Reports of Cases

JUDGMENT OF THE EUROPEAN UNION CIVIL SERVICE TRIBUNAL (Third Chamber)

13 June 2012*

(Civil service — Former official — Social security — Accident — Closure of the procedure for the application of Article 73 of the Staff Regulations — Temporal application of the scale annexed to the new version of the rules on insurance against the risk of accident and of occupational disease — Duration of the procedure)

In Case F-31/10,

ACTION brought under Article 270 TFEU, applicable to the EAEC Treaty pursuant to Article 106a thereof,

Christian Guittet, former official of the European Commission, residing in Cannes (France), represented by L. Levi, lawyer,

applicant,

v

European Commission, represented by J. Currall and D. Martin, acting as Agents, assisted by J.-L. Fagnart, lawyer,

defendant,

THE CIVIL SERVICE TRIBUNAL (Third Chamber)

composed of S. Van Raepenbusch (Rapporteur), President, R. Barents and K. Bradley, Judges,

Registrar: J. Tomac, Administrator,

having regard to the written procedure and further to the hearing on 7 March 2012,

gives the following

Judgment

1 By application received at the Registry of the Tribunal on 14 May 2010, Mr Guittet, a former official of the European Commission, seeks, inter alia, annulment of the decision of 27 July 2009 by which the appointing authority closed the procedure opened under Article 73 of the Staff Regulations of Officials of the European Union ('the Staff Regulations') and assessed his physical/mental impairment ('disability') at 64.5%.

* Language of the case: French.

Legal context

Staff Regulations

2 Under Article 73(1) and (2) of the Staff Regulations:

‘1. An official is insured, from the date of his entering the service, against the risk of occupational disease and of accident subject to rules drawn up by common agreement of the institutions [of the European Union] after consulting the Staff Regulations Committee. ...

2. The benefits payable shall be as follows:

…

(b) [i]n the event of total permanent invalidity:

[p]ayment to the official of a lump sum equal to eight times his annual basic salary calculated on the basis of the monthly amounts of salary received during the 12 months before the accident;

(c) [i]n the event of partial permanent invalidity:

[p]ayment to the official of a proportion of the sum provided for in subparagraph (b), calculated by reference to the scale laid down in the rules referred to in paragraph 1.

…

The benefits listed above may be paid in addition to the benefits provided for in Chapter 3.’

Insurance rules adopted pursuant to Article 73 of the Staff Regulations

Scope and transitional provisions

3 On 1 January 2006, the rules common to the institutions of the European Union on insurance against the risk of accident and of occupational disease (‘the Insurance Rules’ or ‘the new Insurance Rules’), provided for in Article 73(1) of the Staff Regulations, which replaced the previous common rules on insurance last amended on 18 July 1997 (‘the old Insurance Rules’), came into force.

4 Article 1 of the Insurance Rules is worded as follows:

‘These rules lay down, pursuant to Article 73 of the Staff Regulations, the conditions under which insured parties are insured throughout the world against the risk of accident and of occupational disease.

The following are insured under these rules:

— permanent officials;

— temporary staff;

— contract agents.’

5 Article 30 of the Insurance Rules lays down the following transitional provisions:

'[The old Insurance Rules] are hereby repealed.

However, they shall continue to apply to all draft decisions adopted under Article 20(1) before 1 January 2006 ...'

6 Article 31 of the Insurance Rules provides:

'These [new Insurance Rules] shall enter into force on the first day of the month following that in which the agreement between the institutions provided for in Article 73(1) of the Staff Regulations is recorded by the President of the Court of Justice [of the European Union].

They shall apply as from the same date.'

Concept of permanent invalidity

7 Article 11 of the Insurance Rules, headed 'Permanent invalidity', is worded as follows:

'1. Total or partial permanent invalidity shall be measured in terms of physical or mental impairments as laid down in the European disability rating scale given in Annex A.

The practical rules for the use of the scale shown in Annex B shall apply.

…

2. Where an insured party sustains total permanent invalidity as a result of an accident or an occupational disease, the physical or mental impairment shall be 100% and he/she shall be paid the lump sum provided for in Article 73(2)(b) of the Staff Regulations.

3. Where an insured party sustains partial permanent invalidity as a result of an accident or an occupational disease, he/she shall be paid a lump sum provided for in Article 73(2)(c) of the Staff Regulations and determined on the basis of the rates laid down in the scale …

4. Injuries to limbs or organs previously disabled shall only be compensated by the difference between the condition before and that after the accident.

5. ...

6. The total allowance for invalidity on several counts arising out of the same accident shall be obtained through addition but such total shall not exceed either the total lump sum of the insurance for permanent or total invalidity or the partial sum insured for the total loss or the complete loss of use of the limb or organ injured.'

8 Article 12 of the old Insurance Rules provided as follows:

'1. Where an official sustains total permanent invalidity as a result of an accident or an occupational disease, he shall be paid a lump sum provided for in Article 73(2)(b) of the Staff Regulations.

2. Where an official sustains partial permanent invalidity as a result of an accident or an occupational disease, he shall be paid a lump sum calculated on the basis of the rates laid down in the invalidity scale contained in the Annex hereto.'

Additional allowance

9 Article 13 of the Insurance Rules provides that, after consulting the doctors appointed by the institutions or the Medical Committee referred to in Article 22, insured parties are to be granted an additional partial permanent invalidity allowance for physical disfigurement, sexual impairment (excluding reproductive impairment), exceptional pain and suffering not established objectively but medically plausible, and impairment of capacity to exercise leisure activities specific to the insured party. This allowance is to be determined on the basis of the scale for assessing specific forms of impairment contained in Annex C to the Insurance Rules.

Procedural provisions

10 Article 18 of the Insurance Rules provides that decisions recognising the accidental cause of an occurrence or recognising the occupational nature of a disease or assessing the degree of permanent invalidity are to be taken by the appointing authority in accordance with the procedure laid down in Article 20 of those rules, on the basis of the findings of the doctor(s) appointed by the institutions and, where the insured party so requests, after consulting the Medical Committee referred to in Article 22 of those rules.

11 Under paragraph 3 of Article 19 of the Insurance Rules, headed 'Consolidation of injuries':

'The decision defining the degree of invalidity shall be taken after the insured party's injuries have consolidated. The consequences of the accident or occupational disease shall be considered consolidated where they have stabilised or will diminish only very slowly and in a very limited way. To this end, the insured party concerned shall submit a medical report stating that he/she has recovered or that his/her condition has stabilised and also setting out the nature of the injuries. However, the doctor(s) appointed by the institution or the Medical Committee referred to in Article 22 may decide that consolidation has taken place, including in the absence of this medical report.

…'

12 Article 20 of the Insurance Rules provides as follows:

'1. Before taking a decision pursuant to Article 18, the appointing authority shall notify the insured party or those entitled under him/her of the draft decision and of the findings of the doctor(s) appointed by the institution. The insured party or those entitled under him/her may request that the full medical report be communicated to them or to a doctor chosen by them.

2. Within a period of 60 days the insured party or those entitled under him/her may request that the Medical Committee provided for in Article 22 deliver its opinion. The request for the matter to be referred to the Medical Committee shall contain the name of the doctor representing the insured party or those entitled under him/her together with a report from that doctor setting out the medical issues disputed in relation to the doctor(s) appointed by the institution for the purposes of applying these rules.

3. Where, on expiry of this period, no request has been made for consultation of the Medical Committee, the appointing authority shall take a decision in accordance with the draft previously supplied.'

13 The first paragraph of Article 20 of the old Insurance Rules provided as follows:

'The decision defining the degree of invalidity shall be taken after the official's injuries have consolidated. To this end, the official concerned must submit a medical report stating that he has recovered or that his condition has stabilised and also setting out the nature of his injuries.'

14 Under Article 22 of the Insurance Rules, headed 'Medical Committee':

'1. The Medical Committee shall consist of three doctors:

— one appointed by the insured party or those entitled under him/her;

— one appointed by the appointing authority;

— one appointed by agreement between the first two doctors.

Where agreement cannot be reached on the appointment of the third doctor within a period of two months following the appointment of the second doctor, the President of the Court of Justice [of the European Union] shall appoint the third doctor at the request of either party.

Irrespective of the method of appointment, the third doctor must have expertise in assessing and treating bodily injury.

2. The institution shall define the terms of reference provided to the Medical Committee. These shall cover medical matters raised by the report from the doctor representing the insured party or those entitled under him/her and other relevant medical reports transmitted under Article 20(2).

The fees and expenses of the doctors making up the Medical Committee shall be set in accordance with a scale laid down by the … institutions' [h]eads of [a]dministration, depending on the complexity of the case assigned to the Medical Committee.

Before confirming the terms of reference given to the Medical Committee, the institution shall inform the insured party or those entitled under him/her of the fees and expenses which are liable to be borne by them in accordance with paragraph 4. The insured party or those entitled under him/her may not under any circumstances object to the third doctor on account of the amount of the fees and expenses requested by him/her. However, the insured party or those entitled under him/her shall be free at all times to discontinue the procedure for referral to the Medical Committee. In that case, the fees and expenses of the doctor chosen by the insured party or those entitled under him/her and half of the fee and expenses of the third doctor, shall be borne by the insured party or those entitled under him/her in respect of the part of the work that has been completed.

The insured party or those entitled under him/her shall remain liable to his/her doctor for sums agreed with him/her, irrespective of what the institution agrees to pay.

3. The Medical Committee shall examine collectively all the available documents liable to be of use to it in its assessment and all decisions shall be taken by majority vote. The Medical Committee shall be responsible for deciding on and adopting its own rules of procedure. The third doctor shall be responsible for providing the secretariat and drafting the report. The Medical Committee may request additional examinations and consult experts in order to complete the case or obtain opinions which are necessary for carrying out its task.

The Medical Committee may deliver medical opinions only on the facts submitted to it for examination or which are brought to its attention.

If the Medical Committee, whose task is limited to the purely medical aspects of the case, considers that it may entail a legal dispute, it shall declare that it does not have competence to deal with the matter.

On completing its proceedings, the Medical Committee shall set out its opinion in a report to the appointing authority.

On the basis of that report, the appointing authority shall notify the insured party or those entitled under him/her of its decision together with the findings of the Medical Committee. The insured party and those entitled under him/her may request that the Committee's full report be transmitted to a doctor of their choice or that it be communicated to them.

4. Expenses incurred in connection with the proceedings of the Medical Committee shall be borne by the institution to which the insured party belongs.

However, where the opinion of the Medical Committee is in accordance with the draft decision of the appointing authority insured parties or those entitled under them shall pay the fees and incidental expenses of the doctor chosen by them and half of the fee and incidental expenses of the third doctor, whilst the remainder shall be borne by the institution.

…'

15 Article 23 of the old Insurance Rules, relating to the Medical Committee, provided as follows:

'1. The Medical Committee shall consist of three doctors:

— one appointed by the appointing authority;

— one appointed by the official concerned or those entitled under him;

— one appointed by agreement between the first two doctors.

Where agreement cannot be reached on the appointment of the third doctor within a period of two months following the appointment of the second doctor, the President of the Court of Justice … shall appoint the third doctor at the request of either party.

On completing its proceedings, the Medical Committee shall set out its opinion in a report to be communicated to the appointing authority and to the official or those entitled under him.

2. Expenses incurred in connection with the proceedings of the Medical Committee shall be borne by the institution to which the official belongs.

Where the doctor appointed by the official is resident elsewhere than at the place where the official is employed, the official shall bear the cost of the additional fees entailed, with the exception of first-class rail fare or economy-class air fare, which shall be refunded by the institution. This provision shall not apply in the case of an accident which occurred in the course of or in connection with the performance by the official of his duties or in the case of an occupational disease.

Where the opinion of the Medical Committee is in accordance with the draft decision of the appointing authority notified to the official or to those entitled under him pursuant to Article 21, the latter shall pay the fee and incidental expenses of the doctor chosen by them and half of the fee and incidental expenses of the third doctor, whilst the remainder shall be paid by the institution, unless the accident in question occurred in the course of or in connection with the performance by the official of his duties or on his way to or from work or in the case of an occupational disease.

However, in exceptional cases and by a decision taken by the appointing authority after consulting the doctor appointed by it, all the expenditure referred to in the preceding paragraphs may be borne by the institution.'

Facts

16 The applicant was the victim of a serious accident on 8 December 2003. That accident resulted in his becoming an invalid under Article 78 of the Staff Regulations with effect from 1 July 2005.

17 Following the accident report filed by the applicant's spouse, the Commission opened a procedure under Article 73 of the Staff Regulations.

18 On 10 April 2005, the doctor appointed by the institution drew up an interim report with a view to assessing a provisional allowance. In that report, he estimated that the permanent invalidity rate at the time of consolidation was at least 20%.

19 On 30 May 2005, the applicant contacted the Office for the Administration and Payment of Individual Entitlements (PMO), requesting that it review the file, in order to assess the undisputed proportion of the permanent invalidity rate 'at a level better corresponding to reality'.

20 The PMO granted the applicant's request and asked the doctor appointed by the institution to assess accurately the undisputed proportion of the permanent invalidity rate, taking account, where appropriate, of the arguments put forward by the applicant in favour of a higher rate.

21 In a second interim report, dated 1 July 2005, the doctor appointed by the institution took the view that the undisputed proportion of the permanent invalidity rate could be assessed at 40%.

22 On the basis of that report, the PMO, by decision of 8 August 2005, awarded the applicant provisional compensation amounting to EUR 381 812.22. The applicant received payment of that compensation in November 2005.

23 Meanwhile, as regards the consolidation of his injuries, the applicant had forwarded to the PMO a report, drawn up on 28 June 2005 by a doctor chosen by him, stating that his injuries had consolidated. The Commission states, without being challenged on this point, that that report was communicated to the PMO on 30 June 2005.

24 In a report dated 21 September 2006 drawn up under Article 20(1) of the Insurance Rules, the doctor appointed by the institution found that the applicant's sequelae had consolidated since 28 June 2005; applying the new Insurance Rules, it stated that the applicant had a disability rating of 62% breaking down as follows: 37% for the ENT sequelae (12% for hearing loss, 3% for isolated tinnitus, 20% for balance disorders and 2% for olfactory sense), 15% for rheumatological sequelae and 10% for psychological and emotional sequelae. It also found that the applicant was suffering from a permanent aesthetic impairment of 3/7, justifying an additional allowance of 1.5%.

25 By a draft decision of 7 November 2006, the appointing authority, on the basis of the report of the doctor appointed by the institution of 21 September 2006, awarded the applicant a lump sum of EUR 606 126.90, corresponding to disability of 63.5%, for the settlement of which lump sum it was necessary to deduct the amount of the provisional allowance which he had been awarded, that is EUR 381 812.22. Towards the end of 2006, the applicant thus received a payment of EUR 224 314.68, in addition to the provisional allowance already paid.

26 Disagreeing with the draft decision of 7 November 2006, the applicant, by letter of 18 January 2007, requested that the matter be referred to the Medical Committee.

27 Since the doctor appointed by the applicant and the doctor appointed by the institution had been unable to reach agreement on the name of the third doctor required to sit on the Medical Committee, the applicant, by letter of 5 May 2007, applied to the President of the Court of Justice to appoint that doctor. On 25 July 2007, taking note of the appointment of and acceptance of his task by the third doctor, the PMO instructed the latter on behalf of the Medical Committee.

28 The Medical Committee held two meetings, on 3 January and 13 October 2008, following which the third doctor drew up a report dated 12 November 2008 ('the Medical Committee's report').

29 The Medical Committee's report confirms that the applicant has a disability rating of 62% and that the permanent aesthetic impairment of 3/7 justifies an additional allowance of 1.5%. In addition, it finds that the applicant suffers from a loss of amenity of 2/7, justifying an additional allowance of 1%.

30 The Medical Committee's report also confirms the date of consolidation of the applicant's injuries, that is 28 June 2005.

31 The Medical Committee's report was signed by the doctor appointed by the institution.

32 By letters of 2 December 2008, 21 January 2009 and 28 March 2009, the doctor appointed by the applicant announced his disagreement with the Medical Committee's report, which he eventually signed and returned to the third doctor on 28 March 2009. As regards the conclusions reached in that report, the doctor appointed by the applicant thus contended that the Medical Committee should have used the old disability rating scale, which would have resulted in a higher permanent invalidity rate.

33 The Medical Committee's report was received by the PMO on 9 June 2009. On the basis of that report, the appointing authority, by decision of 27 July 2009, granted the applicant a disability rating reaching, in total, 64.5%, and informed him that the balance of the lump sum payable to him, amounting to EUR 9 543.31 and corresponding to a disability rating of 1%, would be paid to him. The sum in question was paid to the applicant on 9 November 2009.

34 On 23 October 2009, the applicant lodged a complaint against the appointing authority's decision of 27 July 2009 under Article 90(2) of the Staff Regulations. The complaint was supplemented by a set of detailed arguments dated 8 December 2009. That complaint was rejected by the decision of the appointing authority of 15 February 2010.

Forms of order sought by the parties

35 The applicant claims that the Tribunal should:

— annul the appointing authority's decision of 27 July 2009 closing the procedure opened under Article 73 of the Staff Regulations following the accident of 8 December 2003 and granting him a disability rating of 64.5%;

— annul, in so far as necessary; the decision of 15 February 2010 rejecting the applicant's complaint;

— in consequence, find that his disability rating is to be assessed on the basis of the old Insurance Rules and disability rating scale in force on the date of the accident and until 1 January 2006, and that the examination of the request lodged by him under Article 73 of the Staff Regulations is to be taken over by an impartially, independently and neutrally constituted medical committee able to work quickly, independently and with an open mind;

— order the Commission to pay default interest on the lump sum payable under Article 73 of the Staff Regulations at a rate of 12% over a period commencing on 8 December 2004 at the latest and until the lump sum is paid in full;

— order the Commission to pay damages assessed *ex aequo et bono* at EUR 50 000 for the non-material damage suffered as a result of the contested decision;

— assess the award of damages at EUR 15 000 for the material damage suffered as a result of the contested decision;

— order the Commission to pay the costs in their entirety.

36 The Commission contends that the Court should:

— declare the action inadmissible and in any event unfounded;

— make an appropriate order as to costs.

Law

Subject-matter of the dispute

37 In addition to annulment of the decision of 27 July 2009 by which the appointing authority decided to grant him a disability rating of 64.5% ('the decision of 27 July 2009'), the applicant seeks annulment of the decision of 15 February 2010 rejecting his complaint. In that regard, it should be borne in mind that a claim for annulment formally directed against the rejection of a complaint has the effect of bringing before the Tribunal the measure against which the complaint was submitted, where that claim, as such, lacks any independent content (see, to that effect, judgment of 17 January 1989 in Case 293/87 *Vainker* v *Parliament*, paragraph 8, and judgment of 6 April 2006 in Case T-309/03 *Camós Grau* v *Commission*, paragraph 43).

38 Since, in this case, the claim for annulment directed against the decision rejecting the complaint submitted against the decision of 27 July 2009 lacks any independent content, the action must be regarded as formally directed against the latter decision.

The claim for annulment

39 In support of his claim for annulment the applicant puts forward eight pleas in law:

— the first alleging the illegality of the disability rating scale applied to him;

— the second alleging breach of an agreement concluded between the European Community and an insurance company and infringement of Article 73 of the Staff Regulations on the ground that the Commission accorded priority to the interests 'of the insurers';

— the third alleging infringement of the right to have a matter adjudicated upon within a reasonable time, of the principle of sound administration and of the duty to have regard for the welfare and interests of officials;

— the fourth alleging breach of the principles of legal certainty and non-retroactivity and infringement of acquired rights;

— the fifth alleging the unenforceable nature of the new Insurance Rules;

— the sixth alleging the irregularity of the appointment of the third doctor on the Medical Committee and breach of the principle of good faith;

— the seventh alleging breach of the principles of collegiate responsibility, independence, impartiality and neutrality which should govern the proceedings of the Medical Committee;

— the eighth alleging non-compliance by the Medical Committee with its terms of reference, a manifest error vitiating the Medical Committee's report and an unlawful statement of reasons for that report.

40 It is necessary to examine first of all the fourth plea, alleging breach of the principles of legal certainty and non-retroactivity and infringement of acquired rights.

The plea alleging infringement of acquired rights and breach of the principles of legal certainty and non-retroactivity

– Admissibility of the plea

41 The Commission contends that the plea in question is inadmissible. It has already been relied on by the applicant in the context of a complaint which he previously submitted in the course of the same procedure opened under Article 73 of the Staff Regulations. However, according to the Commission, that complaint was the subject of a decision of 31 July 2006 rejecting it, which, not having been contested, is no longer open to challenge.

42 However, there is no doubt and indeed it is not disputed by the Commission that the decision of 27 July 2009 is an act adversely affecting an official and that the rejection of the complaint, on which the Commission relies, pre-dates that decision.

43 It is open to the applicant to raise any plea, argument or fact capable of calling into question the legality of an act adversely affecting him, even if he has already relied on that same plea, argument or fact in support of a previous complaint concerning a different act (see, to that effect, judgment of the Tribunal of 14 September 2011 in Case F-12/09 *A* v *Commission*, paragraph 136, the subject of an appeal pending before the General Court, Case T-595/11 P).

– Substance of the plea

44 Under Articles 30 and 31 of the new Insurance Rules, the old Insurance Rules are repealed and the new rules are to enter into force on the first day of the month following that in which the agreement between the institutions provided for in Article 73(1) of the Staff Regulations is recorded by the President of the Court of Justice and are to apply as from that date. In this case, since the agreement between the institutions provided for in Article 73(1) of the Staff Regulations was recorded by the President of the Court of Justice on 13 December 2005, the new Insurance Rules entered into force on 1 January 2006. However, the second paragraph of Article 30 of the new Insurance Rules states that the old Insurance Rules, which must be construed as including the disability rating scale annexed to them, 'shall continue to apply to all draft decisions adopted [by the appointing authority] before 1 January 2006', that is to say, to any draft decision adopted before that date and recognising the accidental cause of an occurrence or the occupational nature of a disease, assessing the degree of disability and determining the amount of the corresponding lump sum.

45 The applicant maintains that the application to him of the disability rating scale annexed to the new Insurance Rules infringes the rights which he acquired under the provisions of the old Insurance Rules. He claims that the accident, the accident report, and even the consolidation of the injuries, give rise to acquired rights on the part of the insured party as of their respective dates. Accordingly, even though no draft decision had yet been adopted by the appointing authority in the course of the procedure opened following the accident of 8 December 2003, the disability rating scale which was annexed to the old Insurance Rules should have been applied to him.

46 The applicant thus pleads the illegality of Article 30 of the Insurance Rules, in so far as it provides for the retention of the disability rating scale annexed to the old Insurance Rules for procedures initiated before 1 January 2006, the date of entry into force of the new Insurance Rules, only in the event that the procedure has, on that date, reached the stage of the draft decision adopted by the appointing authority, whereas, if the accident, the accident report or the consolidation of the injuries took place before 1 January 2006, the old Insurance Rules should continue to apply until the end of the procedure opened under Article 73 of the Staff Regulations.

47 In that regard, it must be recalled, as a preliminary point, that, according to a generally accepted principle, a new rule applies, save as otherwise provided, immediately to situations yet to arise and to the future effects of situations which arose, but were not fully constituted, under the old rule (see, to that effect, judgments of 15 February 1978 in Case 96/77 *Bauche and Delquignies*, paragraph 48; of 16 May 1979 in Case 84/78 *Tomadini*, paragraph 21; of 5 February 1981 in Case 40/79 *P.* v *Commission*, paragraph 12; of 10 July 1986 in Case 270/84 *Licata* v *ESC*, paragraph 31; and of 29 January 2002 in Case C-162/00 *Pokrzeptowicz-Meyer*, paragraph 50; order of 13 June 2006 in Case C-336/05 *Echouikh*, paragraph 54; judgments of 22 December 2008 in Case C-443/07 P *Centeno Mediavilla and Others* v *Commission*, paragraphs 61 to 63; of 30 November 2006 in Case F-77/05 *Balabanis and Le Dour* v *Commission*, paragraph 39; and of 4 September 2008 in Case F-22/07 *Lafili* v *Commission*, paragraph 84).

48 In this case, it must therefore be established whether, at the time when the new Insurance Rules became applicable, that is on 1 January 2006, the applicant was, as he claims, in a situation fully constituted under the disability rating scale annexed to the old Insurance Rules. Only if that were the case could it actually be acknowledged that the scale annexed to the new Insurance Rules – a scale which cannot, moreover, be regarded as a procedural rule (see, *a contrario*, judgment of 6 July 1993 in Joined Cases C-121/91 and C-122/91 *CT Control (Rotterdam) and JCT Benelux* v *Commission*, paragraphs 22 and 23) – was applied in a retroactive manner to the applicant. In that case, it would be necessary to examine the plea of illegality raised by the applicant and, in particular, the legality of the retroactive application of the scale annexed to the new Insurance Rules in the light of the principles of legal certainty and respect for legitimate expectations.

49 Before considering that question, it must be pointed out that, under Article 12(2) of the old Insurance Rules and, indeed, under Article 11(3) of the new Insurance Rules, the lump sum provided for in Article 73(2)(c) of the Staff Regulations in the event of permanent partial invalidity is to be determined on the basis of the rates laid down in the disability rating scale annexed to each of those sets of rules.

50 In those circumstances, in order for the situation of an insured party to be fully constituted under the disability rating scale annexed to the old Insurance Rules, it must be established that, on the day preceding the date of entry into force of the new Insurance Rules, that is on 31 December 2005, at the latest, his situation was such that it was susceptible of giving rise to a right to have his disability assessed according to the rates laid down in the disability rating scale annexed to the old Insurance Rules.

51 In that regard, it must be observed that the mere occurrence of the accident or occupational disease is not sufficient to give rise, on the part of the insured party, to a right to assessment of his disability.

52 It is true that Article 73 of the Staff Regulations provides that an official is 'insured, from the date of his entering the service' against the risks of occupational disease and of accident. That provision also specifies that the benefits covering those risks are 'payable' to the official.

53 However, although the European Union legislature has established an insurance scheme against the risk of accident and of occupational disease, the institutions, acting under Article 73(1) of the Staff Regulations, have made the conferring of entitlement to the insurance benefits in question, and therefore their payment, dependent on compliance with a number of conditions.

54 Thus, under the first paragraph of Article 20 of the old Insurance Rules, as indeed under Article 19(3) of the new Insurance Rules, the decision defining the degree of disability can be taken only after the insured party's injuries have consolidated, consolidation being the condition of a victim whose injuries have stabilised in such a way that they no longer appear likely to get better or heal and that treatment is, in principle, no longer recommended except in order to prevent them from getting worse (judgment of 21 May 1996 in Case T-148/95 *W* v *Commission*, paragraph 36).

55 This means, as the Court of Justice held in its judgment of 14 July 1981 in Case C-186/80 *Suss* v *Commission*, paragraph 15 (see also judgment of 17 February 2011 in Case F-119/07 *Strack* v *Commission*, paragraph 88), that entitlement to payment of the allowance provided for in Article 73(2)(c) of the Staff Regulations in the event of partial permanent invalidity, as in this case, arises only when all the injuries have consolidated. Consequently, it is only as from that date that the insured party has a right to have his disability assessed.

56 Since the situation of the insured party, in the light of his right to have his disability rating assessed, was fully constituted at the time of the consolidation of his injuries, he must, in principle, have applied to him the disability rating scale in force on the date of that consolidation.

57 Moreover, it must be pointed out that, contrary to what the Commission maintains, the insured party's situation as regards insurance against the risk of accident or of occupational disease is substantially different from that of a successful candidate in a competition as regards the right to a classification in grade, which was at issue in *Centeno Mediavilla and Others* v *Commission*, paragraphs 63 to 68. The classification in grade of a successful candidate is dependent on the appointment of the person concerned. However, the administration has a wide discretion as regards the appointment of successful candidates, that wide discretion being the corollary of the fact that the legislation does not provide that successful candidates have a right, in that capacity, to be appointed. On the contrary, the compensation of an insured party following an accident or occupational disease does not result from a choice by the administration, made by virtue of any wide discretion which it may have, but from a finding of permanent invalidity after consolidation.

58 Admittedly, it is true, as the Commission observes, that, on the date of consolidation of the injuries, the insured party is still owed only an 'obligation to make good', and not an 'obligation to pay a fixed sum', since the amount payable is determined only at the time of the adoption of the appointing authority's decision defining, on the basis of the medical assessment, the rate of disability and the amount of the corresponding lump sum.

59 However, although the insured party's financial claim is quantified only at the time of the adoption of the appointing authority's decision, based on the opinion of the institution's doctor or of the Medical Committee, determining the amount of the lump sum payable, such a decision, which, in principle, closes the procedure opened under Article 73 of the Staff Regulations, presupposes that the insured party's rate of disability has been determined beforehand. The question which arises in this case is precisely that of determining the disability rating scale according to which it is the responsibility of the doctor appointed by the institution and, where appropriate, of the Medical Committee, to assess the disability of an insured party the consolidation of whose physical or mental injuries took place before the new Insurance Rules came into force.

60 Finally, if the date of adoption by the appointing authority of the draft decision assessing the insured party's rate of disability and the amount of the corresponding lump sum were to be adopted as the relevant date for the determination of the applicable disability rating scale, as appears from Article 30 of the new Insurance Rules, that could lead to the application of different rules to persons whose injuries nevertheless consolidated at the same time, depending on the degree of promptness shown by the administration in dealing with their respective cases, which would not be without a risk of arbitrariness (see, with regard to the determination of the applicable law concerning the payment of additional pension rights, judgment of 18 October 2011 in Case T-439/09 *Purvis* v *Parliament*, paragraphs 39 and 40).

61 In this case, it is clear from the file and, in particular, from the report of the doctor appointed by the institution of 21 September 2006, that the date of consolidation of the applicant's injuries was determined as 28 June 2005. It was therefore as from that date that the applicant held the right to have his rate of disability calculated according to the disability rating scale annexed to the rules on insurance against the risk of accident and of occupational disease which were applicable on that date, that is to say, according to the disability rating scale annexed to the old Insurance Rules.

62 In the light of the foregoing considerations, it is apparent that Article 30 of the Insurance Rules, in so far as it provides that the scale annexed to those rules is applicable, in the absence of a draft decision determining the rate of disability, to insured parties who are victims of an accident or an occupational disease and whose injuries consolidated before the date of its entry into force, that is, on 1 January 2006, refers, in the case of those insured parties, to situations fully constituted under the disability rating scale annexed to the old Insurance Rules. Article 30 of the Insurance Rules therefore gives, in that regard, retroactive effect to the scale annexed to them.

63 As a general rule, the principle of legal certainty precludes a European Union act from taking effect as from a date prior to its entry into force (see, to that effect, judgment of 22 November 2001 in Case C-110/97 *Netherlands* v *Council*, paragraph 151 and the case-law cited).

64 However, it may exceptionally be otherwise where the purpose to be achieved so demands and where the legitimate expectations of those concerned are duly respected (judgments of 25 January 1979 in Case 98/78 *Racke*, paragraph 20; of 13 November 1990 in Case C-331/88 *Fedesa and Others*, paragraph 45; and *Netherlands* v *Council*, paragraph 151).

65 In this case, the conditions mentioned in the previous paragraph do not appear to be met. First of all, the Commission has not established the existence of a purpose requiring the retroactive application of the new Insurance Rules. In that regard, the argument relating to the inadequacies of the disability rating scale annexed to the old Insurance Rules, which, in the words of *Administrative Notices* No 91-2005 of 19 December 2005 announcing to Commission staff the entry into force of the new Insurance Rules, is 'old, difficult to use and not European in scope' (the old scale having been the 'Barème Officiel Belge des Invalidités' (BOBI), the official Belgian invalidity rate scale), does not explain convincingly why it was necessary, in order to achieve the objective of updating that scale, to give them retroactive effect.

66 Secondly, the application of the disability rating scale annexed to the new Insurance Rules to insured parties who were victims, before the entry into force of those new Insurance Rules on 1 January 2006, of an accident or an occupational disease and whose injuries consolidated before that same date, necessarily infringed the legitimate expectations of those insured parties.

67 As observed by the Commission during the hearing, even assuming that application of the disability rating scale annexed to the new Insurance Rules may, depending on the nature of the injuries in question, sometimes result in an increase in cover of the risk of accident or of occupational disease, and sometimes in a decrease in that cover, by comparison with the disability rating scale annexed to the old Insurance Rules, the unity and uniform application of rules on insurance against the risks of

accident or of occupational disease adopted by agreement between the institutions require, in principle, that the entry into force of those rules occur on the same date in all the institutions and for all their staff, save as otherwise provided for the specific purpose of protecting the rights acquired under the old rules (see, by analogy, *Racke*, paragraph 16). Admittedly, the institutions cannot be prohibited from extending, for situations arising and definitively constituted under the old Insurance Rules, the benefit of the new Insurance Rules if they are more favourable to insured parties, but no transitional provision to that effect is included in the new Insurance Rules.

68 It follows from all the foregoing that the new Insurance Rules must be declared illegal in so far as they provide for the application of the scale annexed to them to insured parties who are victims of an accident or an occupational disease and whose injuries consolidated prior to their entry into force.

69 The Medical Committee, when delivering its report on 9 June 2009, and subsequently the appointing authority, when adopting the decision of 27 July 2009, were therefore wrong to apply the disability rating scale annexed to the new Insurance Rules. The decision of 27 July 2009 must consequently be annulled without there being any need to rule, in the context of the present claim for annulment, on the other pleas in law put forward by the applicant.

The claim for compensation

70 The applicant pleads the existence of three separate heads of damage: damage justifying the payment of default interest, material damage and non-material damage.

Payment of default interest

71 The applicant asks the Tribunal to order the Commission to pay default interest on the lump sum payable under Article 73 of the Staff Regulations.

72 The applicant does not specify, in the part of his pleadings relating to this claim for compensation, the fault on the basis which he submits this claim. However, he states, more generally, that the Commission must incur liability for the unlawful acts which he has alleged in support of his claim for annulment.

73 In the light of the pleas in law and submissions which he has put forward in this respect, it is clear that the applicant seeks to base his claim for payment of default interest on the submission that the administration did not give its ruling within a reasonable time.

74 It must therefore be considered whether the length of time taken to adopt the decision of 27 July 2009 was unreasonable.

75 First of all, it should be noted that Article 20 of the old Insurance Rules provides that the insured party must submit a medical report stating that he has recovered or that his condition has stabilised, so that the appointing authority can adopt a decision determining the rate of disability.

76 However, in this case, it was only by the report of 28 June 2005 drawn up by a doctor chosen by the applicant and communicated to the PMO on 30 June 2005 that the latter was informed of the consolidation of the applicant's injuries, which had taken place on 28 June 2005.

77 Accordingly, as regards the period between 8 December 2003, the date of the accident, and 30 June 2005, the date of the receipt by the PMO of the report of the doctor appointed by the applicant relating to the consolidation of the injuries, the length of time which thus elapsed is therefore attributable, for the most part at least, to the applicant.

78 Next, the period of approximately 15 months, at the end of which the doctor appointed by the institution drew up his report of 21 September 2006 for the appointing authority, does not appear unreasonable. Indeed, that doctor based his assessment on six further examinations carried out during that period and falling within at least four different specialised medical fields (psychiatry, ophthalmology, rheumatology and ENT).

79 Subsequently, the appointing authority's draft decision of 7 November 2006 determining the applicant's rate of disability and the amount of the lump sum awarded as a consequence was communicated to him on 21 November of that year, that is to say, within three months as from the date on which the report of the doctor appointed by the institution was drawn up, which does not appear unreasonable.

80 Disagreeing with the appointing authority's draft decision of 7 November 2006 determining his rate of disability and the amount of his compensation, the applicant, by letter of 18 January 2007, requested that his case be considered by the Medical Committee.

81 Since the doctor appointed by the applicant and the doctor appointed by the institution were unable to reach agreement on the name of the third doctor to sit on the Medical Committee, the applicant, by letter of 5 May 2007, applied to the President of the Court of Justice to appoint that doctor.

82 On 25 July 2007, taking note of the appointment of and acceptance of his task by the third doctor, the PMO instructed the latter on behalf of the Medical Committee.

83 Thus, the length of time which elapsed between the date of the draft decision of 7 November 2006 and 25 July 2007, the date on which the Medical Committee was able to commence its work, is therefore the result of the course taken by the procedure itself and is not attributable to the Commission's inaction.

84 Subsequently, the Medical Committee's report was drawn up on 12 November 2008, that is to say, approximately 15 months after the Medical Committee was able to start its work. Such a length of time does not appear unreasonable in view of the circumstances of this case.

85 Indeed, an initial, admittedly incomplete, Medical Committee report was drafted by the third doctor as early as 10 January 2008, after the holding, on the previous 3 January, of the first meeting of the Medical Committee. However, that report gave rise to various exchanges of letters, including one letter from the doctor appointed by the applicant, two letters from the applicant himself and one letter from the doctor appointed by the institution.

86 In the report of 12 November 2008 which he drew up on behalf of the Medical Committee, the third doctor stated, inter alia, that one of the applicant's letters was accompanied by 'numerous and voluminous annexes' relating to the applicant's outside activities. Also mentioning that the applicant, in a letter of 28 February 2008, had made some new comments concerning attendance by a third person, the third doctor stated:

'[P]ersonally, we were surprised by the size of his claim in the light of the grievances expressed during the first [meeting], and also in the light of the precise questions which we had put to him during that first [meeting]…'

87 Although an insured party cannot be criticised, in a procedure conducted under Article 73 of the Staff Regulations, for sending to the Medical Committee all the documentation or comments which he considers necessary to enable it to reach its decision, it is clear that the production of voluminous documents, as well as the submission, during the procedure, of new comments relating to questions addressed previously, contribute to lengthening the time taken to adopt a decision closing the procedure.

88 Moreover, the third doctor stated in the same Medical Committee's report of 12 November 2008 that it had been difficult to agree, in particular with the doctor appointed by the applicant, on a date for a second meeting of the Medical Committee and that it had not been possible to hold that meeting until 13 October 2008.

89 Admittedly, in a letter of 2 December 2008, the doctor appointed by the applicant stated that he had proposed the dates 26 and 29 September 2008 for the Medical Committee's meeting and that those dates had not suited the other members of the Medical Committee. However, those initiatives on the part of the doctor appointed by the applicant do not make it possible to exempt him from his share of responsibility for lengthening the time required to set the date for the Medical Committee's second meeting.

90 Thus, in the light of the foregoing developments, the period of approximately 15 months which elapsed between 25 July 2005, the date on which the Medical Committee was able to start its work, and 12 November 2008, the date of the Medical Committee's report, does not appear unreasonable.

91 Thereafter, it was not until 9 June 2009 that the Medical Committee's report was finally communicated to the PMO, that is, approximately seven months after the third doctor drew up that report. However, that delay is explained, in part at least, by the fact that the doctor appointed by the applicant first asked the third doctor responsible for drafting the Medical Commission's report, by letters of 2 December 2008 and 21 January 2009, to amend the report – with the content on which the other two members of the Medical Committee agreed – and, failing to secure that amendment, did not return that report bearing his signature until 28 March 2009.

92 Finally, on the basis of the Medical Committee's report which it had received on 9 June 2009, the appointing authority adopted the decision of 27 July 2009 and communicated it to the applicant who thus received it on 9 August 2009. The period of two months which thus elapsed between 9 June 2009, the date on which the appointing authority had available to it the Medical Committee's report, and 9 August 2009, the date on which it sent the applicant the decision of 27 July 2009, does not appear unreasonable.

93 Ultimately, none of the periods of time which elapsed during the different stages of the procedure which led to the adoption of the decision of 27 July 2009 appears unreasonable.

94 Moreover, even taking into account the cumulative effect of all those periods and the share attributable to delays on the part of the administration, it is apparent from all the considerations mentioned in the preceding paragraphs that the time taken to adopt the decision of 27 July 2009 was not unreasonable (see, to that effect, judgment of 13 January 2010 in Joined Cases F-124/05 and F-96/06 *A and G* v *Commission*, paragraph 394).

95 It follows from the foregoing that the applicant's claim that the Commission should be ordered to pay default interest on the lump sum already been paid to him must be rejected.

96 However, the applicant seems to include in the lump sum on the basis of which the default interest is to be calculated not only the lump sum which he has already been paid, but also the additional lump sum which, according to him, he will be paid on the basis of the disability rating scale annexed to the old Insurance Rules.

97 As regards the claim for payment of default interest on the additional sums which are allegedly payable to the applicant by virtue of the application of the disability rating scale annexed to the old Insurance Rules, such a payment requires not only that it is established with sufficient certainty that the applicant is eligible for a rate of disability higher than that which he was granted by the decision of 27 July 2009

but also that the rate of disability to which he will be entitled on the basis of that scale can already be assessed. However, that is not the case. Accordingly, even assuming that the applicant is regarded as submitting such claims, they would be premature and would therefore have to be rejected.

Material damage

98 The applicant includes in the material damage which he claims to have suffered costs related to the operation of the Medical Committee, costs related to the resumption of the proceedings of the Medical Committee following the annulment of the decision of 27 July 2009 and costs and fees for his adviser in respect of the stage prior to the action.

99 As regards the costs related to the operation of the Medical Committee, those costs include the fees of the doctor appointed by the applicant, travel costs and miscellaneous expenses. The applicant estimates all those costs at the sum of EUR 5 500.

100 However, the applicant does not refer, in his pleadings, to any document in the file capable of justifying such an amount.

101 According to the case-law, the damage for which compensation is sought must be actual and certain, which it is for the applicant to prove (see, for example, judgment of 9 November 2006 in Case C-243/05 P *Agraz and Others* v *Commission*, paragraph 27).

102 Moreover, the application does not contain any evidence offered in support in that respect. Under Article 39(1)(e) of the Tribunal's Rules of Procedure, the application is to state the nature of any evidence offered in support, where appropriate.

103 In the absence of the evidence mentioned in the preceding paragraphs, it must be concluded that the applicant has not substantiated the extent of the damage alleged, even though he was in a position to do so, since these are payments which he claims to have made. The applicant's claims for compensation concerning the operating costs of the Medical Committee must therefore be rejected.

104 As regards the costs related to the resumption of the proceedings of the Medical Committee, it will be for the appointing authority, at the conclusion of the procedure conducted again following the present judgment annulling its decision, to adopt a decision on defrayal of the costs of the Medical Committee's proceedings. For the time being, therefore, it is premature to rule on this head of damage.

105 As regards the costs and fees of the applicant's adviser in respect of the stage prior to the action, it must be recalled that the conduct of the pre-litigation procedure, as organised by the Staff Regulations, does not require an official to be represented at that stage, the quid pro quo being that, according to settled case-law, the administration must not interpret the complaints or claims restrictively but should, on the contrary, examine them with an open mind. Accordingly, it must be held that, unless there are exceptional circumstances, an official cannot obtain reimbursement of costs and fees for his advisers in respect of the pre-litigation stage in an action for damages. However, nothing in the file proves the existence of such exceptional circumstances (judgment of 10 December 2008 in Case T-57/99 *Nardone* v *Commission*, paragraphs 139 and 140).

106 It follows from the foregoing that the claim that the Commission should be ordered to pay compensation in respect of the material damage must be rejected.

Non-material damage

107 In this case, the application does not contain any demonstration as to whether the non-material damage for which the applicant claims compensation is incapable of being fully compensated by the annulment of the decision of 27 July 2009 and the measures which the appointing authority will be required to take following that annulment.

108 First of all, the illegality found by the Tribunal, arising from the infringement of acquired rights, is not of a gravity sufficient to justify the award of compensation for non-material damage.

109 Moreover, the applicant merely complains about the – in his view disgraceful – manner in which he was treated by the Commission during the procedure followed under Article 73 of the Staff Regulations, then during the pre-litigation procedure.

110 However, it is not apparent from the documents in the file that the decision of 27 July 2009, nor indeed the rejection of the complaint of 16 February 2010, contain any expressly negative assessment of the applicant's capacities which could hurt him. The same applies to the Medical Committee's report of 27 November 2008 on which those two decisions are based.

111 However, it is clear that, through the effect of this judgment annulling the decision, the applicant is again in a position of waiting for the final outcome of the procedure opened under Article 73 of the Staff Regulations following the accident of 8 December 2003. Such a prolongation of the situation of waiting and uncertainty, caused by the unlawfulness of the decision of 27 July 2009, constitutes non-material damage which must be assessed *ex aequo et bono* at the sum of EUR 2 500.

112 In that regard, given that the non-material damage in question is a direct result of the decision of 27 July 2009, the Commission cannot reasonably rely on the plea of inadmissibility on the ground that it has already ruled, by a decision which is no longer open to challenge, on an equivalent claim for compensation lodged by the applicant under Article 90(1) of the Staff Regulations.

113 Accordingly, the Commission must be ordered to pay to the applicant the sum of EUR 2 500 for non-material damage.

The claim seeking, in essence, a new disability assessment by a medical committee constituted impartially and on the basis of the old Insurance Rules

114 In accordance with settled case-law, it is not for the Courts of the European Union courts to issue injunctions to the administration or make rulings in the abstract in the context of a review of legality based on Article 91 of the Staff Regulations (see, for example, judgment of 12 June 2002 in Case T-187/01 *Mellone* v *Commission*, paragraph 16).

115 The applicant asks the Tribunal to find that the rate of his disability should be assessed on the basis of the disability rating scale annexed to the old Insurance Rules and that 'the examination of the claim lodged by the applicant under Article 73 of the Staff Regulations should be taken over by an impartially, independently and neutrally constituted medical committee able to work quickly, completely independently and with an open mind'. In so far as the applicant thus submits a claim seeking an abstract ruling or an injunction against the administration, that claim must be rejected as inadmissible.

116 It follows that the decision of 27 July 2009 must be annulled and the Commission ordered to pay to the applicant a sum of EUR 2 500 for non-material damage. For the remainder, the applicant's claims must be rejected.

Costs

117 Under the terms of Article 87(1) of the Rules of Procedure, without prejudice to the other provisions of Title 2, Chapter 8 of those Rules, the unsuccessful party is to be ordered to pay the costs if they have been applied for in the successful party's pleadings. By virtue of Article 87(2), if equity so requires, the Tribunal may decide that an unsuccessful party is to pay only part of the costs or even that he is not to be ordered to pay any.

118 It is apparent from the grounds set out above that the Commission has for the main part been unsuccessful. Furthermore, in his pleadings the applicant has expressly applied for the Commission to be ordered pay the costs. As the circumstances of the present case do not justify the application of Article 87(2) of the Rules of Procedure, the Commission must bear its own costs and be ordered to pay the costs incurred by the applicant.

On those grounds,

THE CIVIL SERVICE TRIBUNAL (Third Chamber)

hereby:

1. **Annuls the decision of 27 July 2009 closing the procedure opened under Article 73 of the Staff Regulations of Officials of the European Union following the accident of 8 December 2003 of which Mr Guittet was the victim;**

2. **Orders the European Commission to pay Mr Guittet the sum of EUR 2 500;**

3. **Dismisses the action as to the remainder;**

4. **Declares that the European Commission must bear its own costs and orders it to pay the costs incurred by Mr Guittet.**

Van Raepenbusch Barents Bradley

Delivered in open court in Luxembourg on 13 June 2012.

Registrar
W. Hakenberg

President
S. Van Raepenbusch