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 31 January 2014 is set aside.

b. The applicant is to be reinstated to his weekly payments at the rate applicable at 12 May 2014.

c. The payments are to be back-dated to 12 May 2014.

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

Background

1. The applicant seeks procedural review of a work capacity decision by the Insurer dated 31 January 2014. The decision terminated the applicant's weekly payments of compensation, effective from 12 May 2014.

2. The Insurer wrote to the applicant on 27 September 2013 foreshadowing imminent assessment by them of his work capacity. This followed a letter in identical terms (but with a different signature) dated 14 April 2013. "Fair notice" is clearly not an issue. The applicant sought internal review, which upheld the original decision. Interestingly, the very person who described herself as having conducted an "independent internal review"[1] later provided written submissions to this office on behalf of the insurer and also made a work capacity decision based on findings and recommendations of the merit review service (the recommendations being binding on the Insurer).[2] What the applicant made of the modifying adjective "independent" in the phrase "independent internal review" is not known, but subsequent events might have caused justifiable revision

[1] The letter commences thus: "I refer to my letter to you dated 21/02/2014 and advise that I have now completed an independent internal review of the work capacity decision and wish to confirm the outcome in writing."
[2] See more on this *infra*.

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of his understanding of the word "independent" in the former or any other context.

3. The internal review and merit review having produced disappointing results for him, the applicant sought procedural review by this office. I find that the application was made within time and on the correct form.

Submissions by the applicant

4. 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."* The applicant's grounds for review (rather than submissions *per se*) might be fairly summarised thus:

- The Insurer unfairly ceased his entitlement to weekly payments;
- A doctor the applicant has "never met" concluded that the applicant "could be a courier driver or a delivery driver" even though the relevant medical certificates imposed a lifting restriction;
- The Nominated Treating Doctor and the applicant were "unhappy" about this opinion and were unaware it would be "used against" him;
- The merit review service made a decision prior to receipt of the final report of the treating surgeon following the most up-to-date MRI scan; and
- The treating surgeon was "happy" with the current employment of the applicant since it apparently adds no strain to the spinal cord.[3]

Submissions by the Insurer

5. The Insurer made lengthy submissions. The submissions include a chronology, which is helpful. The submissions refer to the required standard of proof and *Briginshaw v Briginshaw* (1938) 60 CLR 336.

[3] This latter being a "ground" perhaps more in the favour of the Insurer than the applicant.

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The submissions refer to the well-known statement of Dixon J (as he then was) and the submissions state that the standard of proof that applies to a procedural review is that of "*reasonable satisfaction*."

6. The submissions are extensive and seek to comprehensively answer those of the applicant. To the extent that they argue the factual basis of whether or not "fair notice" was given, I accept what the Insurer says. The Insurer seeks to involve an examination of the processes of internal review, rather than to simply look at the original work capacity decision. This is a brave gambit, for reasons hinted at in paragraph 2 above. Further, the insurer goes on to address the issue of a decision made subsequent to the merit review service recommendation. Both internal review and the decision subsequent to the merit review recommendation are irrelevant in my view. This is perhaps just as well for the Insurer, since they take the peculiar step of actually quoting a Guideline which clearly invalidates the last decision. On page 8 of the 10 page submissions, the Insurer quotes Guideline 10.16 of the *Review Guidelines* which says in part this:

> Recommendations by the Authority are however binding on the insurer and must be given effect by the insurer, **independently of the original work capacity decision and any internal review decision**.

The reason this invalidates the decision made subsequent to the merit review recommendation is that the same person who made the subsequent decision also made the internal review decision. If "independently of" is to have a meaning beyond nonsense in this context, it must mean that the person who makes a decision following merit review must be a different person to the one who made the original work capacity decision *as well as* a different person to the one who made the internal review decision. However, as my procedural review concerns only the original work capacity decision, most of what appears above is irrelevant for current purposes.

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The Decision

7. On page two of the letter dated 31/01/2014 giving notice of the work capacity decision, the following sentences appear under a heading referring to relevant legislation:

> We have calculated that you have received weekly compensation benefits for more than 130 weeks and less than 130 weeks in total. This means that you fall into the post second entitlement period, as defined by section 38 of the *Workers Compensation Act* 1987.

8. Clearly the Insurer has made an error. Its very clarity qualifies it as a demonstrable error, as that term is juristically employed.[4] No-one can have received both more than 130 weeks of benefits at the same time as having received less than 130 weeks of benefits. Likewise, the term "post second entitlement period" does not appear in section 38, nor is it defined anywhere in the Act.

9. It follows that the Insurer has breached the Guidelines which require both a clear explanation of the work capacity decision and explanation of the legislative provisions. Breach of the Guidelines combined with demonstrable error must invalidate the original work capacity decision..

FINDING

10. 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 and apply the 1987 Act.

RECOMMENDATION

11. I recommend that the Insurer conduct a new work capacity assessment and make a new work capacity decision in accordance with the WorkCover *Guidelines*. This should be done with current medical

[4] For a recent examination of "demonstrable error" see *New South Wales Police Force v Registrar of the Workers Compensation Commission of New South Wales* [2013] NSWSC 1792 (11 December 2013) at paragraphs 39-56.

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evidence and in light of the merit review recommendation of the Authority.

12. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 12 May 2014 until such time as the new work capacity decision takes effect. Those payments should continue from 12 May 2014, being the date on which they ceased.

13. 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 12 May 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.

Wayne Cooper
Delegate of the WorkCover Independent Review Officer
29 July 2014