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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 application for procedural review is dismissed.

Introduction and background

1. The applicant sustained serious injuries on 21 December 2013 by involuntarily defenestrating six metres from a window in the course of his employment as a Site Supervisor. The sequelae of the episode included fractures to the right humerus and olecranon (proximal head of the ulnar) and the pelvis. In addition the applicant suffered contusions, depression, anxiety, intermittent but persistent headaches, vertigo, lumbar spinal pain and regionalised paraesthesia. He underwent several operative procedures, had some retraining and worked in several different positions for various employers. The Insurer accepted liability and made weekly payments of compensation for all relevant periods.

2. The applicant seeks procedural review of a Work Capacity Decision made by the Insurer on 6 September 2016. The Decision informed the applicant that his weekly payments of compensation would cease, effective from 13 December 2016. For the sake of clarity the Insurer specified that the last day of payment would be 12 December 2016, with nil thereafter. The Insurer advised that since the applicant did not work for 15 hours and earn $183 per week, he failed to meet the requirements of section 38(3)(b) for payments to continue after 130 weeks. This was relevant, since the applicant had by then received weekly payments for 142 weeks.

3. In an exercise akin to piling Pelion upon Ossa, the insurer went on to say that the applicant also failed to meet the requirements of section 38(3)(c). This finding was irrelevant. A consideration of section 38(3)(c) cannot arise unless the applicant first successfully crosses the threshold

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in section 38(3)(b). While clearly an exercise in procedural overkill, this is not a procedural error sufficient to set aside the decision, since the very fact that the question does not arise means that even if the Insurer got it wrong, it cannot affect the outcome of the review process.

4. The applicant sought internal review and the Internal Review Decision was dated 11 November 2016. The Internal Review Decision confirmed the original Work Capacity Decision.

5. The applicant sought Merit Review from the Authority on 8 December 2016. The Authority delivered its Findings and Recommendations dated 19 January 2016. The Authority made findings that the applicant: (i) is able to return to work in suitable employment; (ii) has current work capacity as defined in section 32A; and (iii) does not meet the special requirements under section 38(3) for continuation of weekly payments after the second entitlement period.

6. Anomalously, no recommendation was made to the Insurer. I styled this failure to make a recommendation as "anomalous" on the basis that the merit reviewer completely disagreed with the Insurer's assessment of the applicant's ability to perform suitable work. Whereas the Insurer had determined that the applicant could work as a Site Supervisor, Project Manager or Sales Representative, the merit reviewer ruled all three out on the basis that they had elements within them too difficult for the applicant to cope with in his current condition. The merit reviewer found the applicant capable of working in the role of Office Administrator, principally due to its overwhelmingly sedentary nature.

7. The applicant made an application to this office for procedural review received on 27 January 2017. I am satisfied that the application has been made within time and in the proper form.

8. Section 44A of the 1987 Act provides that a work capacity assessment must be conducted in accordance with the Guidelines. The relevant Guidelines came into effect on 1 August 2016.

Submissions by the applicant

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9. 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."*

10. The applicant made submissions thus:

- He is "appealing" the merit review and "some decisions made about [his] future job roles";
- He says the merit reviewer agreed with him that the Insurer had identified inappropriate "suitable duties" but he also disagrees with the merit reviewer saying he can do administrative work without further retraining;
- Acknowledging that he has "come to the end of [his] claim period," the applicant asserts that he is "left with no re-training, no qualifications, no informal training, no job options, no future, no help, no chance of benefits," [he is] "just left stranded and for what?"
- His life is currently "just one fight after another" with the Insurer.

11. First, I should say that a procedural review is not an "appeal" against the merit review outcome. I cannot look at the merit review in an attempt to correct it. If this is the aim of the applicant, he should seek legal advice about judicial review in the Supreme Court of New South Wales.

12. The complaint about the merit reviewer and the Insurer identifying inappropriate suitable duties is a merit issue, not a procedural issue.

13. The final two complaints are just that, and not submissions about procedural review. They are irrelevant for present purposes.

Submissions by the Insurer

14. The Insurer in reply said only this:

- The Insurer acknowledges [the applicant's] submissions and submits that the Insurer has adhered to the guidelines and legislation.

Decision

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15. The Insurer gave the applicant fair notice of an impending work capacity assessment and decision on 27 July 2016. This complied with the former Guidelines which were in force until 31 July 2016 (see former Guideline 5.2).

16. The insurer advised that the work capacity assessment was completed on 6 September 2016 and that as a result the decision had been made to discontinue payments in accordance with section 38(3).

17. Notice was properly given under section 54(2)(a), with an added four days as required by section 76(1)(b) of the *Interpretation Act* 1987.

18. The applicant was taken through section 43(1)(a),(b) and (f).

19. Section 59A(2) and (3) were clearly explained. The applicant was advised that his entitlement to pre-approved medical expenses could continue for two years after the cessation weekly payments due to his not having greater than 10% whole person impairment.

20. The concept of "current work capacity" as defined in section 32A was fully explained. It was explained that the applicant's own nominated treating doctor certified him fit for work for 8 hours per day, 5 days per week with modified duties.

21. Section 38(3) was fully set out and discussed at length.

22. The evidence relied upon by the insurer was set out, totalling no less than 55 documents. Five of those documents were dated 22 or 23 August 2016. It can scarcely be said that the evidence relied upon was out of date.

23. Four pages were dedicated to showing why the three identified roles would be suitable for the applicant. While the merit reviewer disagreed with the conclusions drawn, the process itself was properly done.

24. I can identify no procedural errors made by the Insurer.

Finding

25. The work capacity decision dated 6 September 2016 was validly made.

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RECOMMENDATION

26. The application for procedural review is dismissed.

Wayne Cooper
Delegate of the Workers Compensation
Independent Review Officer
2 March 2017