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RECOMMENDATION FOLLOWING AN APPLICATION FOR REVIEW OF THE INSURER'S WORK CAPACITY DECISION PURSUANT TO SECTION 44BB(1)(c) OF THE *WORKERS COMPENSATION ACT* 1987.

SUMMARY:

a. **The work capacity decision dated 26 April 2017 is set aside.**

b. **The Insurer is to make a new work capacity decision in accordance with the *Workers Compensation Act* 1987.**

Introduction and background

1. The applicant injured his lumbar sacral region while working as a truck driver in February 2015. He ceased work immediately and has not returned to work.

2. The insurer accepted liability and made weekly payments for all relevant periods. In addition to a claim for weekly benefits, the applicant has an extant claim for lump sum compensation under section 66 alleging Whole Person Impairment (WPI) of 16%. The Insurer has apparently offered to resolve this claim for 13% WPI. It is clear that there is no suggestion from either party that the applicant has WPI either less than 11% or exceeding 20%.

3. The applicant seeks procedural review of a work capacity decision made by the Insurer on 26 April 2017, which advised that his weekly payments would reduce to $0.00 on 26 August 2017.

4. The Insurer determined that the applicant was capable of working 20 hours per week as a Product Assembler, earning $550 per week. The Insurer also determined that the applicant was not capable of performing his pre-injury duties.

5. The Insurer told the applicant that he was currently (as at 26 April 2017) within the second entitlement period (less than 130 weeks of payments received) which is covered by section 37 of the 1987 Act, but that by the time the decision came into effect some four months later he would be in

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the period covered by section 38. The Insurer then proceeded to advise that the applicant would cease receiving benefits because of his failure to comply with the requirements of section 38(3).

6. The applicant sought internal review and on 23 May 2017 the insurer upheld the original decision.

7. An application for merit review was received by the Authority on 26 May 2017 and findings and recommendations were issued on 15 June 2017. The Authority found that the applicant: (i) has current work capacity in accordance with the definition under section 32A; and (ii) is able to return to work in suitable employment as an assembly worker.

8. At paragraphs 23-24 of the merit review the Authority identified a procedural error and commented as follows:

> 23 [The applicant's] entitlement to weekly payments of compensation fell in the second entitlement period at the time the insurer made the work capacity decisions.[1] The Insurer prospectively applied provisions of the 1987 Act to the applicant, which is incorrect.
>
> 24 As the matter has not been referred to the Authority, I have made no findings or recommendations, however, I draw the matter to the attention of [the applicant] and his legal representatives, should they wish to have the matter rectified.

9. The applicant sought procedural review by this Office. I find that the application was made within time in the correct form.

10. Section 44A of the 1987 Act provides that a work capacity assessment must be conducted in accordance with the relevant Guidelines. The relevant Guidelines came into effect on 1 August 2016.

[1] A unique characteristic of the Authority's merit review service is that they refer to a decision in the plural if it has more than one element, whereas people more *au fait* with the genre might restrict the plural use to situations involving more than one decision, like the original work capacity decision, as opposed to (say) the internal review decision. In normal parlance they would be described as two decisions, not twelve. Unlike the author of the old saying: " … there are only 10 types of people, those who get the binary system and those who don't," the progenitor of the Authority's view was no mathematician.

Submissions by the applicant

11. Section 44BB(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.”*

12. The applicant made the following submissions:

- His eligibility for weekly payments was still within the second entitlement period at the time the decision was made. Despite this, the Insurer prospectively applied sections 38(3)(b) and (c) of the 1987 Act, which do not apply to that entitlement period. The correct section would have been section 37; and

- A relevant certificate of capacity states that the applicant cannot walk for more than 100 metres at a time, and this was not properly considered.

13. While the second of these submissions is clearly one going to the merits of the case and therefore outside the scope of procedural review, the first submission has some weight.

Submissions by the Insurer

14. The insurer made the following submissions:

- The Insurer contends that the applicant has raised issues which are not of a procedural nature and therefore fall outside a procedural review; and

- The Insurer submits that while the certificate of Capacity issued by his treating doctor states a restriction of walking no more than 100m, the evidence used in the original Work Capacity Decision and subsequent reviews has been addressed when considering the applicant’s Work Capacity and suitable employment options.

The Decision

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15. The applicant was given fair notice in writing on 3 April 2017 that an assessment leading to a decision was underway. The applicant provided further information to the insurer as a result of this communication.

16. In the notice dated 26 April 2017, the Insurer advised that a work capacity assessment had commenced on 28 December 2016 and was completed on 26 April 2017.

17. The Insurer set out the relevant legislative provisions with an explanation of how they affected the decision-making process. The various entitlement periods were set out, with a clear explanation of why the applicant was then within the second entitlement period. The applicant was taken through section 37.

18. For reasons not otherwise apparent the Insurer then proceeded to discuss section 38, ostensibly on the basis that the applicant would have received more than 130 weeks of payments by the time the decision came into effect on 26 August 2017.

19. This may explain why the applicant was given exactly four months notice, rather than the standard three months plus one week. Since the injury occurred on 28 February 2015, section 38 could not be relevant until the last week of August 2017.

20. At this point the Insurer ventured into the territory described by the Authority and extracted at paragraph 8 *supra*. Based on nothing more than an extrapolation from the applicant's current situation, the Insurer proceeded to advise that he was in breach of section 38(3), having failed to return to work for at least 15 hours per week and not earning at least $183 per week. A serious flaw with this argument is that the applicant cannot have failed to comply with section 38(3) until he is required to do so. It is not possible for the Insurer, the employer or the applicant himself to know what he will be doing in four months time. It is equally impossible to determine that a worker will definitely be in breach of section 38(3). As the Authority correctly said, the prospective application of section 38(3) when it did not yet apply was "incorrect" and might need to be "rectified."

21. Following on from the comments made by the Authority, there seems to be no way around the problem created by the Insurer. The sole grounds

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for terminating the applicant's payments were said to be found within section 38(3), and that section was prematurely and therefore erroneously applied. It follows that this is an error of law which is by definition a procedural error of the type susceptible to review by this Office.

22. I should say that the remainder of the decision-making process was largely error-free, except for one aspect. In both the work capacity decision and the internal review decision the same paragraph was reproduced in the following terms:

> The impact of this decision will mean that your entitlement to medical and related return to work and rehabilitation treatment expenses are limited to a period of 2 years after your weekly payments cease (under section 59A(1) and 59A(2) of the 1987 Act). At the current time and based on this decision, your entitlements to medical and related treatment expenses will expire on 26/08/2022.

23. Of course the two errors in this repeated paragraph are: first, since the applicant has an uncontested WPI claim for greater than 10% the relevant period is five years and not two years; and secondly, two years following 26/08/2017 would expire in 2019, not 2022. The insurer has given the correct notice of 5 years by stating that the expiration date is 26/08/2022, but has done so after erroneously stating that the relevant period is 2 years.

24. On its own, the error described at paragraphs 22-23 *supra* would be insufficient to overturn the work capacity decision, since the applicant was ultimately given the correct notice period, albeit via an unsatisfactory route. However, like the error concerning the misapplication of section 38(3), it is one which might benefit from "rectification," to use the argot of the Authority.

Finding

25. The work capacity decision was invalidly made, since it was based on a section which was not at the time relevant to the applicant's situation.

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RECOMMENDATION

26. The work capacity decision dated 26 April 2017 is set aside.

27. The Insurer is to make a new work capacity decision in accordance with the *Workers Compensation Act* 1987.

Wayne Cooper
Delegate of the Workers Compensation
Independent Review Officer
13 September 2017