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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 application is dismissed.

Introduction and background

1. The applicant suffered injury when she fell down stairs on 09 July 2010 in the course of her employment. The resultant injuries were to the cervical spine and lumbar spine, one shoulder, both wrists and both knees.

2. The insurer accepted liability and made payments for more than 130 weeks. The applicant was an existing recipient immediately prior to 1 October 2012 and accordingly her PIAWE is deemed to be the transitional rate, as indexed.

3. The applicant now seeks procedural review of a Work Capacity Decision made by the Insurer on 30 July 2015. The Decision informed the applicant that her weekly payments of compensation would reduce to $nil from 6 November 2015. The basis for the decision was said to be that the applicant was in breach of section 38(3)(b) and (c), in that she did not work for a minimum of 15 hours per week, nor did she earn the (then) required amount of $173 per week. At the time the applicant had not returned to work.

4. The applicant eventually did return to work in 2017, at which time she sought internal review of the earlier decision based on her changed circumstances. An internal review on 25 May 2017 reached the same conclusion as the original decision. The insurer disputed that the applicant works a minimum of 15 hours per week and also asserted that she could work more than her present hours and earn a higher salary. Therefore section 38(3)(b) and (c) remain relevant.

5. The applicant sought Merit Review from the Authority and the Authority delivered its Findings and Recommendations dated 27 July 2017. The

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Authority made findings that the applicant: (i) has a present inability arising from an injury such that she is not able to return to her pre-injury employment; (ii) is able to return to work in suitable employment as an employed psychologist; (iii) should be assessed for weekly payments under section 38 of the 1987 Act; and (iv) does not meet the special requirements to be entitled to weekly payments after the second entitlement period under section 38(3).

6. The Authority made no consequential recommendation.

7. An application to this office for procedural review was received on 25 August 2017. I am satisfied that the application has been made within time and in the proper form.

Submissions by the applicant

8. 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 has provided the following submissions:

    - The Insurer was in breach of clause 46(3) of the *Workers Compensation Regulation* 2010 which required copies of all reports to be served on a worker about whom a work capacity Assessment was being made; and

    - The Insurer misled the applicant about the availability of rehabilitation assistance.

9. The second submission is irrelevant to procedural review, since whether or not a worker is apprised of the availability of various ancillary benefits, the only thing I can consider is the procedures of the insurer in making the work capacity decision.

Submissions by the Insurer

10. In response the Insurer has submitted that:

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- The Insurer complied with the then applicable *Guidelines*, which did not require copies of documents to be supplied unless a worker specifically asked for them[1]. This conflicted directly with the provision in the (now repealed) Regulation relied upon by the appicant; and

- The Insurer says that the applicant was not misled about the availability of rehabilitation support.

11. As may be inferred from paragraph 9 *supra*, the rehabilitation issue is of no relevance for present purposes.

Decision

12. Section 44A of the *Workers Compensation Act* 1987 (1987 Act) provides that a work capacity assessment must be conducted in accordance with the Guidelines.

13. The relevant Guidelines for the purposes of section 44A were the ***Guidelines*** which came into effect in October 2013. They replaced the previous Guidelines.

14. The applicant was given "fair notice" of the impending decision and an opportunity to provide further evidence.

15. Adequate notice under section 54(2)(a) was given, including an additional period for postal delivery of the decision.

16. Decisions under section 43(1)(a)-(e) were set out and fully explained.

17. Sections 38(3) was clearly and correctly explained.

18. Suitable work was identified and the reasoning fully set out.

19. Recent medical reports, including reports of the applicant's treating doctor, were considered and discussed in the course of the decision.

[1] These *Guidelines* were issued by the regulator and were expressed to have the force of law, being described as "delegated legislation."

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20. As identified by the applicant, not all reports were actually given to the applicant, which on one view of it was a breach of clause 46(3) of the Regulation. The insurer was placed in the invidious position of being subject to *Guidelines* said to have the force of law at the same time that there was in operation a Regulation which was inconsistent with the *Guidelines*.

21. In my view the insurer was entitled to believe that it was bound by the *Guidelines* in force at the relevant time and which stated that copies of documents could be provided to injured workers upon request. The *Guidelines* were issued by the regulator and were said to have the force of law. While the situation is undesirable, it is not one of the insurer's making and in the circumstances no criticism can be made of the insurer for believing itself bound by the *Guidelines*. It follows that the failure to provide copies of reports was not a procedural error in circumstances where the worker had not asked for copies.

22. No procedural errors can be identified in the decision.

Finding

23. Under the legislation the Insurer can make an assessment of the applicant's work capacity and then a decision about that work capacity. The Insurer has done so in this case and has fully complied with the statutory requirements. Accordingly the Work Capacity Decision must be found to be validly made.

RECOMMENDATION

24. The application is dismissed.

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