefits and determinative of the manner in which the benefit is calculated, to a maximum amount of $350,000.

Despite the financial dependency which must be established for eligibility, death benefits are to be paid to the estate of the deceased person, not to their financial dependants. Payment of these benefits into the deceased person's estate will create complexity in the administration of the benefit, potential waste as scheme funds are applied for purposes other than those for which they have been collected. For example, payment of the deceased person's debtors. Additionally, it will create uncertainty for the deceased's financial dependants, as the administration of the estate will take time and the distribution of assets (if any) may be such that they do not receive any part of the benefit.

Recommendation – Death benefits

IAG recommends payment of the death benefit to financial dependents with guideline making powers facilitating the distribution of the maximum amongst the defined class of beneficiaries.

7. Common law damages claims

No-fault accidents

Clause 199 of the Bill provides that the driver of a motor vehicle involved in a motor accident is not entitled to recover damages in relation to personal injuries sustained by the driver if the accident was a no-fault accident or was caused by an act or omission of the driver. It would also follow that all drivers involved in a multi vehicle no-fault accident would be excluded from making a claim for damages.

Additionally, clause 199 appears to contradict clause 209(2)(b) which apportions liability equally between drivers in a multi vehicle accident.

It seems to us that there is some inconsistency in the no-fault provisions that will lead to uncertainty of entitlements in relation to common law damages and disputation in the claim process.

We suggest that greater consideration needs to be given to the intention of the ACT reform and the objective's identified by the Citizens' Jury's objectives. We consider that excluding an injured person who suffers a WPI of 10% from common law damages because they were a driver involved in a multi-vehicle blameless accident which they did not cause is contrary to the objectives of the Citizen's Jury and is unjust. We accept that the driver causing the accident, although they were not at fault, will be excluded from damages in this situation to effect deeming. We consider it possible and desirable to provide eligibility to damages for a driver who has not caused the blameless accident.

Recommendation – no-fault accidents

We recommend that the exclusion applied to drivers involved in a no-fault accident be limited to a driver in a single vehicle accident or the driver in a multi vehicle accident that caused the accident through an act or omission. For example, that the exclusion only apply to the driver suffering an unexpected medical emergency which caused them to cross to the incorrect side of the road and impact with an oncoming vehicle. The driver of the oncoming vehicle, while involved in a multi vehicle accident, should remain entitled to recover damages.

No loss of earnings in first year after accident

Clause 203 of the Bill provides that no damages are payable for any loss of earnings suffered by an injured person in the first year after the motor accident. The exclusion appears based on the assumption that an injured person who is eligible for loss of earnings/ earning capacity damages would also be eligible for income replacement defined benefits. We note that the eligibility criteria for income replacement benefits is far harder to satisfy than that for loss of earnings/ earning capacity damages which means that there

will be a group of seriously injured not at fault people, such as Daria (case study at page 9), who will not be able to recover a full year of losses. We consider this outcome to be inconsistent with the Citizen's Jury objectives.

For those injured people who received income replacement benefits during this period, they will have only received a portion of their actual loss and will not have received compensation for any lost superannuation.

Additionally, an injured person who lodges a late claim for defined benefits may not have received income replacement benefits at all in the first year, or only for a portion of that period.

It seems unreasonable and punitive to treat the most seriously injured in this way. Given that a lack of fault is a requirement for common law claims, along with a WPI of at least 10%, it seems somewhat unjust to include this restriction as a discouragement to claiming damages.

Recommendation – loss of earnings in first year after accident
We recommend that injured people who are eligible for common law damages be permitted to recover their loss of earnings in the first year at the full rate including superannuation. Alternatively, we recommend that the application of the exclusion outlined in clause 203 be limited to those who have previously received income replacement benefits.

Quality of Life payments

We note that it is proposed that acceptance of a quality of life defined benefit payment precludes an injured person from later claiming quality of life damages if they were not at fault and sustained a WPI of 10% or more.

We do not agree with this proposal. As can be seen from the table on page 12, there is a significant difference between the maximum quality of life payments for defined benefits and for common law damages. Accordingly, a seriously injured person is disadvantaged by accepting a quality of life defined benefit, which they may have done because of financial difficulty or need (see case study of Daria, at page 9).

We consider that the proposal to exclude a recipient of quality of life defined benefits from quality of life damages to be inequitable and likely to impact those least able to burden the differential in the payment. That is, seriously injured people without financial resources will likely accept a quality of life defined benefit if it will be paid to them more quickly than a quality of damages payment.

A person who is eligible to make a damages claim is likely to have future needs (medical and loss of earning capacity) that will require compensating as damages. These injured people have already demonstrated that they were not at fault for the motor accident and that they have suffered a WPI of at least 10%. Given this, it seems unjust to use a further threshold. We acknowledge that this proposal may be intended as a device to discourage injured people from making claims for damages, however, we do not support this contention as a person with such serious injuries will rightly make a claim for common law damages to recover for their future needs.

Recommendation – Quality of life damages

We recommend that injured people who are entitled to make a common law claim should able to receive a quality of life defined benefit payment and still be entitled to make a claim for quality of life damages, up to the value of the difference in payments between the two scales (maximum difference of $150,000).

Should the above recommendation not be implemented, it will be crucial to clearly articulate and communicate to injured people the benefits and disadvantages of accepting a quality of life defined benefit payment or pursuing a quality of life damages payment. It would also be necessary, for the purposes of equity, to provide support to enable an injured person to exercise their preference for defined benefits or damages free of the coercive pressure of financial hardship, for example permit an advance payment of economic loss damages in cases of financial hardship to bridge the gap.

8. Dispute resolution

As noted above, IAG also provides CTP insurance in New South Wales. Our recent experience of managing claims under the *Motor Accident Injuries Act 2017* (NSW) suggests that there will be a number of decisions relating to defined benefit entitlement which may become a source of disagreement between the injured person and the insurer. These include:

- Injury causation, particularly in circumstances where the injured person has a pre-existing injury or medical condition
- Whether treatment is reasonable and necessary
- Whether an injury has sufficiently stabilised for the purposes of undertaking an assessment of whole person impairment
- The level of whole person impairment sustained by the injured person
- Pre-injury weekly income, particularly in circumstances where the injured person is self-employed

IAG supports the requirement for insurers to undertake internal reviews of specified decisions, prior to a dispute being referred to an independent third party. We consider that internal reviews are an important step in the dispute resolution process and also act as a quality assurance measure for insurers to monitor the decision-making of its staff and where necessary, make improvements to its decision-making processes and the skills of its staff.

At this stage, we are unable to make any evaluation of or comment on the efficacy of external resolution of defined benefit disputes. It is noted that the Bill delegates the nomination of the body to undertake dispute resolution to the Attorney-General and that dispute resolution processes will be provided at a later date in regulations and guidelines.

The Guide to the Bill provided by the ACT Government indicates that stakeholders are being consulted on dispute resolution options and bodies, such as the Magistrates Court and ACT Civil and Administrative Tribunal (ACAT). Further, it is expected that the Bill, upon introduction, will include more detailed dispute resolution provisions.
Given the absence of detail for comment, we take this opportunity to identify key issues for consideration in the assessment of the appropriateness of any dispute resolution body and process:

- *Accessibility / informality* – most disputes can be resolved without the need for legal representation
- *Transparency / fairness* – parties must be afforded the opportunity to be heard and to obtain cogent reasons for any decision that is made

- *Efficiency / timeliness* – the process from the time of making an application to the making of a decision by the external decision maker must be efficient to ensure any disruption to the flow of benefits and progress of the claim is minimal

9. Issues impacting motor accident injury insurers

Fraud

Clause 300 of the Bill enables an insurer to recover costs associated with fraudulent behaviour on a claim. However, we note there is no provision which creates a specific offence relating to false, misleading or fraudulent behaviour within the Bill.

Recommendation – Fraud
IAG recommends that an offence be included in the legislation, to support clause 376 which requires that insurers take all reasonable steps to deter and prevent the making of fraudulent applications for defined befits and damages claims.

Grounds for licence cancellation

We refer to clause 335 of the Bill which purports to provide the grounds for cancelling an insurer's licence. We are concerned by subsection (a) which provides that the MAI commission can cancel an insurer's licence if "*the MAI commission considers the cancellation appropriate for any reason, including reasons relating to the motor accident injury insurance scheme under this Act generally, whether or not the reasons relate to the efficiency and conduct of the licensed insurer*".

We consider this to be a very broad power with few (if any) restraints or restrictions on its application. This is of particular concern to IAG given the capital required to operate as a CTP insurer in the ACT. We consider that given these capital requirements, insurers should reasonably expect some assurance and certainty in relation to the application of these powers.

IAG would be pleased to share our knowledge and expertise and discuss aspects of this submission with the Committee in greater detail. Should you wish to discuss this submission, please contact me on the number below.

Yours sincerely

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