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 made by the self-insured employer (the Insurer) on 12 August 2013.

2. There is no dispute that the applicant was injured in the course of her employment on 9 August 2010. The applicant has apparently not worked since. 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. 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 which came into effect on 12 August 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 the Insurer is required to give proper notice to the worker (Section 54(2)(a) of the 1987 Act).

[1] Or cessation of weekly benefits.

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7. *Guideline* 5.4.2 requires the Insurer to reference the legislation. The heading of the Notice refers to section 43 of the 1987 Act. The correct reference is to section 54(2)(a) of the 1987 Act. As such the legislation is not properly referenced.

8. The decision states that *"in accordance with Section 43 of the WCA* [the1987 Act] *we wish to advise that your entitlement to weekly compensation will reduce from 19th November 2013".* The correct reference is to section 54(2)(a) of the 1987 Act. The legislation has not been properly referenced. The decision then states that in *"accordance with section 54, your weekly benefits will continue at the current rate for 3 months plus one week (to allow for delivery of this notice) to 9/11/13".* The correct reference should be to section 54(2)(a) of the 1987 Act. The decision does not state which legislation is being referred to. As such, the legislation has not been properly identified. A serious issue for the applicant is that the date has moved forward by 10 days. Section 54(1) of the 1987 Act makes it a serious offence to discontinue or reduce payments without the proper notice period with a penalty of 50 penalty units. A penalty unit is $110 pursuant to section 17 of the *Crimes (Sentencing Procedure) Act* 1999. As such this is a most serious breach, invalidating the Notice and attracting a penalty if acted upon.[2]

9. Following the advice that weekly benefits will continue to 9 November 2013, the decision states that the "*change in your benefit rate will become effective during this notice period".* Does this statement mean that the change in weekly payments will occur during the notice period, rather than 9 or 19 November 2013? If so, upon which date during the notice period will the change occur? The applicant is left thoroughly in the dark as to what this sentence could mean given that she has already been told of 2 dates as to when payments "will" reduce.

10. The notice period 2 paragraphs later under the heading ***"DATE DECISION WILL TAKE EFFECT"*** is given as 19 November 2013. An applicant should not have to determine whether the last date given is the correct one, or whether 2 out of 3 means that 19 November 2013 wins

[2] Since payments were due to reduce on either 9 or 19 November 2013 and today is 27 February 2014, it is probably reasonable to conclude that an offence was committed by reduction of payments with inadequate notice at some time in November 2013, more likely the 19th than the 9th.

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the battle of the dates, or whether the date is an unspecified date during the notice period.

11. 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* 5.3.2 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* 5.3.2 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 line of reasoning for the decision.*

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

12. In this case the applicant does not know when the assessment took place. The Insurer made a Fair Notice call on 15 July 2013. It appears that a follow up letter as required by *Guideline* 5.2 was sent. It is not clear if the applicant was advised in the fair notice call and letter that a work capacity assessment was to take place or had taken place. As such, the applicant cannot know whether the decision was made *"as soon as practicable"* after the assessment.

13. The decision states that "*You have a current work capacity (Section 43(1)(a)).*" Section 43(1)(a) is not the correct section to refer to. Also, the legislation in which section 43(1)(a) is to be found is not referenced. *"Current work capacity*" is a term defined in section 32A of the 1987 Act. That section has not been referred to. The definition in the 1987 Act may not be the understanding of those words as understood by the applicant.

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These are breaches of *Guideline* 5.4.2 and the need to *"reference the relevant legislation."*

14. The decision states that "*You have suitable employment options (Section 43(1)(b)).*" Section 43(1)(b) is not the correct section to refer to. Also, the legislation in which section 43(1)(b) is to be found is not referenced. *"Suitable employment*" is a term defined in section 32A of the 1987 Act. That section has not been referred to. This definition is long and would not reflect the normal usage of those words. These are breaches of *Guideline* 5.4.2 and the need to *"reference the relevant legislation."*

15. Section 38(3)(b) is then set out as follows:

> *(II). You are not working 15 hours per week (section 38(3)(b));*
>
> *(III). You are not earning $155 pr (sic) more per week (section 38(3)(b));*

Again there is no reference to the 1987 Act. The Insurer has failed to refer to section 38(3)(c) of the 1987 Act. That paragraph is a vital link in that sub-section.

16. As section 38 is being relied upon the Insurer is required to make a finding as to the number of weeks payment has been made to the applicant. That has not been done. If it were done then the Insurer would need to set out the relevance of "*second entitlement period"* by reference to section 32A of the 1987 Act. The decision does not refer to "*second entitlement period".*

17. The decision states that the applicant has a work capacity, sets out 3 jobs that the applicant can do full time, earning an average of $717.03 gross per week. How this was arrived at is not explained. Further into the decision the applicant is referred to 2 documents being a Vocational Assessment Report and a Return to Work Plan which were sent with the decision. An Insurer cannot assume that an applicant is able to decipher such documents and fathom the supputation of the "average wage" figure unassisted.

18. The applicant is then advised that her weekly payment is to be reduced to $221.27. How this figure has materialised is left to the imagination of

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the applicant. Based on simple arithmetic the figure may be from reliance on the *"transitional amount".* That amount is currently $938.30. Deducting $717.03 from that amount leaves $221.27. It is no surprise that the "*transitional amount"* is not referred to in the decision. If it were then the Insurer would have been required to reference the relevant legislation. It seems highly unlikely that any person not well experienced in workers compensation would conceive of how the figure was arrived at.

19. Assuming the above arithmetical result to be the reason for the figure arrived at by the Insurer, it cannot be correct. The "*transitional amount*" within section 38 is not used at its full value but at 80%, that is, $750.64. Interestingly, as the decision says that the applicant fails the test in section 38(3) of the 1987 Act then on the face of that she is not entitled to any payment and the "*transitional amount*" payable at any rate is not relevant.

20. The above is further confused by the decision referring to the applicant's pre-injury earnings of $551.72 That figure is not relevant to an applicant being transitioned to the new legislation and provides more confusion when attempting to ascertain why the weekly payment is to reduce to $221.27.

21. The decision was made by [assessor 1] on 12 August 2013, and reviewed and confirmed by [assessor 2] on 12 August 2013. The Internal Review Decision (IRD) of 29 August 2013 states that the same 2 assessors who made the decision made the IRD and it was reviewed by [assessor 3]. While this may appear to be a convergence of interest, the "*Guidelines for Work Capacity Decision Internal Reviews by Insurers and Merit Reviews by the Authority"* 7.2 states *"The internal review is to be undertaken by a person who was not involved in the making of the original work capacity decision."* This review is only with respect to the decision and not the IRD, but the same 2 people being involved with both the decision and the IRD must have been of concern to the applicant, particularly as the decision states that the internal review *"will be conducted by a Senior Claims Officer of [the Insurer], not the person who made the original decision".*

22. *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,*

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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 is silent as to such payments. The applicant may assume that such payments continue while necessary.

23. Section 59A(3) of the 1987 Act also states that the applicant will, after the entitlement to compensation for medical expenses ends under section 59A(2), become eligible for further payments for medical expenses if the applicant becomes entitled to compensation for weekly benefits at some stage in the future and for such time as weekly payments continue. The decision is silent as to this right under the Act.

24. *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 states that it has provided copies of all documents relied upon of which there are 5 listed in the decision. The Insurer does not state that there are no other documents. The insurer's statement suggests to an applicant that there are no other relevant documents. An applicant may well disagree if she has the opportunity to peruse such other documents.

25. The decision refers to "*your functional capacity assessment".* The list of 5 documents in the decision has a document called a "*Functional Capacity evaluation report*". A copy of that document was sent to the applicant. It is not possible to know if these 2 documents are the same, or whether the *"functional capacity assessment"* is different to the document sent to the applicant. In that case the decision maker relied upon a document which has not been made available to the applicant. At the very least the applicant may consider that a document has been withheld.

26. The Insurer also states that the copies of documents are provided pursuant to section 43 of the 1987 Act. Section 43 is not relevant. Documents are provided as required by *Guideline* 5.4.2.

27. The decision notes that the applicant has provided the Insurer with documents in support of the claim. A table is then set out, but strangely

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lists no documents. At the very least the applicant will have provided medical certificates or work capacity certificates. The Insurer has not listed any such certificates. The IRD, however, lists a report from a doctor dated 7 March 2012 which was provided by the applicant. *Guideline* 5.4.2 requires that the decision refer to "*All evidence considered ... regardless of whether or not it supports the decision".* There is no evidence that this has occurred.

28. The difficulty with ascertaining precisely what evidence and documents were available and considered is aggravated for the applicant with the decision in its third paragraph stating that *"Following an assessment of all available evidence on your claim"* compensation will reduce. Clearly, the decision did not take into account all evidence when the IRD lists a medical report which is not referred to in the decision.

29. *Guideline* 5.3.2 states that the decision must *"detail any support, such as job seeking support, which will continue to be provided during the notice period".* The decision states that the applicant *"will be provided with the support to assist in your return to increased hours with assistance in rehabilitation if reasonable and necessary".* This statement in the decision misrepresents the reality that such assistance will only continue during the 3 month notice period. Any applicant would read the decision to mean that this support continues while needed.

FINDING

30. 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

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

32. I recommend that the Insurer pay the applicant the weekly benefit to which she was entitled prior to 12 August 2013 until such time as she is

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properly transitioned. Those payments should continue from 19 November 2013 being the date on which they ceased.

33. 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 worker is not required to produce work capacity certificates for the period from 19 November 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.

IS THERE A MERIT REVIEW?

34. A Procedural Review can only occur when there has been a Merit Review: section 44(1)(c) of the 1987 Act. The applicant must have received the IRD soon after it was made on 29 August 2013. The applicant did not apply to the Authority for a Merit Review until 3 November 2013, a period of about 60 days after the applicant received the IRD. The application was received by the Authority on 4 November 2013.

35. A Merit Review Officer of the Authority sent an email to the applicant on 12 November 2013 advising that the application "*must be made within 30 days after the worker receives notice of the insurer's internal review decision in the form approved by the Authority".* This reference is to section 44(3)(a) of the 1987 Act which sets out the time limit. The "*form approved by the Authority"* did not exist until the iteration of the *Guidelines* of 11 October 2013. The Authority has advised the applicant that her application is out of time when time cannot have begun to run until 11 October 2013 at the earliest. The applicant cannot have received the IRD in the "*form approved by the Authority"* as the form did not exist when the IRD was sent on 29 August 2013. If the Insurer had managed to resend the IRD in the form approved by the Authority on 11 October 2013 then the applicant would still be in time as at 3 November 2013.

36. The email from the Authority states that as the application is out of time *"the Merit Review Service is required to decline to conduct a merit review in relation to this application."* The "*Guidelines for Work Capacity Decision Internal Reviews by Insurers and Merit Reviews by the*

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Authority" 9.13 state that the Authority will notify the worker in writing if the Authority declines to review a decision due to section 44(3)(a) of the 1987 Act. *Guideline* 9.14 states that *"If the Authority declines to review a decision the dispute has not 'been the subject of Merit Review by the Authority' as required by section 44 (1) (c) of the 1987 Act. Under these circumstances, an application may not be made to the WIRO for procedural review until the Authority has been able to conduct a merit review."*

37. As the Authority will know the Supreme Court in *Gaffey v Chief Commissioner of State Revenue* [2000] NSWSC 403 (16 May 2000) said, per Young J,

> "*29. Where a person approaches a public official to make a ruling on a matter pursuant to a taxation law and the person approached declines to do so on the basis that he or she has no jurisdiction, that to my mind, is a decision. It is quite clear that if a person dealing with a matter within his or her competence rules that he or she has no jurisdiction, that is a decision which may be reviewed; see eg Ex parte Hulin; Re Gillespie (1965) 65 SR (NSW) 31."*

38. The consequence of *Gaffey* is that *Guideline* 9.14 is wrong in law. The Authority had jurisdiction to make a decision as the application was made within time. Such an application would still be in time assuming that the decision has still not been sent in the "*form approved by the Authority".* A Merit Review Officer is "*a person dealing with a matter within his or her competence"* and as a result of declining to make a decision the Merit Review Officer has made a decision which can at least be the subject of a judicial review pursuant to the inherent powers of the Supreme Court of NSW.[3]

39. If the above is not correct, the Authority cannot have declined to make a decision simply because the application cannot have been out of time.

[3] A useful discussion of the inherent powers of the Supreme Court might be found in the High Court decision of *Kirk v Industrial Relations Commission; Kirk Group Holdings Pty Ltd v WorkCover Authority of New South Wales (Inspector Childs)* [2010] HCA 1 (3 February 2010).

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The decision was not sent in the approved form because a form did not exist as at the date of the decision. It is not known if the decision has been re-sent in the approved form. If it has, then the application to the Authority was made in time. The decision by the Authority to decline to make a decision is therefore not covered by *Guideline* 9.14. The Authority's decision to decline to make a decision is therefore a decision in the terms described in *Gaffey* and can therefore be subject to judicial review.

40. Since I do not possess the powers of the Supreme Court to invoke prerogative writs, I cannot force the Merit Review Service to perform their statutory function by issuing a writ of mandamus, nor prevent them from making a decision to not make a decision by issuing a writ of prohibition. However, noting that my recommendation is binding on the Insurer and the Authority in any event by virtue of s 44(h) of the 1987 Act, my recommendation as set out in paragraphs 31-33 above must stand.

Wayne Cooper
Delegate of the WorkCover Independent Review Officer
27 February 2014