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, an injured worker, has applied for procedural review of a work capacity decision (the decision) made by the Insurer on 23 July 2013.

2. There is no dispute that the applicant was injured in the course of his employment on 14 September 2007. The applicant returned to his pre-injury employment on a full time basis until 25 August 2008 and thereafter he undertook his duties for a reduced number of hours until September 2008 at which time his employment was terminated. The applicant commenced alternative employment in March 2010. The Insurer made weekly payments as required under the provisions of the *Workers Compensation Act* 1987 (1987 Act).

3. The applicant was in receipt of compensation by way of weekly payments immediately before 1 October 2012. Therefore Clause 8 of Part 19H of Schedule 6 to the 1987 Act required the Insurer to conduct a work capacity assessment for the purpose of facilitating the application of the amended weekly benefits provisions to the applicant.

4. Section 44A of the 1987 Act provides that a work capacity assessment is an assessment of the injured worker's current work capacity and must be conducted in accordance with the *WorkCover Work Capacity Guidelines* (Guidelines).

5. The relevant version of the *Guidelines* is the one published on 27 September 2012 which applied to all claims from 1 January 2013. That publication stated that the *Guidelines* provide instructions and guidance to Insurers regarding the appropriate and consistent application of work capacity assessments and decisions.

6. Once the Insurer has conducted an 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[1] then

[1] Or cessation of weekly benefits.

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the Insurer is required to give proper notice to the worker (Section 54(2)(a) of the 1987 Act).

7. The heading of the decision fails to mention section 54(2)(a) of the 1987 Act. No legislation is referred to in the heading. *Guideline* 5.4.2 requires the Insurer to "*reference the relevant legislation".* Section 54(2)(a) is central to a work capacity decision and must be referred to in the decision, preferably in the heading.

8. The applicant raised one matter in the Application for Procedural Review. 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*[2] *or discretion exercised by the insurer".* The issue raised by the applicant goes to the merits of the matter which is a matter for the judgement and discretion of the insurer. It is therefore not relevant to this review.

9. The Insurer was required by Section 54(4) of the 1987 Act to give the applicant notice personally or by post. This notice was given by post. By virtue of the postal service rule in Section 76(1)(b) of the *Interpretation Act* 1987, the Insurer was required to give the applicant 3 months plus 4 working days, not including the day of posting, for postal service of the notice. Therefore in order to comply with the requirements of Section 54(2)(b) a notice posted on 23 July 2013 would not permit the reduction or cessation of weekly payments until the expiry of three months and four *working* days, not including the day of posting. The decision states that the cessation of benefits will take effect on 23 October 2013, only 3 months later.

10. As such, there has been a failure to give appropriate notice. Strict compliance with this section is required particularly as section 54(1) of the 1987 Act makes cessation or reduction of payments without the appropriate notice an offence (*Maximum penalty: 50 penalty units*). A penalty unit is defined in section 17 the *Crimes (Sentencing Procedure) Act* 1999 as $110.

11. The decision states that "*Under subdivision 3 of the Workers Compensation Act 1987, we are obliged to review your work capacity."*

[2] Judgement is given the wrong spelling "judgment" in the Act.

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The 1987 Act has 2 "*subdivision 3"* headings in different places in the Act. The legislation has not been properly referenced as required by *Guideline* 5.4.2.

12. The decision refers to sections 38 and 43(1)(a)(b)(c)(e) of the "*Workers Compensation Legislative Amendments* 2012*"* and says that as a result weekly payments are to cease. The proper name of the 2012 legislation is the *Workers Compensation Legislation Amendment Act* 2012 and the sections referred to in the decision were in Schedule 1 to that Act. They are not sections of the amending Act. Further, section 30C of the *Interpretation Act* 1987 provides that an amending Act "*is repealed on the day after all of its provisions have commenced".* The parts of the amending Act relevant to work capacity decisions did commence in 2012 and that part of the amending Act was repealed. *Guideline* 5.4.2 requires the decision to *"reference the relevant legislation".* The 1987 Act is not referred to. Section 38(3)(b) and (c) of the 1987 Act are the relevant legislation but they are not referred to and no attempt is made in the decision to explain why payments are to cease. There is no attempt to set out relevant definitions from section 32A of the 1987 Act such as "*current work capacity"* and *"suitable employment."* It is doubtful that any applicant could decipher and piece together these oblique references in order to comprehend why payments are to cease.

13. Section 43(1)(a)(b)(c)(e) of the 1987 Act is also not relevant. That section deals with what decisions are reviewable and how they may be reviewed. The legislation has not been properly referenced as required by *Guideline* 5.4.2.

14. The decision states that the applicant has received "*in excess of 130 weeks".* The decision does not state what the applicant has received 130 weeks of. I can only assume it is a reference to 130 weeks of weekly compensation payments. It is unlikely that a reasonable worker in the position of the applicant would understand this reference. The decision does not state that the 130 weeks relates to section 38(3)(b) and (c) of the 1987 Act and payments after the "*second entitlement period".* Further, the decision does not mention section 32A of the 1987 Act and the definition of "*second entitlement period."*

15. Perhaps any chance the applicant had to understand what is happening is thwarted by the Internal Review Decision (IRD). The IRD states that

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the Insurer has "*deemed that you have received more than 130 weeks of compensation."* The verb "deem" may suggest that less than 130 weeks of compensation has been paid, but that the Insurer is able in some way to decide that 130 weeks has been exceeded.[3]

16. The decision states that a work capacity assessment has been made. The decision does not state that this is a requirement pursuant to Clause 8 of Part 19H of Schedule 6 to the 1987 Act. As such the legislation has not been properly referenced as *Guideline* 5.4.2 requires. The insurer is required to make a decision "*as soon as practicable"* after the assessment is made: Clause 23, Schedule 8, *Workers Compensation Regulation* 2010. There does not appear to be any legislative requirement to notify the applicant of the outcome of the assessment. However, *Guideline* 5.4.2 states that the decision must:

    - *state the decision and give brief reasons for making the decision;*
    - *outline the evidence considered in making the decision, noting the author, the date and any key information. All evidence considered should be referred to, regardless of whether or not it supports the decision;*
    - *clearly explain the reasoning for the decision.*

    My finding is that the *Guidelines* result in the insurer being compelled to reveal the outcome of the assessment.

17. In this case the applicant does not know when the assessment took place. The Insurer made a telephone call to the applicant on 12 June 2013. The decision states that a discussion took place as to the hours the applicant was working. It is not clear whether the applicant was told in the course of call the "*potential outcome of this review and detail the information that has led the insurer to their current position"* as required by *Guideline* 5.2. This call of 12 June 2013 does not appear to satisfy *Guideline* 5.2 which requires an Insurer to make a fair notice call. There

[3] In the 1987 Act "deemed" workers are different to workers *simpliciter* and it follows that the term has a particular meaning when used in conjunction with the 1987 Act, beyond the everyday dictionary definition of "to form or have an opinion, to judge." Counting the number of weeks of compensation paid is scarcely a matter of opinion or judgement.

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was no follow up letter as required by *Guideline* 5.2. The Insurer has not demonstrated that the decision was made *"as soon as practicable"* after the assessment.

18. *Guideline* 5.4.2 requires the Insurer *"to 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".* Section 59A(2) of the 1987 Act states that treatment expenses and related expenses are no longer payable 12 months after a worker ceases to be entitled to weekly payments of compensation. The decision says nothing about any other benefits. In particular section 59A(2) of the 1987 Act is not referred to. The IRD, however, states that the applicant "*may still have an entitlement to reasonably necessary medical treatment."* The IRD is silent as to the circumstances under which the applicant "*may"* be so entitled and the fact that payments are no longer payable 12 months after a worker ceases to be entitled to weekly payments of compensation.

19. In addition, section 59A(3) of the 1987 Act states that the applicant may, after the entitlement to compensation for medical expenses ends, become eligible for further payments for medical expenses if the applicant becomes entitled to compensation for weekly benefits at some stage in the future. This was not disclosed by the Insurer.

20. *Guideline* 5.4.2 requires the decision to set out brief reasons, outline the evidence, and explain the reasoning for the decision. See paragraph 16 above. No reasoning is given, clearly or otherwise. The decision boldly states that the decision is based on the work capacity assessment. No hint is given as to what that assessment may have found.

21. *Guideline* 5.4.2 requires the Insurer to "*outline the evidence considered in making the decision, noting the author, the date and any key information. All evidence considered should be referred to, regardless of whether or not it supports the decision."* The decision states that all relevant documents have been considered. Only 3 documents are listed. What evidence the documents provided is not set out. No suggestion is given that some evidence may have not supported the decision. The applicant is left completely in the dark as to how the Insurer came to its decision.

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22. *Guideline* 5.4.2 also states that the work capacity decision notice must advise the applicant that any documents or information that have not already been provided to the applicant can be provided on request to the Insurer. The Insurer has failed to so advise the applicant. The Insurer does not state that copies of documents have been provided to the applicant The Insurer does not state that there are no other documents other than the 3 "relevant" documents. The insurer's statement suggests to an applicant that there are no other relevant documents. An applicant may well disagree if he has the opportunity to peruse such other documents. Documents are to be provided as required by *Guideline* 5.4.2, which has not been referred to.

FINDING

23. I find that the Insurer has failed to follow the procedures as set out in the WorkCover *Guidelines* which is required by Section 44A of the 1987 Act. The Insurer has also failed to follow the 1987 Act and the *Workers Compensation Regulation* 2010.

RECOMMENDATION

24. I recommend that the Insurer conduct a new work capacity assessment and make a new work capacity decision in accordance with the WorkCover *Guidelines*.

25. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 23 July 2013 until such time as he is properly transitioned. Those payments should continue from 23 October 2013 being the date on which they ceased.

26. Since the applicant is not currently in receipt of weekly payments, clause 21 of schedule 8 of the *Regulation* cannot apply and payments may resume immediately. The applicant is not required to produce work capacity certificates for the period from 15 October 2013 to date by virtue of the operation of section 44B(2) of the 1987 Act. These recommendations are binding on the insurer: see section 44(h) of the 1987 Act.

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10 February 2014