WiRO
WorkCover independent review office

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RECOMMENDATION FOLLOWING AN APPLICATION FOR REVIEW OF THE INSURER'S WORK CAPACITY DECISION PURSUANT TO SECTION 44(1)(c) OF THE *WORKERS COMPENSATION ACT* 1987.

SUMMARY:

a. **The work capacity decision of the Insurer dated 25 September 2014 is set aside.**

b. **The applicant is to be reinstated to his weekly payments at the rate applicable immediately prior to 8 January 2014.**

c. **The payments are to be back-dated to 8 January 2014.**

d. **The payments are to continue until such time as a further work capacity decision is made and comes into effect.**

1. The applicant seeks procedural review of a work capacity decision (second decision) made by the Insurer on 25 September 2013. A decision had also been issued on 23 September 2013 (first decision). The first decision of 23 September 2013 stated that weekly payments were to cease on 2 January 2014. The second decision of 25 September stated that payments were to cease on 8 January 2014. The second decision has 2 covering letters which must form part of the second decision. One of those letters states that *"We refer to the decision made by* [assessor], *it is noted that the date should have stated 17/09/2013."* The first decision states that the decision *"was made by* [assessor] *on 17/06/2013",* 3 months earlier. This confusion is not assisted by both decisions having apparently been made by the same assessor but both decisions are signed by another person, described differently as a Case Manager. It is therefore unclear precisely to whom we are indebted for the benefit of the decisions.

2. The applicant sought internal review. The confusion then continued. There are two Internal Review Decisions issued on 5 November 2013 (first IRD) and 11 December 2013 (second IRD). The first IRD has a covering letter, which again must form part of the IRD. The second IRD has two covering letters, one of which states that the first IRD did not deal properly with the issue of medical expenses. Pausing here, it might be thought that an ordinary person, even one with an extraordinary

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interest in the case, such as the applicant himself[1] or a person reviewing the decision(s), could only speculate on what might turn up in the post next. The Insurer seems to regard "decision" (or "decisions") as a word (or words) signalling no more than an intermediate step (or steps) which might be amended at any time. As a result it issues decisions and IRDs repeatedly with clarifying covering letters that do no more than add to the confusion. The faltering mis-steps causing such confusion might of themselves[2] amount to procedural error.

3. The applicant sought merit review by the Authority. Only one Merit Review Service recommendation was issued, on 19 May 2014. The merit review dealt with the second of the two decisions.

4. The applicant subsequently sought procedural review by this office. The procedural review is with respect to the second decision.

5. The applicant was injured on 22 May 2009. The applicant returned to suitable employment with his employer until his employment was terminated on 14 March 2014, 3 months after the second IRD. He obtained other suitable employment on 3 April 2014 but was made redundant on 13 June 2014 due to a slowdown in his employer's business. The Insurer made weekly payments as required under the provisions of the *Workers Compensation Act* 1987 (1987 Act).

6. The applicant was in receipt of compensation by way of weekly payments immediately before 1 October 2012. Accordingly Clause 8 of Part 19H of Schedule 6 to the 1987 Act required the Insurer to conduct a work capacity assessment for the purpose of facilitating the application of the amended weekly benefits provisions to the applicant's claim. Clause 17 of Schedule 8 to the *Workers Compensation Regulation* 2010 (the *Regulation*) required the assessment process to be completed *"within 18 months"* of 1 October 2012.

7. The relevant version of the *WorkCover Work Capacity Guidelines (Guidelines)* is the one dated 4 October 2013, which came into effect on 11 October 2013. The *Guidelines* provide instructions and guidance to

[1] Here an intensive pronoun, not a redundancy.
[2] A collective pronoun used here also as both an intensive pronoun and a conjunctive pronoun.

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Insurers regarding the appropriate and consistent application of work capacity assessments and decisions.

8. Where the work capacity decision involves a reduction in or cessation of the weekly benefits payable to the injured worker then the Insurer is required to give proper notice to the worker (see section 54(2)(a) of the 1987 Act).

Submissions by the applicant

9. The applicant raised various issues in the Application for Procedural Review. Section 44(1)(c) of the 1987 Act states that this review is "*only of the insurer's procedures in making the work capacity decision and not of any judgment or discretion exercised by the insurer."* Some of the applicant's submissions went to the merits of his matter, that is, the judgement or discretion of the Insurer and are therefore not relevant. His other submissions go to the confused nature of the two decisions and two IRDs. He also submits that an IRD is a new decision and should begin the process again as if a decision had not been made. That is wrong. An IRD is a review of a decision already made: section 44(1)(a) of the 1987 Act.

Submissions by the insurer

10. The Insurer made no submissions.

The Decision

11. One of the covering letters to the second decision (hereafter "decision") states that an assessment has taken place. No date is given as to the assessment. Pursuant to clause 23 of Schedule 8 of the *Regulation* the Insurer is required to "*make a work capacity decision in respect of an existing recipient of weekly payments as soon as practicable after the first work capacity assessment of the worker is conducted".* The applicant cannot know whether this has taken place, and given the way in which the decisions and IRDs have taken place he would little faith that the assessment was undertaken in a timely fashion.

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12. There does not appear to be any legislative requirement to notify the applicant of the outcome of the assessment. However, *Guideline* 5.3.2 states that the decision must:

    - *state the decision and give brief reasons for making the decision;*
    - *outline the evidence considered in making the decision, noting the author, the date and any key information. All evidence considered should be referred to, regardless of whether or not it supports the decision;*
    - *clearly explain the line of reasoning for the decision.*

    My finding is that the *Guidelines* result in the insurer being compelled to reveal the outcome of the assessment which may also reveal the date of the assessment.

13. The same covering letter states that *"medical or related expenses will continue in accordance with the Act".* That sentence is repeated in the decision. Nothing more is said as to how or whether such expenses may be affected, or whether the payments will continue indefinitely. *Guideline* 5.3.2 requires the Insurer *"to state the impact of the decision on the worker in terms of their entitlement to weekly payments, entitlement to medical and related treatment expenses and return to work obligations".* Section 59A(2) of the 1987 Act states that treatment expenses and related expenses are no longer payable 12 months after weekly payments cease. The legislation has not been properly referenced as required by *Guideline* 5.3.2.

14. In addition, section 59A(3) of the 1987 Act states that the applicant may, after the entitlement to compensation for medical expenses is extinguished by the effluxion of 12 months, relumine that very entitlement to medical expenses if the entitlement to compensation for weekly benefits resumes at any stage in the future and for such time as those weekly payments continue. This was not disclosed by the Insurer.

15. Both covering letters refer to the decision resulting in a reduction of weekly payments. One of the letters also states that *"benefits"* will cease. What benefits are to cease is not stated. The applicant could

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probably assume that this is a reference to weekly payments, but it is not clear. While stating reduction is correct, a more useful statement would be that weekly payments of compensation are to cease.

16. One of the covering letters states that the applicant may seek a review of the decision by completing the attached form and to *"provide any further information in support of your request."* This statement may lead the applicant to assume that he is required to provide further information in order to seek a review. That is wrong. The applicant need only, pursuant to section 44(2) of the 1987 Act, *"specify the grounds on which the review is sought."* The letter refers to *"Point 6"* in the notice. Point 6 states that in seeking a review the applicant *"may attach any additional information."* The applicant may well be confused by these two contrasting statements as to what is required when seeking an internal review.

17. Point 6 also states that the request for internal review must be sent within 30 days of receipt of the decision. That is wrong. Section 44(1) of the 1987 Act does not provide any time frame in seeking an internal review. *Guideline* 7.1.2 refers to *"timely lodgement"* and that the application should be lodged *"as soon as practicable after receiving"* the decision.

18. The decision states that 3 months notice is required to be given pursuant to section 54 of the 1987 Act. *Guideline* 5.3.2 requires the Insurer to refer to the legislation. The correct reference is to section 54(2)(a) of the 1987 Act.

19. The decision states that as the *"claim was made before 1 October 2012"* the transitional amount is deemed to be the applicant's *"pre-injury average weekly earning"* (sic). While the claim must have been made before 1 October 2012, the test is to have been in receipt of weekly payments immediately before 1 October 2012. It then states that the applicant's entitlement to weekly payments is determined by section 38 of the 1987 Act. The decision should refer to the "*second entitlement period"* and its definition in section 32A of the 1987 Act and that the applicant's claim falls in the period after the second entitlement period.

20. Section 38(7) of the 1987 is then referred to and the calculation is set out as (AWE x 80%) – (E + D). The letters "E" and "D" are explained,

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but not that these are definitions in section 35 of the 1987 Act. It is not explained that AWE is defined in section 35 of the 1987 Act and means "*pre-injury average weekly earnings".*

21. The decision states that the decision has been made in respect of section 43(1)(a)(b)(c)(d)(e) & (f). Which Act that section is in is not said. If the applicant could find the section in the 1987 Act he would read that the Insurer can make a decision as to pre-injury average weekly earnings (PIAWE). That would leave the applicant wondering why the Insurer has decided to use the transitional rate when it appears to have the ability to make its own decision. The Insurer should have explained that it cannot make a decision as to PIAWE due to clause 1 (the definition of pre-existing recipient of weekly payments), clause 2(1) (the transitional amount and the current indexed amount), and clause 9(3) (the deeming provision) of Part 19H of Schedule 6 to the 1987 Act.

22. Section 43(1) also refers to *"current work capacity"* and *"suitable employment"* which are both defined in section 32A of the 1987 Act. *"Current work capacity"* means an inability to work in pre-injury employment, but being able to work in *"suitable employment".* The definition of suitable employment is an important concept in the 2012 amendments to the 1987 Act. It involves, *inter alia*, having regard to *"the worker's age, education, skills and work experience"* while having no regard to *"the nature of the worker's pre-injury employment".* Few people relying on a normal understanding of English would realise that such a concept would be included in a simple phrase like suitable employment.

23. The decision sets out the calculation taking into account the suitable employment the applicant is undertaking with his employer, who is a self-insured entity. The applicant is working 32 hours per week, less than his pre-injury hours of 38 hours per week. The Insurer then states that if the suitable employment with it ends, then a new calculation as to weekly payments will be made. The decision states that in that case, based on the evidence, his ability to earn will be calculated on working for 38 hours per week. Why there should be two different hourly periods is not explained. If the applicant can work for 38 hours in suitable employment, then that should be the period used with respect to his employment as at the date of the decision, not the 32 hours he is actually working.

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24. Further, the applicant was found to be medically unfit for work as at 14 March 2014. The employer wearing its insurance hat found the applicant fit to work in suitable duties for 38 hours per week, and then wearing its employer's hat found that he was unfit to work 32 hours per week in suitable duties he had been performing for 5 years. The applicant would be rightfully concerned that the decision was a convenient vehicle with which to find him fit for 38 hours per week, and then terminate his employment on medical grounds shortly after with a decision already made that he is fit to work. As the Insurer had later evidence that the applicant was not fit for suitable employment, it seems clear that a new decision should have been made.

25. The decision lists 7 documents and states that those documents have been provided to the applicant. *Guideline* 5.3.2 states that the decision must *"advise that any documents or information that have not already been provided to the worker can be provided to the worker on request to the insurer".* That has not been done.

26. Given that the vast majority of documents said to have been considered are neither work capacity certificates nor declarations by the applicant in a form approved by the Authority as stipulated in section 44B(1)(a) and (b), they are, by definition, irrelevant considerations.

27. *Guideline* 5.3.2 states that the decision must advise what support such as job seeking support will be available during the notice period. The decision is silent as to what support may be available.

28. The applicant alleges that the same person who reviewed the first decision had in turn reviewed the second decision, in clear breach of the principle that a person should not review their own decisions. Put precisely, the allegation is this:

    - Internal review 05/11/2013 made by [named person]. Then [the same named person] makes another review/amendment/decision on 11/12/2013 and states in (.81) that he has not "previously reviewed or approved the work capacity decision made in this case."

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29. It is not alleged that Guideline 7.1.6 has been breached.[3] Nonetheless it is certainly alleged that the Insurer has misled or sought to mislead the applicant. The Insurer made no submissions in this case, a circumstance which is unfortunate, given the gravity of this allegation. I would be loath to conclude that the Insurer acted intentionally to mislead, but I accept that the factual circumstance of the internal reviewer wrongly stating no prior involvement in the case took place. This must constitute demonstrable error.

FINDING

30. I find that the Insurer has failed to follow the procedures as set out in the WorkCover *Guidelines* which is required by Section 44A of the 1987 Act. The Insurer has also failed to follow the 1987 Act and the *Workers Compensation Regulation* 2010.

RECOMMENDATION

31. I recommend that the Insurer conduct a new work capacity assessment in accordance with the WorkCover *Guidelines* and make a new work capacity decision.

32. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled immediately prior to 8 January 2014 until such time as he is properly transitioned. Those payments should continue from 8 January 2014, being the date on which they had formerly ceased.

33. Since the applicant is not currently in receipt of weekly payments, clause 21 of schedule 8 of the *Regulation* cannot apply and payments may resume immediately. The applicant is not required to produce work capacity certificates for the period from 8 January 2014 to date by virtue of the operation of section 44B(2) of the 1987 Act. These recommendations are binding on the insurer: see section 44(3)(h) of the 1987 Act.

[3] Guideline 7.1.6 says that a person who conducts internal review may not be the same person who made the original decision.

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