WorkCover independent review office

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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 3 February 2014 is set aside.

b. The applicant is to be reinstated to her weekly payments at the rate applicable at 14 May 2014.

c. The payments are to be back-dated to 14 May 2014.

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

Background

1. The applicant seeks procedural review of a work capacity decision by the Insurer dated 3 February 2014. The decision terminated the applicant's weekly payments of compensation, effective from 14 May 2014.

2. The Insurer purportedly wrote to the applicant on 17 December 2013 and again on 20 December 2013[1] advising of an imminent work capacity assessment and consequent decision. She replied and sent an old "permanently modified duties" certificate from her nominated treating doctor dated 17 December 2010 under cover of a letter dated 20 December 2013. The Insurer ultimately made a decision and advised the applicant in writing by letter date 3 February 2014.[2] The applicant went through the review process and received notice of a recommendation from the merit review service dated 16 May 2014. An application for procedural review was made to this office on 20 May 2014. I am satisfied that the application is within time and on the proper form.

[1] The applicant denies receipt of the second letter – see paragraph 8 *infra*.
[2] Note that more than 3 years had elapsed between 17 December 2010 and 3 February 2014. There was a slightly more recent certificate from the same doctor dated 3 October 2012, i.e. only 17 months old.

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3. The applicant was injured on or about 18 September 2008 in the course of her employment as a Corporate Information Coordinator. She returned to work on restricted hours (4 hours per day, 5 days per week) on 20 October 2008 and had the duties and hours amended over the ensuing period in consultation with the employer and insurer. She took long service leave in "early 2012" and was advised while on that leave that her employment had been terminated. Since that time she has sought alternative employment, with no success. She currently produces silk art-works which are commercially available from galleries, but this is not accepted by the Insurer as "employment" for relevant purposes. The Insurer made weekly payments as required under the provisions of the *Workers Compensation Act* 1987 (1987 Act).

4. 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.

5. 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).

6. The relevant version of the *Guidelines* came into effect on 11 October 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.

Submissions by the applicant

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 are three-fold:

- First, she believes that the Insurer failed to give proper notice of their decision as she did not receive their "fair notice" letter dated 20

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December 2013 ("not via Express Post or any other means"). She questions whether it was ever sent to her. She alleges that she "later discovered the very different letters of 17/12/2013 & 20/12/2013 attached as a copy of documents to their letter of *Outcome of a Review of a Work Capacity Decision* dated 27 March 2014."

- Secondly, the applicant alleges a "total lack of disclosure" by the insurer – more than once she has sought clarification of the 130 weeks of payments (for instance "minor payments, e.g. payments made on a Sunday" and payments for periods where she had no diary record of taking time off appear to have counted as whole weeks) and the Insurer "continued to ignore [her] requests for clarification." She was never given information about self-employment, even though it was requested. There was no job-seeking support and no help to get back to work before the expiration of 130 weeks.

- Thirdly, she believes that some of the information that the insurer relied upon was incorrect and incomplete and that the Insurer "failed in its duty of care" to her in relation to employment. The applicant believes that the vocational assessment obtained by the Insurer caused her to spend "many hours applying for inappropriate jobs – jobs that [she] would be unable to do without substantial risk of further injury."

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 *Briginshaw v Briginshaw* (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 "*reasonable satisfaction*." The quotation offered is this:

> *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*

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> *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.*[3]

This is an oddity, since the decision is more famous for positing a potential third level of proof, being somewhere between "the balance of probabilities" and "beyond reasonable doubt." The former applies in civil cases and the latter in criminal cases and some of the more eccentric publicists in the area of public and administrative law have seized upon these words from a single puisne judge[4] in a seventy-six year old decision to claim that they are "authority" for the proposition that there is such a third way. It is probably instructive that it is only administrative lawyers who accept this bizarre proposition. While it is possible that the *Briginshaw* test (such as there is such a "test") applies to a procedural review, 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 work capacity decision. Perhaps the *Briginshaw* card is one better played at the merit review stage.

9. The submissions are extensive and seek to comprehensively answer those of the applicant. To the extent that they argue the factual basis of whether or not a further "fair notice" letter dated 20 December 2013 was sent, I accept what the Insurer says. The letter was sent for the purpose of showing the number of weeks of weekly payments received by the applicant, which had been referred to but inconclusively explained in the earlier "fair notice" letter of 17 December 2013. I also accept that the correct notice was given under section 54(2)(a) and that regard was had to relevant factors as set out in the *WorkCover Work Capacity Guidelines* which came into effect on 11 October 2013.[5] I also accept that such submissions of the applicant as refer to the general management of her claim are irrelevant for present purposes.

A threshold question

[3] At 361-2.
[4] As Dixon, J then was.
[5] See paragraph 6 *supra*.

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10. The Insurer included in their submissions a further work capacity decision made following receipt of the recommendation of the merit review service. This might call into question the utility of making a recommendation following procedural review of the original work capacity decision. I have determined that there is a very good reason to persist with the procedural review of the earlier decision.

The Decision

11. On what is peculiarly paginated as "143" of the work capacity decision dated 3 February 2014[6] the insurer purports to list all relevant medical evidence relied upon. This is critical, since earlier in the decision the following words appear:

> "I have assessed you as having current work capacity."

The emphasis here is on the word "current." An examination of the medical reports relied upon does not betray much in the way of currency as at February 2014, since they are listed and dated as follows:

IME Report Dr PM 12/11/**2011**;
IMC Report Dr BS 18/05/**2010**; and
Medical Report Dr GC 17/03/**2010**.

Everything else is either a medical certificate from the applicant's own Nominated Treating Doctor (NTD) or a document not produced by a medical provider. The most recent communication from the NTD was dated 12 July 2013, described somewhat enigmatically as:

> "Fax from NTD approving vocational options."

There are no words quoted and it is not described as a medical report.

12. Relying on this ancient and slender medical evidence, the Insurer has then made the following series of observations:

[6] It is in fact the fifth page of seven.

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> Following your termination, you have registered with 'employment companies' and feel very confident in your job seeking abilities.[7] You have submitted job logs to [the Insurer] from September 2012 up to present applying for positions such as Office Coordinator, Administration Officer, Receptionist, Administrative Assistant and other administration roles. Although you were unsuccessful in obtaining employment in these roles, **these (*sic*) show that you have capacity to work as per your current certification**.[8]

On the contrary, the better view might be that it shows both (a) the cogency of the applicant's third objection listed at paragraph 7 *supra*, and (b) that the applicant is trying to comply with the return to work requirements in the legislation. She may also be required to job-seek for Centrelink purposes. As for "current certification," the Insurer had no current Work Capacity Certificate from the applicant's doctor either during the course of the assessment process or at the time when the decision was made. *Guideline* 2.3 requires that an Insurer's decision should be "timely, informed and evidence based." Had the decision been made a year or so earlier, it may well have complied with the Guideline.

13. The Insurer had no current evidence available to it which could possibly justify the assessment that the applicant had "current work capacity" since the most recent medical report was in excess of two years old, there was no current or even recent Work Capacity Certificate from an NTD and the applicant's correct actions in seeking to return to work were used as a substitute for proper evidence of work capacity.

14. It follows that the Merit Review Service (MRS) had no more recent evidence available to it than did the Insurer. Accordingly, the recommendation of the MRS is also based on ancient and slender medical evidence. Since MRS is not entitled to have regard to procedural issues, it was bound to rely upon such evidence as was available and attempt to make a recommendation based on the merits of the case.

[7] The foregoing reads like a sentence drafted by a fortune-teller. No evidence is given for how the Insurer presumes to know that the applicant is "very confident" about anything.
[8] Emphasis added.

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FINDING

15. 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

16. I recommend that the Insurer conduct a new work capacity assessment and make a new work capacity decision in accordance with the WorkCover *Guidelines*. This should be done with current medical evidence.

17. I recommend that the Insurer pay the applicant the weekly benefit to which she was entitled prior to 3 February 2014 until such time as the MRS recommendation takes effect. Those payments should continue from 14 May 2014, being the date on which they ceased.

18. 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 14 May 2014 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.

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Delegate of the WorkCover Independent Review Officer
27 June 2014

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