

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*.

1. The injured worker applies for procedural review of a work capacity decision made by a licensed scheme agent of the Workers Compensation Nominal Insurer (the Insurer).
2. The applicant was employed as a Head Teacher at a TAFE College where her duties involved administration, teaching and practical training. The subject being textiles, there was some not inconsiderable lifting carrying and bending involved. In 1995 she suffered injury to the back¹ and left leg. There is no dispute about the injury having occurred in the course of employment. The applicant is currently working eight hours per week on suitable duties. The Insurer paid weekly benefits for all relevant periods and therefore the applicant was an existing recipient of weekly payments of compensation immediately prior to 1 October 2012.
3. On 4 July 2013 the Insurer advised the applicant in writing of a work capacity decision which had been made on that date. She was advised that her entitlement to ongoing weekly payments of workers compensation would be terminated since she was found to have no entitlement under section 38 of the *Workers Compensation Act 1987* (1987 Act). She was told the following things:
 - It was noted that the applicant currently works in suitable employment and has received weekly payments for considerably longer than 130 weeks.²
 - “As a result of your work capacity assessment, a decision has been made that you are no longer entitled to weekly payments under the new

¹ As the “spine” was then known. See the Table in the former section 73, *Workers Compensation Act 1987*. See also section 66(2A) which somewhat anomalously still refers to “back,” seemingly in contradiction of the *Guidelines* approved by WorkCover for the assessment of Whole Person Impairment.

² 1,025 weeks, as at that date.

section 38 of the *Workers Compensation Act 1987*. This decision is effective from 10 October 2013.”³

- “Any entitlement you may have to payment of pre-approved reasonable and necessary medical and other expenses, until 10 October 2014, *will not be affected*.”⁴
 - “Your entitlement to weekly payments at your current rate must cease within three months of this decision – please refer to section 54(2)(a).”⁵
 - In addition to those representations, the Insurer also took the trouble to annex copies of selected sections of the 1987 Act, being specifically sections 32A, 36-38, 43-44A and 54. They were attached without annotation or comment. Since the applicant does not have legal qualifications, it is difficult to comprehend the utility of this action, short of thinking only that the Insurer has accepted and acted upon the blandishments of the “Plain English Law” industry which promotes the view that anyone can understand the law as long as it is (a) written clearly and (b) expressed in short, easily digestible sections (two pre-conditions which the extracted sections are unlikely to satisfy).
4. On 21 August 2013 the Insurer wrote to the applicant advising that an Internal Review had upheld the original decision. This letter made no reference whatsoever to the effect of the decision on medical benefits, did not refer to any date of assessment and (a point in its favour) avoided repeating the error of misrepresenting section 54(2)(a).⁶ In this letter the Insurer copied and pasted some sections of the 1987 Act directly into the text of the letter, rather than adding them as an annexure, but not all the same sections as were annexed to the letter dated 4 July 2013. In this later correspondence the applicant was spared the trouble of perusing sections 36-37, 44 and 44A. This might have led a reasonable person to believe that the omitted sections were irrelevant and to question why they were included in the earlier correspondence. No explanation was offered, either in “Plain English” or otherwise.

³ No date or range of dates was given for any “assessment” - Cf: *Workers Compensation Regulation 2010*, schedule 8, clauses 22-23 and 1987 Act, schedule 6, Part 19H, clauses 6 and 9.

⁴ Emphasis added. A classic example of antenantiopsis, where a proposition is expressed as the negation of its opposite. Sometimes more conveniently styled as a litotes.

⁵ Precisely the opposite of what the section says.

⁶ While avoiding a repeat of the earlier error, it also failed to note that an error had been made.

5. The applicant applied to the WorkCover Authority for a Merit Review of the Insurer's decision on 17 September 2013 and in a recommendation dated 19 December 2013⁷ the merit reviewer upheld the original decision of the Insurer. The merit reviewer found that the applicant has no entitlement to weekly payments of compensation in accordance with section 38 of the 1987 Act.
6. On 14 January 2014, the applicant requested the Independent Review Officer to undertake a review of the decision of the Insurer pursuant to Section 44(1)(c) of the 1987 Act. I am satisfied that the applicant has made that application within the time provided by that section and on the correct form.

The Applicant's Stated Grounds for Procedural Review

7. The applicant's grounds for pursuing procedural review are:
 - (i) Medical evidence relied upon by the insurer is out of date and pre-dates the diagnosis of a vertebral fracture which was only found in 2010.
 - (ii) The applicant has never had an assessment of permanent loss of efficient use of the shoulders⁸ or permanent impairment of the neck. This means that it is possible she could qualify as a seriously injured worker if all the losses/impairments could be aggregated.⁹
 - (iii) The applicant thinks that her file may have been disrupted when handed over to the current insurer from the predecessor. She thinks this might explain why new evidence was "overlooked."
 - (iv) The applicant seeks a "just" decision based on current medical evidence.

⁷ Some 93 days having elapsed, in clear breach of Guideline 10.14 of the *Review Guidelines*, which requires a decision be forthcoming "within 30 days of receiving the application."

⁸ More correctly, arms at/above the elbow (see former Table in section 73)

⁹ See clause 13 of schedule 8 to the *Workers Compensation Regulation 2010* (although the entire schedule may well be invalid due to not being incorporated into the *Regulation* correctly [or at all]). See footnote to clause 186 of the *Regulation* and section 35(2)(c) *Interpretation Act 1987*.

Submissions by the Insurer

8. The Insurer made no submissions in response to the application.

Legislation

9. Section 44(1)(c) of the 1987 Act limits the scope of procedural review to a review only of:

the insurer's procedures in making the work capacity decision and not of any judg[e]ment or discretion exercised by the insurer in making the decision.¹⁰

Therefore while it remains the case that no discretion is unreviewable,¹¹ the Insurer's discretion when making a work capacity decision appears only to be reviewable in the course of merit review or Judicial review.

The procedures to be followed by the Insurer are set out in *WorkCover Work Capacity Guidelines* and *WorkCover Review Guidelines*.¹² Both sets of *Guidelines* are said to be delegated legislation and therefore must be complied with in order for a work capacity decision to be validly made. Given the overall beneficial nature of the 1987 Act and the serious consequences to workers if decisions are made incorrectly, strict compliance with the *Guidelines* is required.

Process of the Insurer

10. The decision reached by the Insurer was certainly within the range of available decisions, and was upheld by the merit review service. The applicant has been paid for more than 130 weeks, and therefore section 38 is the applicable section of the Act to calculate entitlement. Being an existing recipient of weekly payments immediately prior to 1 October 2012, the applicant is subject to the transitional rate in Schedule 6, Part 19H, clause 2 of the 1987 Act. However, such considerations are of no

¹⁰ Judgement is misspelt in the Act as "judgment."

¹¹ See *Padfield v Minister of Agriculture, Fisheries and Food*. [1968] AC 997

¹² A short-hand name for *Guidelines for Work Capacity Decision Internal Reviews by Insurers and Merit Reviews by the Authority*.

interest on procedural review where the main relevant consideration is not *why* a decision is made, but *how* it is made.¹³

My Reasons:

11. The applicant's stated grounds for seeking procedural review can be dealt with shortly.

Given that the central submission turns on the non-existence of updated medical evidence post-dating the diagnosis in 2010 of a vertebral fracture sustained in 1995, it is perhaps surprising that the applicant has made no effort to obtain further evidence and to seek additional assessments of permanent impairment to the back, neck, both shoulders, left leg and foot. In light of the Court of Appeal decision in *Goudappel v ADCO Constructions Pty Ltd* (currently on appeal to the High Court) it would certainly be open to the applicant to seek further assessments. To this extent, the remedy lies at least in part within the hands of the applicant herself.

The remainder of the issues raised by the applicant go to the merits of the case and are not appropriate for procedural review.

12. Since procedural review requires a scrutiny of the decision-making processes of the Insurer, including an examination of compliance with legislation and *Guidelines*, rather than a consideration of submissions made by either party, the review process may proceed despite the absence of relevant submissions from either party. Any demonstrable error¹⁴ on the part of the Insurer may invalidate the decision.

13. There are in my view several breaches of the *Guidelines* which either individually or taken together are sufficient to invalidate the work capacity decision made by the Insurer.

- The work capacity decision letter made no reference to the true impact of the decision on the applicant's entitlement to medical and

¹³ For a related and recent discussion of the distinction see *Minister for Immigration and Citizenship v Li* (2013) 297 ALR 225 per Gageler, J at 253.

¹⁴ 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.

related treatment expenses. The only reference was a statement ostensibly seeking to reassure the applicant that her entitlements would remain unaffected until a date in 2014. This did not say that the effect of the decision is that 12 months after the last payment of weekly benefits, the entitlement to medical benefits would automatically come to an end under section 59A(2). Similarly there was no reference to section 59A(3).

- The same can be said of the letter advising the outcome of internal review, which made no reference to medical benefits.
- Neither letter referred to section 59A(2) and (3).
- Collectively this constitutes four errors on the part of the Insurer, since each instance of failure to explain the impact of the decision and reference the legislation is duplicated.
- The description of the effect of section 54(2)(a) in the first letter is a complete misrepresentation of the notice provision, and incorrectly states that payments must cease “within 3 months” of the work capacity decision, whereas the true effect of the section is to say that the payments **may not cease** until three months have elapsed following the provision of notice. That is, the Insurer has styled the section as a maximum payment provision, rather than a minimum notice provision.¹⁵ An attempt was made to remedy this by including a correct description of the effect of section 54(2)(a) in the Internal Review letter, but this cannot cure the original defect and no further notice period was given.
- The relevant *Guideline* is 5.4.2 which requires the Insurer to:
 - Reference the relevant legislation
 - State the impact of the decision **on the worker** in terms of their entitlement to weekly payments, entitlement to medical and related treatment expenses and return to work obligations.

¹⁵ This arises either from confusion or Orwellian doublethink on the part of the Insurer. In either case, the applicant can have no idea of the true effect of the section.

- There is no indication of the date on which the assessment was conducted. While this was not a requirement of the *Guidelines* at the date of the work capacity decision, it has subsequently been added to the 8 October 2013 iteration.¹⁶ Despite this it constitutes an unfairness to the applicant, since the Insurer is required to make a decision “as soon as practicable” after a work capacity assessment¹⁷ and absent being told of the date of assessment the applicant cannot know whether or not this has been done.

14. 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 has been more than one breach of the *Guidelines* which are to be treated as delegated legislation. Accordingly the work capacity decision must be found to be invalid.

Immediacy of Entitlement

15. A worker who has satisfied the provisions of the 1987 Act has an immediate entitlement to compensation. In *Speirs v Industrial Relations Commission (NSW)* (2011) 81 NSWLR 348 Giles, JA (Allsop, P and Hodgson JA agreeing) reviewed the various references to entitlement in the 1987 Act and arrived at the following conclusion [at paragraph 85]:

[I]n my opinion ‘entitled to’ in the definition in s 240(2) of the [1987 Act] does not mean entitlement established by a determination of the Workers Compensation Commission or the District Court, or by decision of the Board. The entitlement is a **right subsisting in law** when there has been injury satisfying s 4 and s 9A of the [1987 Act]. It may be recognised and given effect without tribunal or court determinations, as will commonly be the case.

¹⁶ In the *Guidelines* gazetted on 8 October 2013 such an omission would be a breach of the dodecalogue now appearing in the newly numbered *Guideline* 5.3.2.

¹⁷ See cl 23, schedule 8 of the *Regulation*.

Since the immediate entitlement to compensation is a right subsisting in law, it is hard to see on what basis clause 21 of Schedule 8 to the *Workers Compensation Regulation 2010* presumes to impose a three month “notice period” prior to a worker receiving an increase in payments to which they would otherwise be immediately entitled. By “otherwise” I mean that anyone other than an existing recipient is entitled to an increase in benefits without the preclusion period in clause 21. I note also that section 33 of the 1987 Act requires compensation to be paid “during the incapacity” rather than at some later date. There is no Henry VIII clause making reference to an amendment to section 33 of the 1987 Act and it follows that clause 21 must be *ultra vires* to the extent that it conflicts with the section.

My Recommendation:

17. For the reasons set out above I recommend that the Insurer undertake another work capacity assessment and, if it arises, make another work capacity decision, according to the *Guidelines* as gazetted by the Authority and according to the relevant legislation.
18. Since the applicant was an existing recipient as at 1 October 2012, she remains entitled to receive her pre-transition rate of weekly benefits until such time as she is validly transitioned under the Act. This cannot happen until a valid notice under section 54 is issued. Accordingly she remains entitled to her former weekly payments until she is validly transitioned and a section 54 notice issues and the relevant period of notice therein has expired.
19. Because the review process does not operate as a stay of the original decision, the applicant has not received weekly payments since 10 October 2013. Therefore it cannot be said that she “is receiving” compensation. This means that clause 21 of schedule 8 to the *Workers Compensation Regulation 2010* cannot apply. It follows that she may be restored to the correct pre-transition amount forthwith and back-dated to the date when the last payment was made, since there is no need for the effluxion of any notice period.¹⁸

¹⁸ To the extent that clause 21 of schedule 8 of the *Regulation* conflicts with section 9 (“A worker ... shall receive compensation”) section 33 (“compensation... shall include a weekly



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20. Noting the binding nature of these recommendations¹⁹ I recommend that the Insurer takes my views into account, and I recommend that the Insurer immediately gives effect to them.

Wayne Cooper
Delegate of the WorkCover Independent Review Officer
28 January 2014

payment **during the incapacity**") and section 38(2) ("A worker ... is entitled to compensation"), it is *ultra vires*.

¹⁹ See section 44(3)(h) of the 1987 Act – recommendations made by the Independent Review Officer are binding on the insurer and the Authority.