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

**SUMMARY:**

a. **The work capacity decision dated 18 July 2016 is set aside.**

b. **The Insurer should make a new work capacity decision, listing all relevant documents actually relied upon during the decision-making process.**

c. **Copies of any documents not already given to the applicant should be given to the applicant.**

d. **The insurer might note that the applicant does not have to satisfy the special requirements in section 38(3) for periods during which she is found to have no current work capacity. For such periods the entitlement is to be assessed under section 38(6).**

**Introduction and background**

1. The applicant suffered psychological injury in the course of her employment as an Associate Lecturer at a University in 2013. The Insurer accepted liability and made weekly payments for all relevant periods. She has been certified as having "current work capacity" and "no current work capacity" for various periods, during which time she has received more than 150 weeks of payments.

2. The applicant seeks procedural review of a Work Capacity Decision made by the Insurer on 18 July 2016. The Decision informed the applicant that her weekly payments of compensation would cease on 26 October 2016 because she does not meet all the requirements of section 38(3). This decision was maintained following internal review.
3. The applicant sought Merit Review from the Authority by way of application received 27 September 2016. The Authority originally

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delivered its Findings and Recommendations dated 25 October 2016. The Authority made findings that the applicant: (i) is able to return to work in suitable employment as a Gadner/Care-Giver for five hours per day, five days per week; (ii) has current work capacity, and (iii) does not satisfy the special requirements in section 38(3) because she does not work up to her current capacity or for at least 15 hours per week. Despite making these findings, the merit reviewer saw no reason to make a recommendation of any kind, thus rendering the status of the document issued "non-binding."[1]

4. In an unusual twist, the Authority issued a second determination dated 11 November 2016. This was because a certificate of capacity dated 20 October 2016 had been overlooked. That certificate certified the applicant as having no current work capacity for the duration of the certificate, namely 20 October 2016 to 17 November 2016. As a result of this newly discovered evidence, the Authority made the following findings: (i) from 18 July 2016 to 19 October 2016 the applicant had current work capacity; (ii) from 20 October 2016 to date the applicant has no current work capacity; and (iii) the applicant does not satisfy the special requirements for continuation of weekly payments of compensation after the second period pursuant to section 38.

5. The third finding in paragraph 4 is bizarre, since the applicant is clearly not in possession of "current work capacity," which is a pre-requisite to the application of the "special requirements" in section 38. For the period of the relevant certificate of capacity, which cannot exceed 28 days, her entitlement should be calculated according to section 38(6).

6. An application was made to this Office for procedural review received via email on 21 November 2016. I am satisfied that the application was made within time and in the correct form.

**Submissions by the applicant**

[1] Section 44BB(3)(g) says that recommendations are binding on the Insurer, whereas there is no similar statement in section 44BB(3)(e) and (f) concerning the findings on which recommendations are based.

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7. Section 44BB (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."*

8. The applicant makes two relevant submissions:

   - The Insurer ignored the certificate of capacity issued by the Nominated Treating Doctor (NTD). The NTD never certified her fit for work for 35 hours per week.
   - The Insurer did not provide the applicant with copies of documents requested prior to internal and merit reviews. The Insurer ultimately state that they did not have the documents.

9. The second of the two submissions made by the applicant must be fatal to the Insurer's position. In the Work Capacity Decision a purported list of documents appears under the heading "Evidence we have relied on includes:" Within that list is a report by a psychologist, purportedly dated 13 January 2015. The applicant has never seen this document. When a solicitor representing the interests of the applicant sought a copy of this document, the Insurer replied as follows:

   > "I was … unable to locate a report by [name 1 deleted] dated 13/01/2015 but have enclosed a management plan by [same name] dated 29/01/2015."

10. In the internal review dated 1 September 2016 another list appears, this time under the heading "Evidence considered when making this work capacity decision." The last item listed is described as a "medical report" by [name 2 deleted] dated 24 March 2016. When the solicitor representing the applicant sought this document together with the one referred to in paragraph 7 *supra*, the Insurer replied thus:

    > "We acknowledge your letter requesting copies of a report from [name 1 deleted] dated 13/01/2015 and a copy of a report by [name 2 deleted] dated 24/03/2016.
    >
    > "Please find attached three documents. One is a medical certificate dated 24/03/2016 issued by [name 2 deleted] however, I was unable to locate a report of the same date on

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file. I did however locate a report dated 23/03/2015 and have provided a copy of this also in the event that the date requested was incorrect."

**Submissions by the Insurer**

11. The Insurer did not engage with the above submissions, merely stating that they had considerable difficulty having the applicant examined by an IME, due to being unable to contact the applicant directly. (The applicant's solicitors have insisted that all contact be through them. Despite this I note the Internal Review was sent to what appears to be private residential address.)

**Decision**

12. Apart from the failure to supply documents to the applicant upon request and/or misdescription of documents in both the work capacity decision and the internal review decision, there is another irregularity which cannot go unremarked.

13. There is a well-known doctor who, apparently at the request of Insurers, adopts the practice of attending the premises of Insurers to conduct a "file review" during the course of which some attempt (not always successful) is made to contact the NTD. A conversation allegedly occurs over the phone, following which a report is issued, purportedly setting out the salient features of the conversation. The accuracy of such reports is uncertain at best, but even the author himself frequently reports that he suggested to the NTD that the worker might benefit from an upgrade and needs to get back to work. Often we are told that the NTD "agreed to upgrade the worker's hours" or "agreed to consider" the proposition.

14. Unreliable though such "reports" obviously are, since they involve no examination of the worker and no corroboration of the contents of the alleged conversation by the NTD, they usually involve orthopaedic or neurological injuries, whereas in the present case this same doctor presumes to comment on a case involving psychological/psychiatric injury, an area in which his qualifications are not disclosed. In this instance he seems to have had a conversation with a psychologist,

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rather than the NTD. We therefore have a “report” based on a file review in the absence of the applicant and a telephone conversation with a non-doctor.

15. That this report was relied upon by the Insurer should of itself constitute a procedural error sufficient to set aside the decision. When taken together with the failure to accurately set out the other evidence relied upon and the failure to provide copies to the applicant, there is no alternative but to set the decision aside for procedural error.

**Finding**

16. The Insurer has failed to accurately record and set out the documentary information relied upon in the decision-making process. As a result the Insurer has not provided the applicant with copies of the documents referred to in both the work capacity decision and the internal review decision. This is a serious breach of the Guidelines and is also contrary to the rules of procedural fairness.

**RECOMMENDATION**

17. The work capacity decision dated 18 July 2016 is set aside.

18. The Insurer should make a new work capacity decision, listing all relevant documents actually relied upon during the decision-making process.

19. Copies of any documents not already given to the applicant should be given to the applicant.

20. The insurer might note that the applicant does not have to satisfy the special requirements in section 38(3) for periods during which she is found to have no current work capacity. For such periods the entitlement is to be assessed under section 38(6).

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