WorkCover independent review office

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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 application for procedural review is dismissed.

b. The applicant is to be reinstated her weekly payments at the rate applicable immediately prior to 19 September 2014.

c. The payments are to be backdated to 1 January 2015.

d. Such payments are to continue until receipt by the applicant of this recommendation.

Introduction and background

1. The applicant seeks procedural review of a work capacity decision made by the Insurer on 19 September 2014. The decision advised the applicant that her weekly payments of compensation would cease from 1 January 2014. The applicant sought internal review of the decision on 2 October 2014 and the Internal Review Decision was dated 27 October 2014. That decision affirmed the original decision to cease payments.

2. The applicant then sought Merit Review from the Authority on 12 November 2014 and a recommendation was issued on 9 December 2014. Merit Review also affirmed the original decision.

3. The applicant then applied to this office for procedural review on 8 January 2015. I am satisfied that the applicant has made the application for procedural review in the proper form and within time.

4. Historically this is not the first time the applicant has been the subject of a work capacity decision. In 2013 a work capacity decision was overturned by the Merit Review Service, which recommended that weekly payments be continued. The decision dated 19 September 2014 is a separate, subsequent decision unrelated to the first.

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5. In 2003 the applicant suffered injury to her right arm in the course of her employment as a Machine Operator. She returned to work but could not continue and was terminated in 2005. She currently works for a family business. At the time of the relevant work capacity decision the applicant was in receipt of weekly payments in the sum of $443.80 as a result of the earlier recommendation of the merit review service in 2013.

6. The applicant and her employer say that she is currently working 15 hours per week and is paid $180 per week. The Insurer does not concur. To the contrary, the Insurer alleges that the applicant and her employer are colluding to give a false impression that she works 15 hours, whereas they claim to have evidence which counters this claim.

7. The applicant was an "existing recipient" of weekly payments immediately prior to 1 October 2012 and for related purposes this would be regarded as an "existing claim."

8. Section 44A of the *Workers Compensation Act* 1987 ("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 11 October 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 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 requested a procedural review. Grounds relied upon are in these precise terms:

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- The Insurer failed to provide [the applicant] with a copy of all evidence relied on in support of the work capacity review and in particular [the applicant] was not provided with copies of all the surveillance material relied on by the Insurer to terminate weekly payments.

- Consequently [the applicant] was denied an opportunity to make submissions in relation to that evidence.

Submissions by the Insurer

12. The Insurer has made submissions in response to this application which are primarily concerned with the propriety of relying on surveillance video and reports. In full, those submissions are thus:

The Insurer acknowledges [the applicant's] submissions and responds as follows:

- The Insurer notes that the *Guidelines for Work Capacity Decision Internal Reviews by Insurers and Merit Reviews* by the Authority states:

  9.25 *Any surveillance images to be lodged with the Authority are to be provided by the insurer in DVD format and must first be provided to the worker. Any investigator's or loss adjuster's report concerning those surveillance images must also be provided with the images when they are provided to the worker and when lodged with the Authority.*

  9.26 *If surveillance images have been provided by an insurer to a worker for the first time in support of a reply lodged with the Authority, the worker will be offered an opportunity to respond to the surveillance images.*

- The Insurer submits that a copy of all the DVD's and reports were provided to [the applicant].

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- The Insurer submits that the Surveillance reports, along with an IME report was sent to [the applicant] on 21 August 2014.

- The Insurer submits that a Fair Notice letter was provided to [the applicant] on 28 August 2014, attaching the surveillance reports again and all the documents that were relied upon in the Work Capacity decision.

- The Insurer submits that the Surveillance DVD's were provided to [the applicant] on 8 October 2014.

- The Insurer submits that the Surveillance DVD's were again sent to [the applicant] on 19 November 2014, along with the Insurer's Merit Review Reply.

- Therefore, the Insurer submits that [the applicant] was provided with all the evidence relied upon, including the all the surveillance material relied upon and therefore complied with **Guideline 9.25**.

- The Insurer submits that [the applicant] was provided with an opportunity to respond. [The applicant] made submissions in internal review application form dated 2 October 2014 and merit review application form 12 November 2014, in accordance with **Guideline 9.26**.

- The Insurer notes that [the applicant] made further submissions in an email dated 27 November 2014.

The Decision

13. The subject of the mysterious video evidence appears to be the non-attendance at work (or more properly, non-attendance at the address of the workplace) of the applicant. It appears that constant surveillance reveals that the applicant does not attend work when she says she does and when in attendance stays for considerably fewer than 15 hours per week. The insurer has drawn the bizarre conclusion that this entitles them to say she can work more than 15 hours per week. Sensible observers might have concluded the opposite. However, I am

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constrained by section 44(1)(c) and therefore cannot consider the merits of the decision or look behind any discretion exercised by the insurer. The Merit Review Service concluded that on balance the applicant probably worked fewer than 15 hours per week and therefore did not qualify for further payments under section 38(3)(b). I am unaware of any warrant in the possession of an Insurer (or any other person) to require a worker to perform specific work tasks to its satisfaction in addition to the requirement in section 38(2) to "return to work ... for a period of not less than 15 hours per week."

14. Nonetheless, however peculiar the decision of the Insurer or the merit review service might be, I am unable to scrutinize the merits of either. The Insurer is completely correct in its submissions that the way the surveillance material was revealed is in accordance with the Guidelines.

15. It might have gone further and noted that there is long-standing authority for the proposition that a litigating party can exercise a discretion to withhold evidence it possesses which will not advance the other party's case in order to prevent the tailoring of a story to accommodate uncomfortable facts: *Markus –v- Provincial Insurance Company Ltd* (1983) 25 NSWCCR 1. In a more recent case which applied the *Markus discretion* (as it is known) the NSW Supreme Court, referring to affidavits rather than surveillance reports or videos, made the following observations:

"The evidence has been specifically prepared to challenge important parts of the plaintiff's case and the credit of the first and second plaintiffs. Were the affidavits to be made available to the plaintiffs, there would be an inevitable risk of the plaintiffs being tempted to tailor their evidence to meet this evidence. In my opinion, the elements for the exercise of the discretion have been made out by the defendant."[1]

16. It follows that even if I could scrutinise the discretion of the Insurer, the withholding of video surveillance evidence until a later time than normally required by the Guidelines might not be thought unfair in the circumstances.

[1] *Halpin & Ors v Lumley General Insurance Ltd* [2009] NSWSC 644, at 41 per Hoeben, J.

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17. Section 54(2)(a) of the 1987 Act requires at least three months and four working days' notice be given if payments are being reduced or ceased having regard to Section 76(2)(a*)* and *(b)* of the *Interpretation Act* 1987. In this decision the Insurer has referenced and explained both sections of each piece of legislation. As a result the applicant was advised that her payments would cease from 1 January 2015. This is the required notice period and the Insurer has complied with the legislation and the relevant Guideline.

18. Guideline 5.3.2 also requires the Insurer to advise the applicant of the impact the decision has on her entitlement to medical and related treatment expenses. In this decision the Insurer has referenced and explained Section 59A(2) and (3). The applicant was advised that payment of her pre-approved medical and related treatment expenses would cease 12 months after the cessation of her entitlement to weekly payments. It was also explained that the applicant may again become entitled to payment of medical expenses by virtue of Section 59A(3) of the 1987 Act.

19. The Guidelines also require the Insurer to explain the relevant entitlement periods, reference the relevant legislation, state the decision and give brief reasons for making the decision. The applicant was informed that she had received 573 weeks of payments of compensation as at 19 September 2014 and that her claim is to be assessed under Section 38 of the 1987 Act.

20. The decision of the Insurer dated 19 September 2014 has displayed a careful consideration of the requirements of the Guidelines and the legislation.

Stay

21. Clause 30 of schedule 8 to the *Workers Compensation Regulation* 2010 provides for a stay of any work capacity decision by an insurer while any such decision is the subject of review pursuant to section 44 of the 1987 Act, as long as the decision relates to an "existing claim." Accordingly the stay referred to in clause 30 must apply to the present case. For this reason the applicant should continue to receive compensation at the rate applicable immediately prior to the date of purported cessation of

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benefits arising out of the original work capacity decision until such time as this current recommendation is received by the applicant. In this case the applicant should be restored to her former benefits from 1 January 2015.

Finding

22. There are no procedural errors identifiable in the decision. The Insurer has complied with the Guidelines and relevant legislation.

RECOMMENDATION

23. The application for procedural review is dismissed.

24. The applicant is to be reinstated her weekly payments at the rate applicable immediately prior to 19 September 2014.

25. The payments are to be backdated to 1 January 2015.

26. Such payments are to continue until receipt by the applicant of this recommendation.

Wayne Cooper
Delegate of the WorkCover Independent Review Officer
19 February 2015