WiRO

WorkCover independent review office

Level 4, 1 Oxford Street, Darlinghurst NSW 2010
T: 13 9476
contact@wiro.nsw.gov.au
www.wiro.nsw.gov.au

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 (first decision) by the Insurer on 28 June 2013.

2. The applicant was injured on 30 July 2001. The applicant returned to suitable employment. 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 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 (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* came into effect on 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 or cessation of 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

7. The applicant raised various matters 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 or discretion exercised by the insurer".* The first issue is

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that the applicant was issued with a second decision on 14 August 2013(second decision). That was in similar terms to the first decision, but altered the date of cessation. The reason was that the first decision did not provide proper notice. The second decision provided adequate notice. The Insurer states that the second decision would also be the subject of the Internal Review. As such, this review will be a review of both decisions

8. The applicant's further submissions go the merits of his claim, that is, the judgement or discretion of the Insurer. Such matters are not relevant to a procedural review.

Submissions by the Insurer

9. The Insurer made no submissions.

The Decision

10. There are 2 "decisions", a most unsatisfactory outcome. The second decision states that the Insurer has "*made a new decision that is the same as the previous decision, however, the effective date has been altered…"* It is unclear what is meant by *"same as the previous decision".* The first point of difference is the date the decisions become effective. The dates are not the "*same*". Both decisions have a heading "*What has [the Insurer] determined to be the relevant facts to my case?"* What follows is not the "*same*" in both decisions. The first decision is 3 and a half pages and the second decision is 2 and a half pages. The one point of agreement is that the weekly payments will cease.

11. The second decision states that "*we note that this decision remains the subject of an internal review in response to your application."* It is somewhat unclear what "*this decision"* refers to. The previous paragraph refers to the decision of 28 June 2013. The words "*this decision*" may be a reference to the first decision or a reference to the second decision. The previous paragraph states that "*We refer to our previous work capacity decision made on 28 June 2013 (original decision)."* Had the author been referring to the first decision she would have used the term "*original decision"* which is her own term. The result must be that the

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Insurer is stating that the Internal Review relates to both decisions and therefore this procedural review is with respect to both decisions.

12. Section 54(2)(a) of the 1987 Act requires the Insurer to give 3 months notice of a reduction or cessation of weekly payments as a result of a work capacity decision. The notice provisions are subject to a penalty if the notice period is not provided pursuant to section 54(1) of the 1987 Act. The penalty is 50 penalty units. A penalty unit is $110 pursuant to section 17 of the *Crimes (Sentencing Procedure) Act* 1999.

13. The first decision has allowed 3 months from the date of the decision on 28 June 2013 to 28 September 2013. The *Interpretation Act* 1987 at section 76(1)(b) states that receipt of a posted letter is *"taken to have been effected on the fourth working day after the letter was posted".* Section 76(2) defines "*working day"* as any day that is not a Saturday, Sunday, public holiday or a bank holiday. Providing 3 months notice requires 3 months plus 4 days. As such, the Insurer has not provided notice as required.

14. The Insurer attempted to repair this fault by issuing the second decision on 14 August 2013. Adequate notice was provided on this occasion with cessation of payments to occur on 21 November 2013.

15. Between the dates of the two decisions WorkCover gazetted new guidelines on 9 August 2013, which would apply to the second decision but not to the first.[1] Guideline 5.4.2 in the original *Guidelines* and Guideline 5.3.2 in the second version both require the decision to *"reference the relevant legislation."* Both decisions state that notice is given of the decision in accordance with section 54. The correct reference is to Section 54(2)(a) of the 1987 Act.

16. Neither decision states that as a result of changes to the law that a work capacity assessment is required to be made, and that in certain circumstance a work capacity decision must be made. The decision does not reference the relevant legislation which is clause 8 of Part 19H of Schedule 6 to the 1987 Act in relation to the requirement to undertake

[1] The first decision must comply with *Guidelines* gazetted on 28 September 2012, whereas the second decision must comply with those gazetted on 9 August 2013. Guideline 5.4.2 in the original *Guidelines* was transformed into Guideline 5.3.2 in the second incarnation, although 5.3.2 is a dodecalogue whereas the former 5.4.2 was a decalogue..

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an assessment and section 43 of the 1987 Act in relation to making a decision.

17. The first decision states that an assessment has taken place. The second decision is unclear as to whether a work capacity assessment has taken place, although it states *"we have completed the assessment.*" Both decisions have a heading "*Work capacity assessment decision".* What follows is a word salad. No explanation is given as to what the heading means. Is it the assessment or the decision? The applicant is told that his "*claim falls within the 261+ Weeks period."* One may bravely infer that the applicant has received more than 261 weeks of weekly payments, but the decisions do not explicitly say so. The relevance of 261 weeks is not explained. This may be because it has no relevance, which is the case. It may be a reference to the 5 year limit on payments of weekly compensation[2] but that would not yet be applicable to the applicant.[3]

18. The relevant number of weeks is 130 being the end of the *"second entitlement period".* That would have required the decisions to refer to section 32A of the 1987 Act and the definition of *"second entitlement period."* It follows that *Guidelines* 5.4.2 & 5.3.2 respectively have not been complied with.[4] Section 38 of the 1987 Act would also need to be referenced.

19. The Insurer is required to make a decision "*as soon as practicable"* after the assessment is made: see 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, *Guidelines* 5.4.2 and 5.3.2 require 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*

[2] Section 39 of the 1987 Act.
[3] Clause 4, Schedule 8, *Workers Compensation Regulation* 2010.
[4] In particular, the common requirement to *"reference the relevant legislation."*

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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. In this case the applicant cannot know when the assessment took place and whether the decision was made as soon as practicable after the assessment.

20. The decisions then set out the test for a continuation of weekly payments pursuant to section 38(3)(b) of the 1987 Act. The section is not referenced. The decisions then state that "*You are currently engaged in suitable employment for 15 hours or more per week"* and also that *"You have a current work capacity for greater than 15 hours per week".* Such insight can only be admired: that an applicant who is working more than 15 hours per week actually has that capacity. The decisions do not state that "*current work capacity"* is defined in section 32A of the 1987 Act, and that definition is qualified by *"suitable employment"* which is also defined in section 32A. *"Suitable employment"* is an important definition as it is unlikely to be what the applicant would believe that phrase to mean.[5]

21. The applicant is then told that his "*weekly entitlement"* is calculated as follows: ($938.30 x 80%) – ($994.04 + $0.00) = $0.00. Where this formula may have come from is left unsaid. The same is so for the figure of $938.30. Why something has to be reduced to 80%, rather than just start with the lower figure is a complete mystery for anyone not properly referred to the legislation. Section 38(6) of the 1987 Act is not referred to and section 35 of the 1987 Act and its definition of the terms used in the formula is not referred to.

22. The $938.30 figure is the transitional amount. It is essential that it be set out as such, together with the relevant legislative references. Such

[5] To the confusion of any person trying to interpret "*suitable employment*," section 32A requires an insurer to "have regard to" the worker's "age, education, skills *and work experience"* in paragraph (a)(ii) and also to have ***no*** regard to " .. *the nature of the worker's pre-injury employment"* in paragraph (b)(iii). While there is possibly some obscure logical reasoning process behind this, I am unaware of what it is and should not need to be apprised of it in order to understand the definition of a term, which definition itself is supposed to be an explanatory provision. Apparently your work history is relevant, except if it pre-dates your injury.

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references would include definitions such as AWE in section 32A of the 1987 Act.

23. The next heading is *"What legislation and guidelines were used to make this decision?"* It is then stated that the definitions in section 32A of the 1987 Act are relied upon. There is no attempt to relate this back to the earlier parts of the decision under the heading *"Work capacity assessment decision".* The decisions then state that the weekly entitlements are based on section 38. Section 38 of what legislation is not said, but a reference to special requirements for payments after 130 weeks is referred to. An applicant may wonder as to the relevance of 130 weeks, and marvel as to how it is almost half of 261 weeks. The decisions then state that the decisions *"have also complied with"* the *Guidelines*. It would be instructive to know which *Guidelines* the decision-maker considers have been complied with, or whether the decision-maker has a copy of the *Guidelines*.

24. Both decisions then refer to *"What information was considered when making the work capacity assessment?"* Three documents are then set out: the claim form (1 August 2001); medical certificates of the NTD; and pay advice/pay slips. While this is interesting, the applicant would have a great deal more interest in the information which was taken into account in the decisions. The assessment is itself a document which should be taken into account in the decisions. It also seems unlikely that after nearly 13 years that there are no other documents. The insurer is required by *Guideline* 5.4.3/5.3.2 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".* None of this *Guideline* has been complied with.

25. *Guidelines* 5.4.2/5.3.2 also state 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.

26. The next heading is *"What has [the insurer] determined to be the relevant facts to my case?"* At this point the 2 decisions are no longer the same. The first decision sets out the applicant's age, work

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experience, physical restrictions, and suitable employment. The second decision states that all information has been considered and that *"we have matched your existing skills, education and work experience to jobs available in the Australian market place." Guidelines* 5.4.2/5.3.2 require the Insurer to "*state the decision and give brief reasons for making the decision"* and to "*clearly explain the line of reasoning for the decision".* None of this has been complied with.

27. The decisions have a heading "*What were the reasons for the decision?"* The second decision has this heading directly under the heading *"What has [the Insurer] determined to be the relevant facts to my case?"* The heading is, therefore, superfluous. The first decision set out some issues as to current work capacity and suitable employment. The amount the applicant is able to earn *"has been calculated on the number of hours that you are able to work and multiplied by the minimum hourly rate that is set out in:"* Set out in *what* is unsaid and therefore unknown..

28. The decisions state that the applicant may request internal review which must be sent within 30 days of receiving the decision. The *Guidelines for work capacity decision Internal Reviews by insurers and Merit Review by the WorkCover Authority* 6.5 which came into effect on 1 January 2013 say that the application for internal review must be lodged within 30 days of receiving the decision. Section 44(1)(a) of the 1987 Act does not impose any set time limit. The iteration of the *Guideline* which came into effect on 11 October 2013 correctly sets out that there is no time limit, and that the application for internal review must be lodged *"as soon as practicable after receiving"* the decision. The lack of a set time limit leaves what is an appropriate time most unclear.

29. The applicant is advised that if he is dissatisfied with the internal review he may seek a merit review from WorkCover. Again, the Insurer has not referred to section 44(1)(b) of the 1987 Act.

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.

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The Insurer has also failed to follow and apply the 1987 Act and the *Workers Compensation Regulation* 2010.

31. The plethora of errors, omissions and misapplications of the relevant legislation, *Guidelines* and the *Regulation* in this case are of no credit to the Nominal Insurer. WorkCover might be reminded that even though this is conduct by an *agent*, the principle underlying the whole law of agency is "*qui facit per alium, facit per se*: who acts through another acts himself."[6]

RECOMMENDATION

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

33. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 28 June 2013 until such time as he is properly transitioned. Those payments should continue from 21 November 2013, being the date on which they ceased.

34. 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 21 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(3)(h) of the 1987 Act.

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

[6] As recently quoted by Neilson, DCJ in *Porto v SAS Trustee Corporation* [2014] NSWDC 15 (21 March 2014) at 156.

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