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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*.*

SUMMARY:

a. The work capacity decision of the Insurer dated 7 January 2014 is set aside.

b. The applicant is to be reinstated to their weekly payments at the rate applicable at 7 January 2014.

c. The payments are to be back-dated to 8 April 2014.

d. Such payments to are to continue until such time as a further work capacity decision is made and comes into effect.

Introduction and background

1. The applicant seeks procedural review of a work capacity decision made by the Insurer on 7 January 2014. The applicant sought internal review and the Internal Review Decision (IRD) was issued on 6 February 2014. She then sought Merit Review and applied to the Authority on 25 February 2014. The Authority issued the Merit Review recommendation on 16 April 2014, 50 days later.[1] Following receipt of the Merit Review Service (MRS) recommendation, the applicant made application to this office on 28 April 2014. Accordingly I am satisfied that the application has been made within the designated time and on the correct form.

2. The applicant was injured on 1 March 2005. She returned to suitable employment with the employer. That suitable employment was no longer available as at February 2011, and the applicant's employment was terminated in June 2012. Since July 2013 the applicant has had suitable employment with another employer. The Insurer made weekly payments

[1] *Guideline* 10.14 of the *Guidelines for work capacity decision Internal Reviews by insurers and Merit Review by the WorkCover Authority (Review Guidelines)* which came into effect on 11 October 2013 says, relevantly: "*The Authority will write to the worker and insurer as soon as practicable and* ***preferably within 30-days of receiving the application*** *advising of the outcome of the merit review."* (Emphasis added.)

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as required under the provisions of the *Workers Compensation Act* 1987 (1987 Act).

3. The applicant was in receipt of compensation by way of weekly payments immediately before 1 October 2012. Accordingly Clause 8 of Part 19H of Schedule 6 to the 1987 Act required the Insurer to conduct a work capacity 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 11 October 2013.[2] 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 in the 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 applicant's submissions go to the merits of the decision and are therefore not relevant to a procedural review.

Submissions by the Insurer

[2] The same date as the *Review Guidelines*, see footnote 1 *supra*.

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8. The Insurer made submissions. The points raised will be dealt with in the decision. The Insurer also provided a useful chronology and copies of correspondence, such as the Fair Notice letter of 5 November 2013, and notes kept with respect to telephone calls between it and the Insurer (including the Fair Notice telephone call of 5 November 2013).

The Decision

9. The decision is dated 7 January 2014. Section 54(2)(a) of the 1987 Act requires 3 months notice be given when weekly payments are to be reduced of ceased. The decision states that payments of weekly compensation will cease on 8 April 2014. That time frame does not allow sufficient time for the applicant to receive the decision through the post. Section 76(1)(b) of the *Interpretation Act* 1987 states that when a document is to be served by post that service will be taken to be effected on the fourth working day after it was posted. The fourth working day after 7 January 2014 is 13 January 2014. In this case the applicant advises in her application for internal review that she received the decision on 10 January 2014. The applicant has not been given 3 months notice as required. The Insurer made a submission that the decision *"dated 7 January 2014 states Section 54 notice period of 3 months but dates from 07/01/2014-08/04/2014 represents 13 weeks notice".* I assume that this is meant to be an admission that appropriate notice was not given, but given the garbled nature of the sentence it is difficult to know whether such an assumption is correct.

10. In addition, reference is made to section 54 of the 1987 Act. The correct reference is to section 54(2)(a) of the 1987 Act. *Guideline* 5.3.2 requires the Insurer to reference the relevant legislation. An allusion is not a reference.

11. The decision states that a work capacity assessment was made on 6 January 2014. The decision does not state that this is a requirement pursuant to Clause 8 of Part 19H of Schedule 6 to the 1987 Act. As such the legislation has not been properly referenced as *Guideline* 5.3.2 requires. There does not appear to be any legislative requirement to notify the applicant of the outcome of the assessment. However, *Guideline* 5.3.2 states that the decision must:

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- *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 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.

12. *Guideline* 5.3.2 requires the Insurer *"to state the impact of the decision on the worker in terms of their entitlement to weekly payments, entitlement to medical and related treatment expenses and return to work obligations."* Section 59A(2) of the 1987 Act states that treatment expenses and related expenses are no longer payable 12 months after weekly payments cease. The decision states that the decision *"does not immediately affect your entitlements to medical and related treatment expenses".* Section 59A is not referred to as required by *Guideline* 5.3.2. The Insurers submission is an admission that section 59A was not referred to in the decision, but that was remedied in the IRD. The IRD cannot remedy a fault in the decision. The IRD, however, fails to advise as to section 59A(3) of the 1987 Act.

13. Section 59A(3) of the 1987 Act states that the applicant may, after the entitlement to compensation for medical expenses ends, become eligible for further payments for medical expenses if the applicant becomes entitled to compensation for weekly benefits at some stage in the future.

14. Section 43 of the 1987 Act is referred to and it is stated that the Insurer may make decisions about *"current work capacity", "suitable employment", "the amount that a worker is able to earn in suitable employment",* and *"the amount of an injured workers pre-Injury weekly earnings or currently* (sic) *weekly earnings".* Both *"current work capacity" and "suitable employment"* are defined in section 32A of the 1987 Act. The decision fails to refer to section 32A. The definition of *"current work capacity"* means an applicant who cannot return to her pre-injury

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employment. That would not be obvious from the usual meaning of the phrase. That definition is qualified by the term *"suitable employment"*. That phrase bears little resemblance to a usual understanding of it. For example, *"suitable employment"* includes employment *"regardless of whether the work or the employment is available."*

15. The reference to *an injured workers pre-Injury weekly earnings or currently* (sic) *weekly earnings"* is not of assistance in a matter where the applicant is being transitioned and the average weekly earnings is a statutory rate set by Clause 2, Part 19H of Schedule 6 of the 1987 Act *(transition amount).* Under the heading *"Reason(s) for decision"* the applicant is advised that she was receiving weekly payments as at 1 October 2012 and as a result she has a *"deemed pre-injury average weekly earnings ("PIAWE") of $948.50."* This would perhaps leave the applicant ruminating on why the Insurer would claim that it may make decisions about "*pre-Injury weekly earnings"* but then state that it is bound to use a set figure. Also, 1 October 2012 is irrelevant. What is relevant is that the applicant was in receipt of weekly payments *immediately before* 1 October 2012.

16. The decision states that documents are enclosed which *"are the documents that are relevant to our decision."* Five documents are listed. The decision states that the documents were provided pursuant to section 74 of the *Workplace Injury Management and Workers Compensation Act* 1998 and clause 37 of the *Workers Compensation Regulations* (sic) 2003. Section 74 deals with claims in dispute and is not relevant. In any event, the 2003 *Regulation* was repealed on 1 February 2011. The relevant provision would be clause 46 of the *Workers Compensation Regulation* 2010.

17. *Guideline* 5.3.2 requires the Insurer 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."* By stating that "*documents that are relevant to our decision"* are enclosed the Insurer may lead the applicant to the seemingly inevitable conclusion that only documents that assist the Insurer in reaching its conclusion were considered and that documents which do not support the Insurer's conclusion have been ignored. The applicant would be comforted that her conclusion was correct when she received the IRD. The IRD refers to other documents

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including from an Independent Medical Examiner, the current Nominated Treating Doctor, an Occupational Therapist, and a Psychologist. She may well be less comforted when the IRD does not state that there are no other documents, including documents which may not support the Insurer's decision and IRD.

18. *Guideline* 5.3.2 states that the Insurer must *"advise that any documents or information that have not already been provided to the worker can be provided to the worker on request to the Insurer."* The decision has failed to so advise the applicant.

19. The decision was issued by the employer. It appears, therefore, that the employer is a self-insurer. The IRD was issued with a letterhead which has both the name of the employer and an Insurer (a licensed scheme agent). It is difficult to know which entity is responsible for producing the decision and the IRD. The submissions made for this Procedural Review are on letterhead which only names the Insurer. At what stage has the self-insurer outsourced the decision-making function to a licensed scheme agent? The identity of the decision-making body should be made clear from the outset. This is important if, for example, the applicant sought to have the decision judicially reviewed by the Supreme Court as referred to in section 43(1) of the 1987 Act.

20. The end of the decision advises as to assistance that may be available to the applicant. It states that one place to seek assistance is her *"union or Solicitor."* That is correct, but it would be of assistance to the applicant to be advised that a solicitor is unable to charge for any such assistance pursuant to section 44(6) of the 1987 Act. The applicant would realise that it would be difficult to locate a solicitor who is prepared to work for free. The IRD states that assistance can be obtained from a *"Lawyer (at your own expense)."* If the applicant seeks assistance from a solicitor it cannot be at her expense. Section 44(6) of the 1987 Act applies again with respect to advice given with respect to seeking a Merit Review.

FINDING

21. Given the argosy of errors coursing through the work capacity decision, not doubt launched and helped on their way to a large extent by the intricacies and complexities of the relevant *Guidelines,* I find that the Insurer has failed to follow the procedures as set out in the WorkCover

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Guidelines. This is required by Section 44A of the 1987 Act. The Insurer has also failed to follow the 1987 Act and the *Regulation.*[3] It might be convenient to here emphasize that the failure to conduct the decision-making process in strict accordance with the *Guidelines*, while fatal to the decision, does not reflect any fault on the part of the decision-maker.[4]

RECOMMENDATION

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

23. I recommend that the Insurer pay the applicant the weekly benefit to which she was entitled prior to 7 January 2014 until such time as she is properly transitioned. Those payments should continue from 8 April 2014 being the date on which they ceased.

24. Whether or not the applicant can now be transitioned is unknown. Clause 8(2) of Part 19H of Schedule 6 to the 1987 Act states *"The insurer who is liable to make weekly payments of compensation to an existing recipient of weekly payments must conduct a work capacity assessment of the worker no later than 12 months (or such longer period as may be prescribed by the regulations) after the commencement of the weekly payments amendments*." Clause 17 of Schedule 8 to the *Regulation* states that *"A period of 18 months is prescribed for the purposes of clause 8 (2) of Part 19H of Schedule 6 to the 1987 Act."* This means that the assessment must be made by 31 March 2014. As this can no longer be achieved it is difficult to see how the applicant can now be transitioned. Clause 17 ceased to have effect on and from 1 April 2014.

25. 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 8 April 2014 to date by virtue of

[3] The *Regulation* 2010, not the repealed *Regulation* 2003.
[4] See generally *SZFDE v Minister for Immigration and Citizenship* (2007) 232 CLR 189.

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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.

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Delegate of the WorkCover Independent Review Officer
14 May 2014