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 on 12 July 2013.

2. The applicant was employed as a high school teacher and suffered injury in the course of that employment with a deemed date of injury being 3 June 1998. He was ultimately retired, medically unfit, in May 2003. There is no dispute about the injury having occurred in the course of employment. The Insurer 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*[1] of compensation immediately prior to 1 October 2012.

3. On 12 July 2013 the Insurer advised the applicant in writing of a work capacity decision which had been made on that date.[2] He was advised that his entitlement to ongoing weekly payments of workers compensation would "reduce"[3] from 24 October 2013 since he was found to have "no entitlement" under section 38 of the *Workers Compensation Act* 1987 (1987 Act). He was also told the following things:

- It was noted that the applicant has received weekly payments for considerably longer than 130 weeks.[4]

[1] See Schedule 6, Part 19H, Division 1, 1987 Act*:* ***existing recipient of weekly payments*** *means an injured worker who is in receipt of weekly payments of compensation immediately before the commencement of the weekly payments amendments*.
[2] An event seemingly lacking any spatio-temporal contiguity with the rest of the world, since it refers explicity to a conversation which had supposedly *already* taken place "on 26/07/2013." This is may be the first work capacity decision ever made in the 4th dimension.
[3] That term appears in the heading.
[4] 644.6 weeks as at 12 July 2013. Oddly, this became 662.6 weeks in the internal review letter dated 17 September 2013, some 9 weeks after 12 July 2013. This leaves 9 weeks unaccounted for and is demonstrably erroneous – 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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- "As a result of your work capacity assessment,[5] a decision has been made that your entitlement to weekly payments under the new benefits scheme wil reduce from $350 to $nil from 26/07/2013."[6]

- In the very next sentence the applicant is told that his payments will in fact continue until 24 October 2013 provided work capacity certificates continue to be provided.

- "Any entitlement you may have to payment of pre-approved reasonable and necessary medical and other expenses, until 24/10/2014, will not be affected."[7]

- "You have a current capacity to work and have returned to work for not less than 15 hours OR less than 15 hours per week: please refer to Section 43(1)(a) of the [1987 Act]."[8]

- The applicant is told that his "AWE" of $1,075.74 is "the transition amount" which is "specified in the legislation."[9]

- Perhaps most interestingly of all, the applicant was told that "the following occupations" had been identified by the Insurer as suitable employment. The occupations were then described as follows:

    - "List suitable employment."

4. On 17 September 2013 the Insurer wrote to the applicant advising that an Internal Review had upheld the original decision. The Internal Review letter at least did the applicant the service of identifying "casual teaching" as "suitable employment."

5. The applicant applied to the WorkCover Authority for a Merit Review of the Insurer's decision and the application was received on 4 October

[5] No date or range of dates was given for any "assessment" - Cf: Schedule 8, clauses 22-23 *Workers Compensation Regulation* 2010, and Schedule 6, Part 19H, clauses 6 and 9 of the1987 Act.
[6] A clear breach of the notice requirement in section 54(2)(a) of the 1987 Act.
[7] A litotes, where a statement is implied by the denial of its opposite, possibly done in this case to reassure the applicant that all would be well for the foreseeable future, rather than explaining the full effect of the work capacity decision – see s 59A(2),(3).
[8] Here the Insurer has introduced an exciting new element of multiple choice which is otherwise unknown to the law.
[9] As at 12 July 2013 the *transitional amount* was in fact $938.30.

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2013. The decision of the Merit Review Service, dated 3 February 2014[10] upheld the Insurer's decision.

6. On 20 February 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 various:

(i) He is engaged in ongoing an incomplete litigation with the insurer and his medical treatment is also incomplete and ongoing;

(ii) Both the Insurer and the Authority's Merit Review Service have made decisions based on out-dated reports which are irrelevant to his current work capacity;

(iii) Neither the Insurer nor the Authority have sought reports from his treating specialist[11];

(iv) He believes himself to be a "seriously injured worker" in that he thinks he would exceed 30% Whole Person Impairment, if assessed under the relevant WorkCover Guides[12] which would preclude the Insurer from conducting a work capacity assessment in the absence of the applicant's express consent; and

[10] Some 122 days after receipt of the application, in clear breach of *Review Guideline* 10.14 which at the time the application was lodged on 4 October 2013 required a MRS decision to issue "within 30 days." The purpose of this Guideline is unclear, since there is no known remedy for breach and in the version published on 8 October 2013 the "30 days" was changed from a mandatory requirement to the following: " … as soon as practicable and preferably within 30 days …" The amendment might be exculpatory of the Authority but is of no benefit to injured workers.

[11] Given the ongoing nature of litigation, it is surprising that the applicant's own solicitors have not obtained such reports. In any event the insurer explicitly refers to [and quotes from] such a report dated June 2013 in the Internal Review letter dated 17 September 2013.

[12] A course of action currently unavailable due to the operation of Schedule 6, Part 18C, clause 3 of the 1987 Act – see: *BP Australia Ltd v Greene* [2013] NSWWCCPD 60 (11 November 2013).

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(v) There are other "errors in the paperwork" of the Insurer, including the assertion that the applicant holds a Masters Degree in Applied Science. He does not.

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.[13]

Therefore while it remains the case that no discretion is unreviewable,[14] 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*.[15] 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.[16] 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

[13] Judgement is misspelt in the Act as "judgment."
[14] See *Padfield v Minister of Agriculture, Fisheries and Food.* [1968] AC 997
[15] A short-hand name for *Guidelines for Work Capacity Decision Internal Reviews by Insurers and Merit Reviews by the Authority.*
[16] 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.[17]

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. Despite this the practice of Insurers relying on medical evidence which is not recent enough to qualify in anyone's language as "current" must imperil the validity of any decision made concerning a worker's "current work capacity." The conduct of the Merit Review Service is not subject to the scrutiny of the WorkCover Independent Review Officer and accordingly nothing raised by the applicant in relation to merit review is of relevance.

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[18] 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 letter of 12 July 2013 gave two different dates for the cessation of entitlement: "26/07/2013" and "24 October 2014." They cannot both

[17] 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.
[18] 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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be correct and the applicant cannot be expected to know which is right or even more likely to be right.

- To the extent that notice was erroneously given to 26 July 2013, this was in breach of section 54(2)(a). I accept that the very next sentence gave correct notice under that section to 24 October 2013, but by then the damage had, so to say, been done. There was no hint of rectification in the second sentence, since no error was acknowledged in the first.

- 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 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).

- Neither the original letter of 12 July 2013 nor the Internal review letter of 17 September 2013 referred to section 59A(2) and/or (3).

- There is no indication in the letter of 12 July 2013 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.[19] 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[20] and absent being told of the date of assessment the applicant cannot know whether or not this has been done. It is unlikely that the applicant was assisted by being told that the letter confirmed a conversation to be held in two weeks time.[21]

[19] 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.
[20] See cl 23, schedule 8 of the *Regulation*.
[21] See footnote 2, *supra*.

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- The insurer gave two differing estimates of the number of weeks of weekly payments received by the applicant[22] 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.

  It might fairly be thought that an insurer which variously tells an applicant in two letters dated 67 days apart that the applicant has received 644.6 weeks of payments and then 662.6 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. The introduction of the multiple choice element in decision-making (see paragraph 3, footnote 8 *supra*) does not assist workers and ought not be encouraged.

15. That an Insurer could confuse "AWE" with the transitional amount is almost as hard to believe as that Insurer's repeated misuse of the words "transition amount" as opposed to the correct term: *transitional amount*. While only the former error is fatal, the latter is also unacceptable.

16. The pitfalls inherent in the template approach to decision-making and notice-giving are perhaps nowhere better illustrated than the listing of suitable employment options as: "List suitable employment." An error waiting to happen, this one would on its own be sufficient to invalidate the whole process. Given the number of similarly avoidable errors in this decision-making process, it is unnecessary to single out any one instance of procedural failure as particularly critical.

17. 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 1987 Act and the

[22] See footnote 4, *supra*.

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

Immediacy of Entitlement

18. 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 "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

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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 24 October 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 of $350 per week 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.[23]

20. Noting the binding nature of these recommendations[24] I recommend that the Insurer takes my views into account, and I recommend that the Insurer immediately gives effect to them.

Wayne Cooper
Delegate of WorkCover Independent Review Officer
25 March 2014

[23] 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*.
[24] See section 44(3)(h) of the 1987 Act – recommendations made by the Independent Review Officer are binding on the insurer and the Authority.