WiRO
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*.*

1. The applicant seeks procedural review of a work capacity decision made by the Insurer.

2. The applicant was employed as a carpenter and cabinet-maker and suffered injury in the course of that employment which resulted in his inability to continue performing that role and ultimately being terminated from that employment in 2002. There is no dispute about the injury having occurred in the course of employment. Although the applicant has returned to work intermittently he is currently unemployed and has been since 2011. The Insurer has paid weekly benefits for all relevant periods under the *Workers Compensation Act* 1987 (1987 Act) and therefore the applicant was an existing recipient of weekly payments of compensation immediately prior to 1 October 2012.

3. On 7 August 2013 the Insurer advised the applicant in writing of a work capacity decision which had been made on that date. He was advised that his entitlement to ongoing weekly payments of workers compensation would "reduce to nil"[1] from 15 November 2013 since he was found to have no entitlement under section 38 of the *Workers Compensation Act* 1987 (1987 Act). He was told the following things:

- The relevant entitlement periods in the legislation were clearly and correctly explained.

- It was noted that the applicant 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 your entitlement to weekly payments under the new benefits scheme will reduce to nil from 15 November 2013."[3]

[1] A wording perhaps thought to be more palatable to the applicant than "cease" or "terminate," without actually having to say so.
[2] 572.2 weeks, as at 7 August 2013. Oddly, this became 722 weeks in a letter dated only 36 days later on 12 September 2013 advising the outcome of internal review. They cannot both the right, in which case this constitutes a demonstrable error (see note 11, *infra*).

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- "Any entitlement you may have to payment of pre-approved reasonable and necessary medical and other expenses, until 15 November 2014, will not be affected."[4]

4. On 12 September 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 and did not refer to any date of assessment.

5. The applicant applied to the WorkCover Authority for a Merit Review of the Insurer's decision and the application was received on 19 September 2013. The decision of the Merit Review Service, dated 6 January 2014[5] upheld the Insurer's decision.

6. On 20 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) The treating GP has certified the applicant unfit for duties as a cabinet-maker, maintenance worker and hand-packer;

(ii) The same GP has diagnosed "pain flare-ups/neck and back pain" and there is "on and off capacity for work";

(iii) The GP recommends further treatment, "including pain management";

(iv) Most of the evidence relied upon by the Insurer is over two years old;

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[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] An antenantiosis, where a statement is made by the denial of its opposite, possibly done in this case with the same motivation as hinted at in footnote 1, *supra*.
[5] Some 109 days after receipt of the application, in clear breach of *Review Guideline* 10.14 which requires a decision to issue "within 30 days."

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(v) "As injury occurred on 31 July 2001 has not been assessed – there is no evidence as to Whole Person Impairment, it is premature to transition";

(vi) "Left elbow has been denied and should be included in issues of capacity and identified jobs."

Submissions by the Insurer

8. The Insurer was invited to make submissions but declined to do so.

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.[6]

Therefore while it remains the case that no discretion is unreviewable,[7] 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*.[8] 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.[9] 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

[6] Judgement is misspelt in the Act as "judgment."
[7] See *Padfield v Minister of Agriculture, Fisheries and Food.* [1968] AC 997
[8] A short-hand name for *Guidelines for Work Capacity Decision Internal Reviews by Insurers and Merit Reviews by the Authority.*
[9] They contain what some describe as "soft" law. See seminar paper Kerr, D – *Challenges facing Administrative Tribunals – The complexity of legislative schemes and the shrinking space for preferable decision making* – Council of Australasian Tribunals, 18 November 2013.

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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 interest on procedural review where the main relevant consideration is not *why* a decision is made, but *how* it is made.[10]

My Reasons:

11. The applicant's stated grounds for seeking procedural review mainly go to the merits of the case and are not appropriate for procedural review. It might be noted by the Insurer however that if they are to make a further work capacity assessment and/or decision concerning this worker, it would be advisable to find medical reports more recent than those relied upon to date, since it is the current work capacity of the applicant which is relevant.

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 error[11] on the part of the Insurer may invalidate the decision.

13. There are in my view breaches of the *Guidelines* and the 1987 Act which 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 related treatment expenses. The only reference was a statement

[10] 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.
[11] 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.

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ostensibly seeking to reassure the applicant that his entitlements would remain unaffected until a date in 2014. It 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.

- 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.[12] 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 assessment[13] and absent being told of the date of assessment the applicant cannot know whether or not this has been done.

- The insurer gave two wildly differing estimates of the number of weeks of weekly payments received by the applicant[14] which must call into question the attention to detail of the Insurer in this case. Guideline 2.4 requires the Insurer to have "a tailored approach" to work capacity assessments, stating as follows:

> 2.4 Work capacity assessments should be tailored to the worker. An understanding of the worker's circumstances and their injury ensures the right approach at the right time.

[12] 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.
[13] See cl 23, schedule 8 of the *Regulation*.
[14] See footnote 2, *supra*.

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It might fairly be thought that an insurer which variously tells an applicant in two letters dated 36 days apart that they have received 572.2 weeks of payments and then 722 weeks of payments (and without noting the obvious discrepancy) has failed to properly consider the "the worker's circumstances" as required by Guideline 2.4

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 breaches of the 1987 Act and 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.

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

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"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, he remains entitled to receive his pre-transition rate of weekly benefits until such time as he is validly transitioned under the Act. This cannot happen until a valid notice under section 54 is issued. Accordingly he remains entitled to his former weekly payments until he 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 15 November 2013. Therefore it cannot be said that he "is receiving" compensation. This means that clause 21 of schedule 8 to the *Workers Compensation Regulation* 2010 cannot apply. It follows that he 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.[15]

20. Noting the binding nature of these recommendations[16] I recommend that the Insurer takes my views into account, and I recommend that the Insurer immediately gives effect to them.

[15] To the extent that clause 21 of schedule 8 of the *Regulation* conflicts with section 9 ("A worker ... shall receive compensation") and section 33 ("compensation... shall include a weekly payment ***during the incapacity***") it is *ultra vires*.
[16] See section 44(3)(h) of the 1987 Act – recommendations made by the Independent Review Officer are binding on the insurer and the Authority.

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