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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 work capacity decision of the Insurer dated 30 August 2013 is set aside.

b. The subsequent internal review decision dated 16 September 2014 is set aside.

c. The applicant is to be reinstated to his weekly payments at the rate applicable immediately prior to 9 December 2013.

d. The payments are to be back-dated to 9 December 2013.

e. Such payments are to continue until such time as a further work capacity decision is made and comes into effect.

Introduction

Preliminary: which decision?

1. The applicant seeks procedural review of a work capacity decision made by the Insurer. Exactly when the relevant decision was made is debatable, since there was initially a decision made on 30 August 2013 which resulted in ongoing payments being made to the applicant. The quantum of those ongoing payments was queried nearly one year later by solicitors instructed by the applicant who purported to seek an "internal review" by application dated 19 August 2014. A decision issued on 16 September 2014 which purported to terminate the weekly payments, effective immediately. The decision advised the applicant that his weekly payments of compensation would cease that very day, without notice as required under section 54(2)(a) of the 1987 Act.

2. The applicant sought merit review and a recommendation issued on 29 October 2014.[1] Since the merit review service of the Authority supported

[1] Despite this, it was dated 31 October 2014. If this case were not complicated enough already, copy of the merit review recommendation dated 31 October 2014 was received in this office on

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the Insurer's decision, the applicant sought procedural review by this office on 31 October 2014. I am satisfied that the applicant has made the application for procedural review in the proper form and within time.

3. A complication is caused in this case by an intervening event. On 28 October 2014 the Insurer issued a further decision which they said "should be read in conjunction with the Internal Review Decision … dated 16 September 2014." The precise intended meaning of "in conjunction with" is unclear, since this later decision has not been the subject of merit review and the letter contains the following bizarre sentence[2]:

   "*Please note that this Notice is a separate, discrete decision to the earlier decisions made in relation to your claim for workers compensation."*

   If the italicised sentence quoted were true, a reader could be forgiven for asking what significance ought to be placed on the words *"[T]his notice should be read in conjunction with the Internal Review decision … dated 16 September 2014,"* which words form the opening sentence of the letter.

4. I can only assume that the Insurer is seeking to smother any attempt to overturn the earlier decision on either merit review or procedural grounds by interposing a "new decision" prior to the outcome of merit review. The merit review service makes no reference to this later decision, and clearly they were not informed of it by either party prior to their recommendation being made.

5. This causes the dilemma at procedural review of whether (a) the first decision in August 2013 should be disregarded altogether and the decision of 16 September 2014 be regarded as the relevant "work capacity decision" with the one dated 28 October 2014 being thought of as the internal review of the September decision, or whether (b) the decision of August 2013 is still relevant and the decision of 16 September 2014 remains the relevant internal review decision. I prefer

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30 October 2014 along with the application for procedural review, which was dated 30 october 2014.

[2] This is not the only sentence in this series of decision which might be fairly so styled.

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the second option, particularly since the purported "new" decision dated 28 October 2014 comes to the same conclusion as the internal review dated 16 September 2014 and on the same grounds and is invalid and should be set aside for exactly the same reasons.

Background

6. On or about 9 March 2011 the applicant suffered injury as a result of a fall in the course of his employment as a Quality Assurance Manager. Around eleven months later he was made redundant by that employer and in August 2012 he commenced working as a Sales Assistant at a well-known chain of liquor outlets. The applicant remains employed there at the present time.

7. The applicant was in receipt of weekly payments immediately before 1 October 2012. Accordingly *Clause 8* of *Part 19H* of *Schedule 6* to the *Workers Compensation Act* 1987 (the 1987 Act) required the Insurer to conduct a work capacity assessment.

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

9. The relevant version of the *Guidelines* came into effect on 12 August 2013. The *Guidelines* provide instructions and guidance to Insurers regarding the appropriate and consistent application of work capacity assessments and decisions.

10. Once the Insurer has conducted a first assessment then the Insurer is required to make a work capacity decision. Where that decision involves a reduction in the weekly benefits payable to the injured worker then the Insurer is required to give proper notice to the worker (Section 54(2)(a) of the 1987 Act).

Submissions by the applicant

11. Section 44(1)(c) of the *Workers Compensation Act* 1987 (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 listed the following grounds for review:

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- No notice period has been provided in accordance with section 54 of the Act and clause 9.1.10 of the *Guidelines*.

By way of further background, I quote in full the relevant sentence from the internal review decision of which the applicant complains:

> " … this decision is effective from today, 16/9/2014."

Submissions by the Insurer

12. The Insurer has not provided submissions in response to the application for procedural review, but did respond to the same point in the course of the internal review decision and the merit review process. Here is the relevant part:

- Having reviewed the earlier work capacity decision dated 30/8/13, I acknowledge that the notice does not reference section 54 of the Act.

- However, in considering this omission, I refer [the applicant's solicitors] to the final paragraph of [clause] 5.3 of the *Work Capacity Guidelines* which states:

> "*A reduction or discontinuation in weekly payments due to information supplied by the worker does not require formal notification by the insurer*."

- As the work capacity decision dated 30/8/2014 was based primarily on [the applicant's] role with [the liquor outlet] it is therefore questionable as to whether any reference to, or notice period under section 54 is relevant in this case.

13. It is hard to follow the reasoning of the Insurer here, since notice was in fact given in the course of the original decision dated 30 August 2013 in the following fairly clear terms:

> **How this decision affects your claim**
> After review of your claim, I can confirm that you have received a total of 78 weeks of benefits, are therefore in the 2nd entitlement period and

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you are working an average greater than 15 hours per week (based on the average determined by your payslips from pay end date 7/7/13 – 18/8/13)

Therefore, the following formula is applied:
Average Weekly Earnings (AWE of $938.30 as determined by WorkCover) x 95% (As you are working in excess of 15 hours per week) = $891.39 less earnings (Earnings as reflected in your payslips) = Workers Compensation Benefit irrespective of your pre-injury duty rate:

The above formula will be used to calculate your weekly benefits following the 3 month and 7 day notice period.

The above formula will be used to calculate your weekly benefits as from 9/12/2013.

14. The deficiency is not with the notice itself (which is more than adequate and complies with section 54(2)(a) and the Guidelines) but rather with the non-reference to section 54(2)(a). The failure to reference the section is a breach of Guideline 5.3.2 (see below).

The Decision

15. *Guideline 5.3.2* requires the Insurer to 'reference the relevant legislation' and '*state the impact of the decision on the worker in terms of entitlement to weekly payments, entitlement to medical and related expenses and return to work obligations.'*

16. The Insurer actually concedes that the worker was not given the proper notice but seeks to excuse this clear breach of the legislation by reliance on a misreading of the *Guidelines*. It should be noted that the Insurer did in fact provide the correct notice in the decision dated 30 August 2013 and it is wrong to concede otherwise. However, since the worker was far more adversely affected by the outcome of internal review, the failure to give notice in that later decision is the subject of what follows.

17. True it is that if information supplied by the worker leads to a reduction or cessation of weekly payments, no notification of reduction or cessation of payments may be required in some circumstances, but this must be information of the kind which includes elements such as the worker being employed in full-time work, earning the same or more than their *pre-injury average weekly earnings* and/or advising the Insurer that they are no longer claiming weekly payments. These examples are

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merely illustrative and there will be many more types of relevant information which might excuse an insurer from notifying a worker of a subsequent (and consequent) decision. It is obvious that a worker need not be told that their payments will be stopped if they asked for them to be stopped.

18. This Insurer goes much further that what the *Guidelines* say or intend and presumes to conclude that the provision of any information by the worker which leads to an adverse impact on the worker's weekly payments is a fact which of itself excuses the Insurer from telling the worker that a decision has been made (which is what "notification" means) and the impact of the decision. It also wrongly concludes that the Insurer can cease weekly payments on the day a decision is made.

19. The Insurer is wrong in its approach. The *Guidelines* do not permit an insurer to cut off payments without notice. All they absolve an insurer from is the otherwise useless task of telling a worker who longer seeks payments that they will no longer receive payments they no longer seek. Section 54(2)(a) is in clear terms and need not be repeated here. The worker was an existing recipient and had been paid for 78 weeks as at the date of the decision dated 30 August 2014. Accordingly there is a statutory requirement for three months notice to be given. It was clearly given on 30 August 2013, although no reference was made to the section. For inexplicable reasons section 54(2)(a) was subsequently flagrantly breached in the course of Internal Review.

20. Although the failure to give notice is sufficient to invalidate the internal review decision, the Insurer committed an equally serious breach of the *Guidelines* in relation to the explanation and interpretation of section 59A. Clearly section 59A was not an issue as at 30 August 2013, since weekly payments were continuing as a result of the decision. But in the course of the Internal Review the Insurer relied on section 59A(1) to say that payments of medical and related expenses would cease on the same day that weekly payments ceased.[3] This was said to be the case because the application had been made more than one year ago and payments for medical expenses could only be made in that

[3] We might note here that for payments to have ceased, they had to have commenced beforehand. They must have also continued, as they had in this case for considerably more than 78 weeks.

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circumstance if weekly payments "are or have been paid or payable." In the Internal Review decision, the Insurer concluded the point with these words:

"*This means that if there are no changes to your current circumstances, your entitlement to reimbursement for medical expenses will cease on 16/9/2014*."

It has to be said that this is a novel interpretation of the Act. Given the receipt by the applicant of weekly payments for well in excess of 78 weeks, the Insurer might have regard to section 59A(2) when re-doing these decisions. In addition a quick perusal of *Vella v Penrith City Council* [2014] NSWWCC 363 (at paragraphs 48-96) might be in order.

21. Although it post-dates the internal review and cannot form any serious part of these reasons, the subsequent decision made on 28 October 2014 by the Insurer "in conjunction with" but discretely and separately from the internal review decision made a much better fist of explaining section 59A and even went so far as to quote section 59A(3). But even that decision proceeded on the assumption that section 54(2)(a) was irrelevant, noting only that:

"*Your entitlement to benefits were ceased as from 16 September 2014 as per the Internal review process*."

FINDING

22. 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 breaches of the *Guidelines* which are to be treated as delegated legislation. Accordingly the work capacity decision must be found to be invalid.

23. The decision of 30 August 2013 is invalid because there was no proper reference to section 54(2)(a). This breaches Guideline 5.3.2.

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24. The Internal review decision of 16 September 2014 is invalid because it breaches the notice requirements in section 54(2)(a) and the Guidelines as well as wrongly explaining section 59A.

25. The decision dated 28 October 2014 cannot stand, because it is predicated on the validity of the decision dated 16 September 2014 in relation to the notice requirements in section 54(2)(a).

RECOMMENDATION

26. The work capacity decision of the Insurer dated 30 August 2013 is set aside.

27. The subsequent internal review decision dated 16 September 2014 is set aside.

28. The applicant is to be reinstated to his weekly payments at the rate applicable immediately prior to 9 December 2013.

29. The payments are to be back-dated to 9 December 2013.

30. Such payments are to continue until such time as a further work capacity decision is made and comes into effect.

Wayne Cooper
Delegate of the WorkCover Independent Review Officer
12 December 2014