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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. On 9 August 2001 the applicant suffered injury to the neck, shoulders and lower back in the course of her employment as a Process Worker. Had she been so injured one year later, the injuries would be styled as "cervical spine," "upper limbs" and "lumbar-sacral spine." The applicability of the concept of "whole person impairment" might be the cause of some confusion for present purposes, on which see paragraphs 18-19 *infra*.

2. The insurer accepted liability and made weekly payments for all relevant periods.

3. The applicant currently works reduced hours, being certified for 20 hours per week, but was only offered 16 hours per week by her employer.

4. The applicant seeks procedural review of a "Work Capacity Decision" made by the insurer on 6 April 2018. The insurer informed the applicant that she was in the period after 130 weeks of payments, and was therefore subject to scrutiny under section 38. I note *passim* that the applicant had received no less than 850 weekly payments as at the date of the decision.

5. A pre-requisite to the applicability of section 38 is found in section 38(2), being the requirement that the worker not be found to have "no current work capacity." Since the applicant was working for 16 hours per week as at the date of the decision, the section is applicable.

6. The insurer found that the applicant did not satisfy section 38(3)(c). Even accepting that the applicant worked 16 hours per week and earned more than the required minimum amount (as indexed), the insurer noted that the applicant was certified to work for 20 hours per week. Section 38(3)(c) says:

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> (3) A worker (other than a worker with high needs) who is assessed by the insurer as having current work capacity is entitled to compensation after the second entitlement period only if:
>
> (c) the worker is ***assessed by the insurer*** as being, and as likely to continue indefinitely to be, incapable of undertaking further additional employment or work that would increase the worker's current weekly earnings.

7. On that basis, the insurer used its discretion to find that the applicant was not working to maximum capacity, and made the decision to terminate payments.

8. The same decision was made following internal review.

9. The applicant sought Merit Review from the Authority by way of application received on 4 June 2018. The Authority delivered its Findings and Recommendations dated 25 July 2018. The Authority made a finding that:

    - The applicant does not satisfy the special requirements under section 38 for the continuation of weekly payments of compensation.

10. The merit reviewer made the following recommendation:

    - The Authority makes no recommendations.

11. An application was made to this office for procedural review received on 11 September 2018. Mindful that that is more than two months after the date of the merit review, I am not satisfied that the application has been made within time.

12. Section 44A of the 1987 Act provides that a work capacity assessment must be conducted in accordance with the relevant *Guidelines*.

**Submissions by the applicant**

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13. 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."*

14. The applicant submits that:

- The decision made by the insurer is incorrect and should be reviewed by WIRO; and
- Also procedures are incorrect.

15. It might be noted that there is no specific reference here to either section 38(3)(c) or to the concept of a worker with 'high needs.'

**Submissions by the Insurer**

16. The Insurer made no submissions beyond noting that this claim was subject to a discrete reference to the WIRO Solutions Group.

**Decision**

17. The Insurer has conducted a thorough work capacity assessment and made a decision about the work capacity of the applicant. It follows that section 38(2) is satisfied and the only two issues which remain contentious are: (i.) can the insurer's decision under section 38(3)(c) be reviewed under section 44BB(3)?; and (ii) is the applicant an injured worker with "high needs"?

18. Taking the second question first, there is no evidence before the insurer, the Authority or this office to suggest that the applicant meets the threshold of "greater than 20% whole person impairment," which is the minimum for a finding of "high needs." Several assertions were made in the correspondence between the applicant's legal representatives and the Authority to the effect that such evidence did exist, but it was never produced. The onus lies with the applicant to prove that she is a worker with high needs, whereas the applicant seems to be arguing that the insurer bears an onus to disprove this. The Supreme Court has ruled on this question in the case of *Hallman v The National Mutual Life Association of*

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*Australia Ltd* [2017] NSW 151 [per Wilson, J at 40-43] and found that the Insurer does not need to be satisfied about any level of permanent impairment before making a work capacity decision. The onus of proof lies with the worker.

19. It is entirely possible that the applicant possesses medical reports giving her high assessments for the permanent impairment of body parts under the former table of disabilities, which was in force as at the date of her injury. Such assessments to not translate across to 'whole person impairment' at the same level.

20. The first question can be answered with a simple 'no.'

21. The reason for this is found in section 44BB(1)(c), quoted at paragraph 13 *supra*. It is clear that the words "assessment by the insurer" in section 38(3)(c) (see paragraph 6 *supra*) fall squarely within the wording of section 44BB(1)(c) limiting procedural review to matters excluding "any judgment or discretion exercised by the insurer."

22. In the event that the applicant seeks to challenge the exercise of discretion by the insurer under section 38(3)(c) the only forum where this might have prospects of success is the Supreme Court of NSW which has the power to issue prerogative writs. As the House of Lords found in *Padfield v Minister of Agriculture, Fisheries and Food* [1968] AC 997 there is no such thing as an unreviewable discretion. Privative clauses of themselves cannot oust the jurisdiction of the Royal prerogative, which is exercised by the Supreme Court. This office does not have prerogative powers and is therefore unable to interfere with decisions made under section 38(3)(c).

23. The Insurer seems to have otherwise fully complied with the legislative requirements when making the decision in question.

24. The Guidelines and legislation were fully complied with and there are no procedural errors in the decision-making process.

**Finding**

25. The Insurer has made no errors of a procedural nature and the work capacity decision was validly made.

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26. In any event the application to this office was made out of time, however I have exercised some discretion in favour of the applicant and conducted a procedural review.

**RECOMMENDATION**

27. The application for procedural review is dismissed.

Wayne Cooper
Delegate of the Workers Compensation
Independent Review Officer
15 October 2018