Level 4, 1 Oxford Street, Darlinghurst NSW 2010
T: 13 9476
contact@wiro.nsw.gov.au
www.wiro.nsw.gov.au

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 application for procedural review is dismissed.

Introduction and background

1. The applicant seeks procedural review of a work capacity decision made by the Insurer on 28 May 2015. The decision notice informed the applicant that his weekly payments of compensation would be reduced from $917.63 to $172.12 and that the decision would come into force on 6 September 2015. The applicant sought internal review and the Internal Review Decision was dated 23 July 2015. That decision confirmed the original work capacity decision.

2. The applicant applied to the Authority for Merit Review on 26 August 2015. On 25 September the Merit Review Service produced a document headed "FINDINGS AND RECOMMENDATIONS ON MERIT REVIEW BY THE AUTHORITY." The merit reviewer found that he could not be satisfied on the evidence available that the applicant was a "seriously injured worker" which emboldened him to then decline to make any recommendation. Illogical though this appears to be, the merit reviewer seems to have approached the case on the basis that the applicant took no exception to the calculation of his weekly benefits, but rather objected to the proposition that the insurer had any right to make a work capacity decision in the first place, due to his allegation of being a "seriously injured worker," as that term is defined in the legislation. Once it was found that the applicant was not a seriously injured worker, there was apparently thought to be no need to further scrutinize the work capacity decision.

3. The applicant then made an application to this office dated 25 October 2015. I am satisfied that the applicant has made the application for procedural review in the proper form and within time.

Level 4, 1 Oxford Street, Darlinghurst NSW 2010
T: 13 9476
contact@wiro.nsw.gov.au
www.wiro.nsw.gov.au

A threshold question

4. The “”no recommendation” produced by the Merit Review Service might have had jurisdictional implications for procedural review. This Office can only conduct a procedural review after “merit review by the Authority” (see section 44(1)(c) of the *Workers Compensation Act* 1987 [1987 Act]). On one view, it is arguable that the failure by the merit reviewer to make a recommendation means that the merit review has yet to be concluded, since the merits of the case were not addressed. If so, this Office would have no jurisdiction.

5. There are, however, two arguments the other way: first, the merit reviewer did make a finding which arose out of an examination of the evidence available, which might satisfy the description of “merit review;” and, secondly, the Act only says in section 44(1)(c) that “merit review” has to have occurred, not that a recommendation has to have been made.

6. Section 44(3)(e) says that the reviewer must notify the parties of any findings and may make recommendations based on those findings. Interestingly, section 44(3)(g) says that the recommendations are binding on the parties, whereas no mention is made of the effect of any findings, beyond their being the basis for any subsequent recommendations.

7. Thus it seems that the “finding” that there is insufficient evidence to conclude that the worker is not a “seriously injured worker” is of no effect in the absence of a consequent recommendation. Like an abandoned participle left dangling over the edge of an ill-constructed sentence, a “finding” with no consequent recommendation is a wretched thing with no work to do, perhaps raising false hope in some but of no use to any.

8. Even if it were the case that a stray “finding” with no consequent recommendation were thought a jurisdictional impediment for this Office, the recent decision by Davies, J in *The Trustees of the Sisters of Nazareth v Simpson* [2015] NSWSC 1730 provides a solution. At paragraphs 22-24 his Honour made the following analysis of the review process as set out in section 44:

Level 4, 1 Oxford Street, Darlinghurst NSW 2010
T: 13 9476
contact@wiro.nsw.gov.au
www.wiro.nsw.gov.au

22. It should first be remarked that the Scheme for review provided for in s 44 is unusual. After a work capacity decision referred to in s 43 is made the worker, if dissatisfied, may only refer the decision for an internal review by the insurer under s 44(1)(a). If still dissatisfied the worker may seek a merit review by the Authority.
23. It is only after a merit review by the Authority that the worker may refer a work capacity decision for review to the Independent Review Officer under s 44(1)(c) and that is "as a review only of the insurer's procedures in making the work capacity decision and not of any judgment or discretion exercised by the insurer in making the decision".
24. This has the odd result that although there has been a merit review by the Authority, ***the Independent Review Officer, who finds some defect in the insurer's procedures, can make a recommendation which has the effect of overturning the merit review by the Authority*** although there was no error in that review.

9. Since the recommendation of this Office may (however inadvertently) "overturn" the merit review, any want of form in the merit review might accordingly be supplied by a subsequent recommendation from this Office, although whether the same might be said of a want of substance is unlikely, since this office can only look to procedural matters.

10. Section 44A of the 1987 Act provides that a work capacity assessment must be conducted in accordance with the *WorkCover Work Capacity Guidelines*[1] (Guidelines).

Submissions by the applicant

11. 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 has applied for a procedural review. He has appended, in various instalments, over 130 pages of purported "submissions," virtually none of which relate even remotely to the insurer's procedures in making the work capacity decision.

[1] As they somewhat anachronistically continue to be styled.

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12. The applicant has provided what he describes as a "Summary of Submissions," as follows:

> [T]hat the decision is procedurally flawed for the following reasons:
>
> (a) *Section 32A* - The Worker submits that he is a "seriously injured worker" within the definition of S. 32A of the *Workers Compensation Act 1987* and therefore cannot be subject to a work capacity assessment; and/or
>
> (b) *Denial of Natural Justice and Procedural Fairness* - The Worker has not been in all good conscience been accorded natural justice and procedural fairness in the process of assessing permanent impairment (and has in fact, knowingly and deliberately, if not recklessly caused a delay in the final assessment of permanent impairment); and/or
>
> (c) *Failure to Comply With Procedure* – The Worker submits there has been a failure of the insurer to follow appropriate procedure in the Work Capacity Decision and asserts multiple breaches of the Work Capacity Guidelines, hence breaches of the requirements of the 1987 Act;
>
> (d) *Model Litigant Policy* – The Worker submits that there have been multiple breaches of the Model Litigant Policy and these have prejudiced the rights of the Worker in obtaining a fair and appropriate decision with respect to work capacity;
>
> (e) *Other Matters* – The Insurer failed to consider the medical evidence of Professor W (an AMS in the insurer's view) who details impairment.

13. For present purposes a closer particularisation of the submissions is unnecessary. It might be thought that (a) and (c) have some potential for relevance, although clearly (a) cannot be resolved in the absence of a specific agreement between the parties or a binding finding by the Workers Compensation Commission (WCC). Neither currently exist and the applicant bears the onus of proof in any pending or future proceedings in the WCC. Had the "finding" by the merit review service on this point been binding on the parties, it would have been adverse to the applicant. This Office has no power to determine whether or not an applicant is a seriously injured worker.
14. Further submissions were forwarded by the applicant, including this (dated 10 November 2015):

Level 4, 1 Oxford Street, Darlinghurst NSW 2010
T: 13 9476
contact@wiro.nsw.gov.au
www.wiro.nsw.gov.au

1.FURTHER SUBMISSIONS

1.1. Decision of the Insurer

The Worker makes the submission that the decision of the insurer is procedurally flawed for the following reasons:

 In the decision of 28 May 2015, the insurer makes the following assessment:

"Section 43(1)(c) of the Workers Compensation Act 1987; a decision about the amount an injured worker is able to earn in suitable employment. In accordance with Section 43(1)(c) of the Workers Compensation Act 1987, I have determined you would be able to **earn an average amount of $616.20 (gross) per week** based on 15 hours (as per your WorkCover NSW Certificate of Capacity certification) working as a University Tutor/ATAS Tutor in the open labour market based on the following information: … " (p. 18)

 In the internal review decision of 27 July 2015, the insurer makes the following assessment:

"In coming to a decision about your ability to earn, I consider you have demonstrate an ability to earn in your current employment with Southern Cross University for several years. As such and in accordance with Section 43(1)(c) of the Workers Compensation Act 1987, I have determined you would be able to earn an average amount of $ 616.20 (gross) per week based on 15 hours working as a University Tutor/ATAS Tutor in the open labour market." (p. 7)

1.2. Submission of the Worker

The Worker directs the delegate to the WCD #149, dated 22 September 2015 by Delegate Emanuel, who states:

> 18. The legislation at Section 43(1)(c) of the 1987 Act is clear in that the insurer is to make a decision about the "**amount an injured worker is able to earn in suitable employment**" (emphasis added).
> 19. In this particular case the insurer has decided that the applicant is able to earn "an average of $20.88 gross per hour being an averageof $835.00 gross per 40 hour week." The use of the word average infers that the insurer has obtained more than one hourly rate for the suitable employment option and calculated an average hourly and weekly figure.

Level 4, 1 Oxford Street, Darlinghurst NSW 2010
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> 20. The definition of the word “average” in the Oxford English Dictionary1 is “to estimate, by dividing the aggregate of a series by the number of its units; to take the average of.”
> 21. **The insurer is to make a decision as to the actual amount the applicant is able to earn in suitable employment**. The applicant is unable to earn an “average” of more than one hourly / weekly rate as this calculated amount does not exist and is fictitious ...
> 24. The **non-compliance with the Guidelines and legislation referred to in the preceding paragraphs is sufficient to set aside the work capacity decision** dated 2 April 2015.

The Worker submits that the decision of the Insurer in the current matter also relies upon the application of an “average”, with the Worker working as a tutor in the open labour market. The Worker therefore submits that the failure to provide an actual amount is a breach of the Guidelines and legislation.

1.3. Decision of the Merit Reviewer

In the submissions of the Worker dated 25 October 2015, the Worker made it very clear that the Authority’s Merit Reviewer was required, under the guidelines, “**consider all of the material substantively and on its merits as if the original work capacity decision had not been made**, and is obliged to make findings that they think are more likely than not to be correct” (p. 38 of Submission, 25 May 2015).

Furthermore the Worker asserted that the decision of the Merit Reviewer did not comply with this requirement because it decided, from the outset, not to review matter relating to the calculations because:

“In his application for merit review, [the applicant] has not disputed the Insurer’s decisions on 28 May 2015 about matters under section 43(1)(a)–(e) of the 1987 Act. Accordingly, I am not satisfied those decisions have been referred to the Authority for review under section 44(1) of the 1987 Act and I make no findings or recommendations on those matters.”

1.4. Submission of the Worker

The Worker made it very clear that the guidelines do not require that the Worker to specifically identify this area requires review in order for it to be reviewed. The requirements for a Merit Review are only that the Merit Reviewer be satisfied that there is a foundation for such review.

Level 4, 1 Oxford Street, Darlinghurst NSW 2010
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The Worker's Merit Review Application dated 26 August 2015 was clear in its intent – that the decisions to be reviewed, were to be reviewed in their entirety:

"Which Work Capacity Decision(s) Do You Wish To Have Reviewed by WorkCover?

Work Capacity Decision of 28 May 2015 and Internal Review of 23 July 2015 (cover letter less annexures was emailed to me the insurer 27 July 2015, received in part thereafter, with Service ovvurring (sic) on 11 august 2015 for the full decision)."

The Worker made it clear that in order to change the Work Capacity Decision, that he want the "Decision Set Aside", an "Investigations of the Actions of the Respondent" and requests that the "Worker [be] granted procedural fairness …"

Given the obligation of the Merit Review to review the entire decision from the outset, this was very clearly not done, nor intended to be done with respect to the assessment of the Wages component. It was most definitely omitted.

The Worker submits that had the Merit Reviewer complied with the guidelines, the issues with respect to the use of an "average" would have been identified and established. The Legislation is beneficial legislation and the purpose of the scheme is to be fair. The Worker submits that the actions of the Merit Reviewer denied procedural fairness and natural justice.

2. FURTHER SUBMISSION: SETTING ASIDE OF WORK CAPACITY DECISION

The Worker submits that the Work Capacity Decision of 28 May 2015 should be set aside in its entirety on the basis of the above submissions.

15. Shortly it might be observed that at 1.2 above the applicant has misconstrued the reasoning of Delegate Emanuel. In the case cited the Delegate had commented on the practice of insurers averaging earnings over a variety of possible occupations remunerated at differing rates, whereas in the instant case the Insurer has specifically referred to the actual earnings rate of the applicant in his current position, "averaging" no more than the hours worked. There was no attempt by this Insurer to "average" differing hourly or weekly rates of payment. Accordingly the submission is misconceived.

Level 4, 1 Oxford Street, Darlinghurst NSW 2010
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16. At 1.3 and 1.4 the applicant identifies what might be a fatal flaw in the merit review undertaken in this case. If so, it is an issue which cannot be determined by this Office, but may well be susceptible to judicial review by the Supreme Court of New South Wales. Despite the comments by his Honour Davies, J in *The Trustees of the Sisters of Nazareth v Simpson* (see *supra* at paragraph 8, *et seq*), while it is possible that the indirect effect of a procedural review by this Office may be to "overturn" a merit review recommendation, there is no power vested in this Office to specifically review the findings and recommendation of the merit review service. It follows that even if I accepted everything the applicant says in points 1.3 and 1.4 I would have no power to take remedial action.

17. A further difficulty with the above submissions is that they were received on 10 November 2015. The original work capacity decision was dated 28 May 2015 and this appears to be the first occasion on which the substantive merits of the work capacity decision were raised, ironically in the only forum which cannot consider the substantive merits of the decision. The applicant may well be under a limitation restriction in raising this issue more than 30 days after the internal review was concluded by the Insurer. Once again, that is a matter for another forum.

Submissions by the Insurer

18. In summary, the Insurer submits that all procedures have been correctly followed. More specifically, the Insurer has attempted to address the submissions made by applicant, setting out those submissions and responding to them thus:

> **"Insurer's response to Application for Procedural Review of Work Capacity Decision by the WorkCover Independent Review Officer**
>
> "In response to the worker's submissions above, [the Insurer] submits that it has complied with all procedural requirements stipulated by the numerous pieces of workers' compensation legislation in the making of a work capacity decision.
>
> "The Insurer confirms [the applicant] has commenced numerous proceedings in the Compensation Court of NSW and

Level 4, 1 Oxford Street, Darlinghurst NSW 2010
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www.wiro.nsw.gov.au

the Workers Compensation Commission (WCC). A chronology of each set of proceedings is annexed to Annexure D and entitled Annexure 2 (pages 5 -10)[2].

"The Insurer does not consider the large part of [the applicant's] submissions are related to the procedure surrounding the making of the work capacity decision, but are rather and more bluntly related to the ongoing dispute before the Workers Compensation Commission. A chronology of the current proceedings before the Workers Compensation Commission is annexed to Annexure D and entitled Annexure 1 (pages 11 – 22).[3]

"Moreover, a large portion of [the applicant's] submissions also relates to the Merits of the work capacity decision, a fact which has already been the subject of Recommendations of the Merits Review Service on 25 September 2015.

"The Insurer does not intend on addressing each individual submission made by the worker, noting the extreme length of such submissions.[4]

"In response to the worker's lengthy submissions, [the Insurer] respond as follows:

1. "Seriously injured worker and assessment of lump sum compensation

"[The applicant's] submission has previously been addressed in the Insurer's Reply to the Application for Merit Review by the Authority.

"As part of the work capacity decision made on 28 May 2015, consideration was given as to whether or not the applicant meets the requirements of a seriously injured worker as provided in Section 32A of the *Workers Compensation Act* 1987.

"As the injury was sustained prior to 1/1/2002, the applicant has been paid lump sum permanent impairment compensation in

[2] Annexures not reproduced herein.
[3] See note 2.
[4] While the submissions are lengthy, to the extent of possibly amounting to an abuse of process, they are made in response to a work capacity decision which annexed over 1,450 pages.

accordance with a Table of Maims assessment. The Insurer refer to Annexure 2 and make reference to proceedings 5 (No 9588 of 2005). In those proceedings, an Award for lump sum compensation was made. Copies of that Award and related documents are contained at Annexure D pages 23 – 34 of the Reply. As such, the Insurer agree the applicant is a worker whose injury has resulted in a permanent impairment.

"However, the Insurer does not consider the applicant meets the additional criteria provided in the definition of seriously injured worker because:

- He has not been assessed by a trained assessor to have permanent impairment of more than 30% OR
- An approved medical specialist has not declined to make an assessment of his condition OR
- The Insurer is not satisfied that the degree of permanent impairment is likely to be more than 30%.

"As such, the Insurer does not consider the applicant meets the necessary requirements to be deemed a seriously injured worker pursuant to Section 32A of the *Workers Compensation Act* 1987 at this point in time.

"The Insurer makes the following further comments in this regard:

(a) "The applicant submits the insurer have omitted from the decision the major reports in relation to the Table of Disability Calculations (page 3 of his submissions). By this statement, he refers to the reports of Dr B, Dr Wa and Dr Wh. Copies of those reports are annexed to the work capacity decision and as part of the Application for Internal Review. The applicant's argument in this regard relates to the weight given to those reports (page 4 of his submissions). The Insurer has given weight to the opinions of the applicant's treating specialists in making the above decisions. This weight does not mean any other report should be excluded permanently but rather provides the applicant with reasoning as to how information has been considered in making the work capacity decision.

Level 4, 1 Oxford Street, Darlinghurst NSW 2010
T: 13 9476
contact@wiro.nsw.gov.au
www.wiro.nsw.gov.au

(b) "The work capacity decision is not a decision that amounts to an assessment of permanent impairment. As previously stated, the work capacity decision provides the applicant with reasoning as to how information has been considered in making the work capacity decision.

(c) "The applicant makes numerous submissions surrounding the meaning of a permanent impairment assessment. The Insurer does not intend on interpreting the law surrounding such issues and confirm the current position of the law.

"The Insurer refers to Annexure 2, noting the current proceedings before the WCC include a claim for **further** lump sum compensation based on an assessment made by a non-accredited WorkCover assessor. The applicant asserts, in effect, that as this is a pre-2002 claim, assessors of permanent impairment do not need to be accredited. The Insurer does not agree with this assertion. The Insurer confirms this claim is presently in dispute and before the WCC.[5]

(d) "The applicant makes numerous submissions surrounding the requirements of a trained impairment assessor. The claim in respect of impairment is presently in dispute and before the WCC.

(e) "The Insurer will not be addressing any matters relating to when the claim for permanent impairment was made or any matters relating to the current WCC proceedings, noting this matter is presently in dispute before the WCC. CGU consider the appropriate place for determination of such issues is the WCC.

(f) "The Insurer confirms the making of the work capacity decision has been conveyed to the applicant in plain English. In his submissions, the applicant interprets numerous pieces of workers compensation legislation, including the intent of the 2012 legislative amendments. The

[5] In which case the applicant might note section 44(5) does not operate to stay the current WCC proceedings, since those proceedings do not concern "a dispute about weekly payments of compensation payable to a worker."

Level 4, 1 Oxford Street, Darlinghurst NSW 2010
T: 13 9476
contact@wiro.nsw.gov.au
www.wiro.nsw.gov.au

Insurer does not intend on re-interpreting the law surrounding such issues and confirm the current position of the law.

2. "Accusations Relating to Procedural Fairness/Natural Justice/Good Conscious/Model Litigant

"The applicant's submission has previously been addressed in the Insurer's Reply to the Application for Merit Review by the Authority.

"In his submissions, the applicant interprets numerous pieces of workers compensation legislation. The insurer does not intend on re-interpreting the law surrounding such issues and confirm the current position of the law.

"The Insurer refers you to Annexure 1 (pages 11-22 of Annexure D) relating to the current WCC proceedings.[6]

"The applicant makes numerous serious allegations as follows:

- That the Insurer has been engaged in misleading and deceptive conduct to avoid procedural fairness.
- That the Insurer have engaged in Model Litigant breaches.
- Numerous unfounded accusations against Professor D W AO and Dr S P.

"The applicant also alleged the Insurer knowingly or recklessly delayed him from obtaining a permanent impairment assessment. He also alleges an abuse of process. The applicant's grievances relate to the striking out of proceedings number 7 (matter 5494/2013) on the basis that he was not ready to proceed. Any delays in the current proceedings are noted in the Annexure 1 (pages 11-22 of Annexure D) relating to the current WCC proceedings. We refer you in this regard.

"The Insurer takes such accusations seriously and disputes such allegations.

"The Insurer confirms the applicant is advised of his rights to make a complaint and provide feedback. At this time, he continues to exercise his right to make such complaints,

[6] Not reproduced herein.

Level 4, 1 Oxford Street, Darlinghurst NSW 2010
T: 13 9476
contact@wiro.nsw.gov.au
www.wiro.nsw.gov.au

including to WorkCover[7], the Minister's office, the Health Services Commissioner and the Legal Services Commissioner. At this time, all allegations are unfounded.

3. "Medical Reports

"The applicant's submission has previously been addressed in the Insurer's Reply to the Application for Merit Review by the Authority.

"The Insurer will not be addressing any submissions made by the applicant relating to the admissibility of legal reports. The Insurer will also not be addressing the applicant's numerous unfounded accusations against Professor D W AO, Dr P or any other practitioner. Any questions relating to admissibility are within the jurisdiction of the WCC to determine. At this time, the WCC have not made any such decision.

"For the current purposes, the Insurer again makes reference to the work capacity decision, noting the Insurer has given weight to the opinions of the applicant's treating specialists in making an assessment of the applicant's current work capacity. Reasons for this weight are clearly outlined in the work capacity decision. The process undertaken in making the work capacity decision has clearly been outlined to the applicant.

4. "Review of Work Capacity Decision

- "In his submissions, the applicant attempts to interpret numerous pieces of workers compensation legislation in lay terms. The Insurer does not intend on re-interpreting the law surrounding such issues and confirm the current position of the law.

- "The applicant submits the Insurer has failed to consider all available evidence in the making of the work capacity decision. He specifically makes reference to the omission of a report of Dr Wh dated 26 May 2014, and reports of Dr Wa from December 2012. The Insurer makes reference to the work capacity decision and notes the report of Dr Wh dated 26 May 2014 and the report of Dr Wa dated 25 May 2014 are annexed. The reports of Dr Wa from December 2012 have been considered but not included in circumstances where there is more

[7] As the *State Insurance Regulatory Authority* then was.

Level 4, 1 Oxford Street, Darlinghurst NSW 2010
T: 13 9476
contact@wiro.nsw.gov.au
www.wiro.nsw.gov.au

current information available to make an assessment of the applicant's current work capacity.

- "The applicant submits the Insurer's approach in making the work capacity decision "has been directed at the obtaining of an adverse report for the purposes of cancelling management, medical support, entitlements and income support." In making the work capacity decision, the insurer has considered all available information and taken weight[8] to the applicant's own treating specialists. Again, the Insurer submits this is a merits based matter and outside of the scope of the procedural review.

- "The applicant makes numerous submissions (page 44) surrounding the Merit Reviewer personally. The applicant similarly makes such statements in relation to both the original decision maker and the internal decision reviewer (pages 77 and 78). The applicant's personal views of each decision maker are not relevant for the purposes of this review.

- "The applicant makes submissions that the Insurer failed to provide "all relevant information" to the Merits Review Authority. The applicant is in possession of all information sent to the Merit Review Authority. The applicant's argument rests in his interpretation of 'relevant'.

- "The applicant asserts, without evidence, that the Merit Reviewer has breached his obligations pursuant to section 43(3)(e) of the Workers Compensation Act. The applicant also alleges the Merits Review Service denied him procedural fairness and caused gross deficiency as he has incorrectly applied the law. The mere fact that the applicant does not agree with the Recommendations reached by the Merits Reviewer is not sufficient cause make unfounded and unsupported statements.[9]

- "The role of the Merits Reviewer is not to make liability decisions or determinations at law (including assessments of impairment), but rather to undertake an independent review the work capacity

[8] Possibly a typographical parapraxis: more likely the weight was given than taken.
[9] Since there was in fact no recommendation made by the Merit Review Service, it is likely that applicant is doing something other than disagreeing with it.

decision pursuant to section 44 of the Workers Compensation Act. The Insurer considers the role of the Merit Review has been fulfilled. The Insurer acknowledges and agrees that the Merit Reviewer has acted independently and assessed the evidence before him equally in coming to his decision.

- "The applicant submits it is not possible to ascertain if all material was considered because the Merit Reviewer failed to detail the documents reviewed. All documents provided to the Authority were provided to the applicant. Noting the in excess of 1,500 pages of documents, the detailing of such information would have been longer than the decision itself. This statement is again unfounded and not evidence based. The Insurer considers the Merit Reviewer has reviewed all documents before him in coming to his decision.

- "The applicant then asserts that the Insurer had at no time provided an accurate list of all documents relevant to the work capacity decision (page 48). Pages 4-7 of Annexure B, together with the Insurer's Reply form (Annexure A) outline the documents considered as part of the work capacity decision and internal review decision. "The question of whether or not they are relevant to the making of the same is outlined in the work capacity decision.

- "The applicant alleged at no stage did the Merit Review Service consider the reports of Dr B dated 20 August 2015 and Dr Wh dated 25 August 2015 (sic). The Insurer notes the reports are in fact annexed to the applicant's own Application for Merit Review by the Authority on 26 August 2015. The Insurer is unsure the meaning of his comments relating to non-referral by the insurer and do not consider there has been an omission. Again, the applicant's argument in this regard relates to the weight given to those reports rather than direct omission.[10] The Merit Reviewer has provided evidence based reasons for his Decision.[11]

[10] See note 8.
[11] Strictly speaking, not a "decision." Merit Review only does recommendations (albeit binding) which may form the basis for an insurer's subsequent decision. The abject outcome for a "finding" made in the absence of a consequent recommendation is discussed at paragraph 7, *supra*.

Level 4, 1 Oxford Street, Darlinghurst NSW 2010
T: 13 9476
contact@wiro.nsw.gov.au
www.wiro.nsw.gov.au

- "The applicant concludes his submissions by suggesting the Merit Reviewer avail themselves of their powers in order to investigate the behaviour of the insurer. The Insurer does not consider this to be within the scope of the legislative function of the Merits Review Service.

5. "Making and Effects of work capacity decision

"The applicant makes submissions that the effects of the work capacity decision will render him without income, without access to medical expenses and inability to build on his family. The Insurer notes the applicant's ability to earn is based on his current employment and payslips, deeming an ongoing entitlement of $172.12 per week. On this basis, we note the applicant still has access to reasonable and necessary medical expenses. Whether such expenses are reasonable and necessary is a separate matter, noting the current dispute before the WCC. The insurer submit this is a merits based matter and outside of the scope of the procedural review.

6. "Provision of Legal Services

"The applicant makes submissions relating to the provision of legal services at page 54.

"The applicant's submission has previously been addressed in the Insurer's Reply to the Application for Merit Review by the Authority.

"The Insurer confirms the applicant is self–represented in the proceedings presently before the WCC.

"The Insurer has no control over any assessment or decision made by ILARS to provide funding to an Applicant. Should the applicant not agree with such an assessment or decision, this should be raised with ILARS directly.

"The applicant also makes reference to a decision of Arbitrator Stanton dated 6/6/2014. The Insurer make reference to proceedings 7 (matter number 5494/2013), noting these proceeding were struck out on the basis that the applicant was not ready to proceed. Whilst the apliocant may not agree with this decision, it has been made by the WCC.

Level 4, 1 Oxford Street, Darlinghurst NSW 2010
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contact@wiro.nsw.gov.au
www.wiro.nsw.gov.au

"This is not relevant for the purposes of the current review."

The Decision

19. Due to the focus by the applicant on various issues unrelated to the actual work capacity decision of the Insurer, including the way previous litigation was conducted, disputes about suitability of Independent Medical Examiners (including an allegation that one had a conflict) and discussion of numerous perceived insults, affronts and similar outrages perpetrated by or on behalf of the Insurer over a number of years, the worker spent comparatively little time saying anything about the actual decision made on 28 May 2015. It might be instructive to note that in correspondence to the Insurer the applicant advised that he had always intended to seek procedural review by this Office, irrespective of the outcome of merit review. Whether such a statement is evidence of either frivolous or vexatious intent might also be a matter for another forum.

20. Following a perusal of the notice sent to the worker dated 28 May 2015 I have formed the view that the Insurer has complied with all procedural requirements. More specifically:

- A fair notice call took place on 13 March 2015, terminated at the request of the applicant who said "put it in writing." The Insurer did exactly that and a letter of the same date which summarised the content of the telephone call as well as setting out the usual information found in a "fair notice letter" was sent.

- The Insurer advised that the work capacity assessment was completed on 28 May 2015.

- Further information provided by the applicant in response to the fair notice telephone call and letter was referred to in the notice and set out in a table on pages 4 and 5.

- All other information relied upon by the insurer was not only referred to, it was also enclosed, including various medical reports from the very doctors the applicant accuses the Insurer of ignoring or giving no weight to.

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T: 13 9476
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- The Insurer explained that statutory imperatives required them to "transition" the applicant's claim on or before 31 August 2015. This meant that it was not possible for the work capacity decision to be delayed so as to await the outcome of WCC proceedings.

- The applicant was clearly told that his weekly payments would be varied on and from 6 September 2015.

- The notice is no less than 23 pages long and the Insurer has taken pains to refer to all relevant sections of the legislation and has provided explanations where necessary.

- The reasoning behind the decision was more than adequately explained.

- The notice provided was in excess of that required under section 54(2)(a).

- Since the applicant will continue to receive weekly payments, it follows that section 59A(2) is irrelevant for present purposes.

Finding

21. Under the legislation the Insurer can make an assessment of the applicant's work capacity and then a decision about that work capacity, but they must comply with the legislation, the Regulation and the Guidelines in order to produce a procedurally correct result. In the current instance there have been no breaches of the legislation or the Guidelines which are to be treated as delegated legislation. Accordingly the work capacity decision must be found to be validly made.

RECOMMENDATION

22. The application for procedural review is dismissed.

Level 4, 1 Oxford Street, Darlinghurst NSW 2010
T: 13 9476
contact@wiro.nsw.gov.au
www.wiro.nsw.gov.au

Wayne Cooper
Delegate of the Workers Compensation
Independent Review Officer
26 November 2015