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 (decision) by the Insurer dated 16 October 2013.

2. The applicant was injured on 1 May 2012. He returned to suitable employment but that work was terminated on 23 August 2013. 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

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7. 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 applicant's 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

8. The Insurer made lengthy submissions. The submissions include a chronology, which is helpful. The submissions refer to the required standard of proof and *"Brigginshaw (sic) v Brigginshaw (sic) (1938) CLR 336 (at 361-362)."* The reference should be (1938) 60 CLR 336. The submissions refer to the well-known statement of Dixon J (as he then was) and the submissions state that the standard of proof that applies to a Procedural review is that of "*comfortable satisfaction*". What His Honour actually said in *Briginshaw* is:

> *Except upon criminal issues to be proved by the prosecution, it is enough that the affirmative of an allegation is made out to the reasonable satisfaction of the tribunal. But reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences.*

The test is *"reasonable satisfaction",* not *"comfortable satisfaction".* I agree that the *Briginshaw* test applies to a procedural review although it is difficult to see how relevant it could be when the facts upon which I am to be reasonably satisfied are the words in a decision.

9. The submissions claim that the decision complies with *Guideline* 5.4.2 and the decalogue of guidelines contained therein. That is a reference to the *Guidelines* gazetted on 28 September 2012. The proper reference is

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to *Guideline* 5.3.2 of the *Guidelines* which were gazetted on 9 August 2013 and superseded the *Guidelines* of 28 September 2012. The *Guidelines* will be referred to within this review.

A threshold question

10. The Insurer included the following in the Chronology referred to above:

> "MRS provided [the Insurer] with electronic copies of its Decision dated 26/02/2014 and its letter to [the applicant] dated 26/02/2014.
>
> "MRS did not uphold [the Insurer's] work capacity decision and the decision maker ultimately determined that because they were not satisfied that the suitable employment that was identified in the earning capacity assessment report (which was approved by the NTD as being suitable employment for [the applicant]) was actually suitable employment for [the applicant] and it therefore determined that he has no current work capacity. On that basis, it decided that [the applicant] was entitled to weekly payments of compensation at the rate of $758.80 per week.
>
> "I am instructed that [the Insurer] is currently preparing a further work capacity dispute notice for issue to [the applicant], which adopts the recommendations made in the MRS decision, as required by Section 44(3)(g) of the Act."

This raises the question of what utility there might be in WIRO conducting a procedural review of a decision which MRS has already overturned. The answer is that MRS has made a binding recommendation which will take effect once implemented by the Insurer from that prospective future date, or at the earliest, from the date of the MRS recommendation. In contradistinction to this, if procedural review shows that no valid decision was ever made by the Insurer, I may recommend that payments be reinstated from the *date of cessation* up to the date on which payments resumed as a result of the MRS recommendation. Accordingly it remains appropriate for a procedural review to proceed.

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The Decision

11. After referring to the fair notice telephone call and letter, the decision has a heading *"WHAT IS WORK CAPACITY."* The next sentence is *"As an injured worker, your 'work capacity' is your fitness to work"* and 3 alternatives are set out. Using the phrase *"work capacity"* would suggest to an applicant that the term has some special meaning. That is not the case. Section 32A of the 1987 Act defines "*current work capacity*" and that term is qualified by the definition of *"suitable employment"* which is also in section 32A. The legislation has not been referenced as required by *Guideline* 5.3.2.

12. The next heading is "*BACKGROUND*." The decision states that the applicant is required to be transitioned. The decision does not state that an assessment, which had taken place, is required pursuant to Clause 8 of Part 19H of Schedule 6 to the 1987 Act. The legislation has not been properly referenced as required by *Guideline* 5.3.2. It is not stated that the decision has to be made "*as soon as practicable"* after the assessment as required by clause 23, Schedule 8, *Workers Compensation Regulation* 2010.

13. The decision next states that workers whose claims were made prior to 1 October 2012 and who were in receipt of weekly compensation at 1October 2012 and 1 January 2013 are required to be transitioned. The only correct part of this statement is that the applicant must have had a claim prior to 1 October 2012. What was happening on 1 October 2012 and 1 January 2013 is irrelevant. What is relevant is that the applicant was in receipt of weekly payments *immediately before* 1 October 2012.[1] The legislation has not been referenced. The relevant legislation is clause 1, Part 19H of Schedule 6 to the 1987 Act.

14. The decision then states that the applicant is currently in receipt of *"S38 (repealed) benefits."* Which legislation section 38 may be found in is not disclosed.

[1] As a matter of chronological necessity an applicant must have made a claim before 1 October 2012 in order to be in receipt of weekly payments immediately before 1 October 2012.

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15. The next heading is "*ASSESSMENT*" and what follows from that heading is faultless. The same cannot be said of the following heading *"LEGISLATION RELEVANT TO WORK CAPACITY DECISION".* The applicant is told that he falls into the second entitlement period, and section 37 of the 1987 Act is referred to. What is not referred to is section 32A of the 1987 Act and the definition of "*second entitlement period*". The applicant is told that an applicant working less than 15 hours and earning less than $168 per week is entitled to weekly payments. The formula pursuant to section 37(3) of the 1987 Act is then set out. The legislation is not properly referenced as only "section 37" is referred to, not section 37(3). The amount of $168 is irrelevant. That is the figure used in section 38(3)(b) of the 1987 Act and is of no relevance with respect to this matter. The formula relies on 80% to reduce AWE. The decision states that the 80% "*is the percentage based on the amount of weeks that you have been paid weekly compensation".* If that were the case, the applicant would be interested to know precisely how many weeks of weekly payments he had received. The decision only states that he has received more than 13 weeks and less than 130 weeks. Leaving aside that *"less than 130 weeks of accumulated benefits*" misrepresents the definition of "*second entitlement period*" in section 32A of the 1987 Act, the 80% has nothing to do with the number of weeks of weekly payments. It is a figure used in the legislation in order to calculate a rate of pay in certain circumstances.

16. The decision then refers to E and D and sets out their meaning. No reference is made to section 35 of the 1987 Act in which these definitions reside.

17. 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, *Guideline* 5.3.2 requires 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*

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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.

18. The next heading is *"DECISION and REASONS."* Again the applicant is told that he falls into the second entitlement period, and again section 32A of the 1987 Act is not referenced. The applicant is told that the second entitlement period is weekly payments *"for more than 13 weeks and less than 130 weeks".* Had the legislation been referenced the applicant would know that the second entitlement period ends at 130 weeks and is not less than 130 weeks.

19. The decision states that the applicant is not working in suitable employment. Section 32A of the 1987 Act and the definition of "*suitable employment"* is not referenced. The definition of "*suitable employment"* is not a definition that would be readily identifiable with the common usage of that phrase.[2]

20. Under the heading "*HISTORY"* a chronology is set out. The term "*suitable duties"* is used with no reference to the legislation. This must confuse the applicant as the term "*suitable employment*" has previously been used. "*Suitable duties"* is not defined in any relevant legislation.

21. The decision has as its next heading *"ABILITY TO EARN IN SUITABLE EMPLOYMENT."* The applicant would by this time be likely to be more confused as to the meaning of "*suitable employment*" and "*suitable duties,"* and whether the terms are interchangeable.

22. The next heading is "*CALCULATION".* The formula from section 37(3)(a) of the 1987 Act is set out, but the reference is only to section 37 of the

[2] 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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1987 Act. The decision then sets out "*AWE"* and refers to "*Schedule 6 Savings, transitional and other provisions Part 19H, Division 2(9)"* of the 1987 Act. There is no Division 2(9). This is a garbled reference to clause 9 of Part 19H of Schedule 6 of the 1987 Act. The decision again refers to the applicant being subject to the transitional rate as his claim was made prior to 1 October 2012, not being in receipt of weekly payments immediately before 1 October 2012.

23. Under the heading *"NOTICE"* the applicant is advised that he is given 3 months notice of the change to his payments pursuant to section 54 of the 1987 Act, plus a further 7 calendar days pursuant to section 76(1)(b) of the *Interpretation Act* 1987. That section of the *Interpretation Act* 1987 refers to the fourth working day after the letter is posted. Seven calendar days would normally be sufficient, as it is in this case, but a letter posted on 24 December 2013 would not have reached the fourth working day until 2 January 2014, more than 7 calendar days later.

24. The decision sets out a list of documents which have been relied upon in making the decision. It is not clear as to whether there are any other documents. *Guideline* 5.3.2 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.

25. The decision states 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.

26. 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.

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FINDING

27. 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 and apply the 1987 Act and the *Workers Compensation Regulation* 2010.

RECOMMENDATION

28. I recommend that the Insurer conduct a new work capacity assessment and make a new work capacity decision in accordance with the WorkCover *Guidelines*. It is noted that in submissions the Insurer has indicated that this procedure was already in train. If completed, there is no need to duplicate the work.

29. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 16 October 2013 until such time as the MRS recommendation takes effect. Those payments should continue from 22 January 2014, being the date on which they ceased.

30. 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 16 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(3)(h) of the 1987 Act.

Wayne Cooper
Delegate of the WorkCover Independent Review Officer
10 April 2014

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