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 28 August 2013 is set aside.

b. The applicant is to be reinstated to his weekly payments at the rate applicable at 28 August 2013.

c. The payments are to be back-dated to 6 December 2013.

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

1. The applicant seeks procedural review of a work capacity decision made by the Insurer on 28 August 2013. The decision determined to cease weekly payments. The applicant sought internal review. The Internal Review Decision (IRD) was consistent with the original decision. The applicant sought Merit Review by the Authority. The Merit Review decision was issued on 21 May 2014. I am satisfied that the application for procedural review dated 11 June 2014 was made within time and on the correct form.

2. The applicant sustained both physical and psychological injuries in the course of a work-related journey on 1 August 2011. He continues to work for the same employer, but on reduced hours.

3. The applicant was in receipt of compensation by way of weekly payments immediately before 1 October 2012 and is therefore able to be styled as an "existing recipient of weekly payments" as that term is defined in the 1987 Act.[1] 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.

[1] See clause 1, division 1, part 19H, schedule 6 to the 1987 Act.

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Submissions by the parties

4. 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 makes two broad submissions: first, he asserts that he is a seriously injured worker and therefore could not be subject to a work capacity assessment; secondly, he alleges that the Insurer was in some way biased concerning the interpretation and gathering of medical evidence for his psychological injury.
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5. Both submissions must fail. The applicant has provided no evidence to the Insurer or the Merit Review service which would indicate that he is a seriously injured worker. He seems to be of the belief that the Insurer bears the onus of proving his case in this respect. There is nothing preventing the applicant from seeking referral to an approved medical specialist, but this step remains untaken. The same can be said of the argument about medical evidence of psychological injury.

6. The Insurer made no submissions.

The Decision

7. The decision pre-dates the versions of the Guidelines which came into effect on 11 October 2013. Therefore it does not follow the *"Best Practice Decision-Making Guide"* which is referred to in *Guideline* 5.1 of the earlier version of the Guidelines. As such, this is a breach of the *Guidelines.* This breach cannot have been avoided because the *"Best Practice Decision-Making Guide"* has never existed. It would appear that the author of the *Guidelines* failed to make a simple inquiry as to whether that document existed before completing the *Guidelines*.

8. Here it might be apposite to note the approach of the High Court in *SZFDE v Minister for Immigration and Citizenship*[2] which affirmed the view of French, J (as he then was) at first instance in the Federal Court[3]

[2] (2007) 232 CLR 189.
[3] (2006) 154 FCR 365, at 391-2.

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that a failure to apply correct procedure (even, as in that case, to the extent of failing to provide a fair hearing) does not "depend on any finding of fault on the part of the decision-maker."[4]

9. *Guideline* 5.4.2 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 a worker ceases to be entitled to weekly payments of compensation. The decision states that "*any entitlement you may have to payment of pre-approved reasonable and necessary medical and other expenses, until the 6th of December 2013, will not be affected."* This statement gives no information to the applicant about the effect of section 59A(2) on such entitlements beyond 6 December 2014 (the correct date). The effect of section 59A(2) of the 1987 Act has therefore been incorrectly explained and misrepresented.

10. In addition, 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. This was not disclosed by the Insurer. This is in clear breach of the Guidelines.

11. On the second page of the decision section 54(2)(a) of the 1987 Act is also misrepresented in a very material and prejudicial way. The applicant is told the following:

    " – your entitlement to weekly payments at your current rate ***must cease within 3 months of this decision*** – please refer to Section 43(1) and 54(2)(a) of the *Workers Compensation Act* 1987."

    The effect of section 54(2)(a) is precisely the opposite of what is said – it requires an insurer to continue making payments for a period of no less than three months from the date notice is received.

[4] See Pearson, L. – *'Fair is Foul and Foul is Fair': Migration Tribunal and a Fair Hearing* – Chapter 19 of Groves, M (Ed.) *Modern Administrative Law in Australia,* CUP, Melbourne 2014, at page 436.

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FINDING

12. As a result of the three matters raised in paragraphs 9, 10 and 11 above 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 comply with the 1987 Act. The decision must be set aside.

RECOMMENDATION

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

14. Whether or not the applicant can now be transitioned is a vexed issue. 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*". The *Workers Compensation Regulation* 2010 Clause 17 of Schedule 8 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 1 April 2014. As this can no longer be achieved it is difficult to see how the applicant can now be transitioned.

15. I recommend that the Insurer pay the applicant the weekly benefit to which she was entitled prior to 28 August 2013 until such time as he is properly transitioned. Those payments should continue from 6 December 2013 being the date on which they ceased.

16. 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 6 December 2013 to date by virtue of the operation of section 44B(2) of the 1987 Act. These

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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 July 2014