WiRO

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(C) OF THE *WORKERS COMPENSATION ACT 1987.*

1. Mr Peter Molloy is the applicant for a review of the decision made by Racing NSW Insurance Fund ("Insurer"). The Insurer is a Specialised Insurer licensed by the WorkCover Authority of New South Wales.

2. The applicant worked as jockey when he suffered injury in the course of his employment both before and after 30 June 1987. His employer at the time was the Orange Jockey Club.

3. As a result of the applicant's work-related injuries Bagnall, CCJ(A) of the former Compensation Court of NSW made an award of compensation in his favour on 31 August 2000 for lump sums under sections 66 and 67of the *Workers Compensation Act 1987* (1987 Act) in a combined total of $30,000 as well as an award under section 40 of that Act for partial incapacity in the amount of $66 per week, backdated to 28 July 1997. In addition a small award was entered under section 16 of the *Workers Compensation Act 1926* (1926 Act) in the sum of $1,205 for 5% loss of the full efficient use of the left arm or the greater part thereof. The precise wording of the weekly benefits order was as follows:

   > "That the respondent pay the applicant on the basis of partial incapacity, weekly compensation at the rate of $66 per week from 28 July 1997, such weekly payment to continue in accordance with the provisions of the Act."

   The Insurer continued to make payments of $66 per week under the award, which was never reviewed by either the Compensation Court of NSW or the Workers Compensation Commission.

4. The Insurer purported to issue a notice of a work capacity decision pursuant to Section 43 of the 1987 Act on 24 April 2013. The applicant was advised that his weekly benefits would be reduced to "nil" and that the decision would come into effect 3 months and 5 days after the date of the letter, in compliance with section 54 of the 1987 Act and the postal service rule (see section 76(1)(b) of the *Interpretation Act 1987).* The notice did not say precisely when a work capacity assessment had

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occurred. The only hint as to timing might be found in the following two sentences:

> "At the time of our assessment, and our letter dated 9 April 2013, you were invited to provide any further evidence which might cause us to review our initial assessment. No such evidence was provided within the two week fair notice period given."

Whether this is an admission that the *assessment* was actually made on 9 April 2013 is not known.

5. On 7 June 2013 the Insurer wrote to the applicant advising of the outcome of an internal review of the decision dated 24 April 2013. The internal review upheld the original decision.

6. A WorkCover Merit Review was completed and a Statement of Reasons issued on 30 July 2013. The Reviewer upheld the determination of the Insurer.

7. On 7 August 2013 the applicant requested the Independent Review Officer to undertake a review of the decision of the Insurer pursuant to Section 44(c) of the *1987 Act*. I am satisfied that the applicant has made that application within the time provided by that section.

Applicant's Grounds for seeking Procedural Review

8. The applicant made lengthy submissions, which might fairly be summarised in five points:

   a. No expert evidence to address the issue of "seriously injured worker" with 30% WPI. A work capacity assessment cannot be made of such a worker unless requested by the worker.

   b. No evidence the insurer sought from the worker a "self-report of his abilities." (See *WorkCover Work Capacity Guidelines* especially 4.)

   c. No evidence that the insurer made its decision "in a manner consistent with the findings of Acting Judge Bagnall. The Orange

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Jockey Club and its insurer on its behalf are estopped from determining any matter in a way that is inconsistent with these findings."

d. The Insurer had no jurisdiction to terminate an award of the former Compensation Court of NSW, since jurisdiction for terminating awards was transferred to the Workers Compensation Commission in 2002 by operation of section 105 of the *Workplace Injury Management and Workers Compensation Act 1998*.

e. No evidence of when the insurer purportedly made a work capacity assessment and *therefore* no evidence that three months had elapsed from that date until the date of the work capacity decision. Three months must have elapsed between the two dates, by virtue of the operation of Schedule 6 Part 19H Clauses 6 and 9 of the 1987 Act.

The Legislative Framework

9. The legislative framework which governs the entitlement to and the transition from the previous benefits is complex and must be difficult for an injured worker without legal assistance to navigate through and to understand its impact. Set out shortly, there may be thought to be no less than four steps involved, all of them mandatory.

i. An insurer may make a work capacity assessment at any time (see section 44A(1)). Section 44A(3) also provides that an assessment is not necessary for the making of a work capacity decision.

ii. Section 43 provides that a work capacity decision may be made by an insurer and is binding on the parties, subject to review only under section 44 or by judicial review in the Supreme Court of NSW. Under *WorkCover Work Capacity Guidelines* published on 28 September 2012 (the version relevant for the purposes of Mr Molloy's claim), *Guideline 5* states in part:

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> "A work capacity decision is a discrete decision that may be made at any point in time and can be about any one of the factors described in section 43(1), such as the worker's capacity to earn in suitable employment. This is different to a work capacity assessment which is a review process that may or may not lead to the making of a work capacity decision or another type of decision regarding a claim."

iii. In *Guideline 5.2* a "fair notice provision" sets out the information which must be communicated to a worker "at least two weeks prior to" the work capacity decision.[1] So far the Insurer would have had to make an *assessment*, or be in the process of making an *assessment*, and prior to the finalisation of that *assessment* and the subsequent making of a *decision*, "at least two weeks" notice must be given to the worker of the following matters:

- inform the worker that a review of their current work capacity is being undertaken and that a work capacity decision is going to be made;
- an explanation that this review may include further discussions with other parties such as their employer, nominated treating doctor or other treatment providers;
- advise the potential outcome of this review and detail the information that has led the insurer to their current position;
- provide an opportunity for the worker to supply any further information to the insurer for further consideration and the date that this information is to be provided by; and
- tell the worker wheh this decision is expected to be made.

This pentalogue of bullet points is prefaced with the following words (emphasis added):

> "...the insurer must ... communicate this to the worker in a way that is appropriate in the circumstances of the case, and *preferably by telephone* or in person."

[1] This of course means that a decision cannot be made "at any point in time," (*contra Guideline 5)* since it cannot be made until the fair notice period has elapsed.

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In a workers compensation system where the overwhelming majority of claimants are manual workers with limited education, and a high percentage do not have English as a first language, it is surprising that it would be thought appropriate to try to communicate important and complex information concerning a workers livelihood over the telephone rather than in writing. Further, in the process of determining whether or not a worker has been afforded procedural fairness, it is impossible for a reviewer to know the adequacy or even the accuracy of any information communicated verbally to a worker by an insurer over the telephone.

iv. In the event of a decision resulting in a variation of the weekly benefits payable to a worker, section 54 requires that the worker be given at least 3 months notice of that proposed variation, which must be notice delivered either in person or by post. I should emphasize here that there is no statutory requirement for a "notice" to be given to a worker of a *decision* under section 43. The notice requirement in section 54 arises from a proposed variation in payments and therefore the issue of "notice" may not arise in circumstances where no variation in payments results from a work capacity decision.

10. I note that in both the first edition of the *WorkCover Work Capacity Guidelines* published on 28 September 2012 and those more recently published on 8 August 2013, reference is made to the *Best Practice Decision-Making Guide. Guideline 5* concludes with this sentence:

"Work capacity decisions should be made in line with the *Best Practice Decision-Making Guide.*"

Guideline 5.1 says in part:

"When making a work capacity decision the insurer should follow the *Best Practice Decision-Making Guide* .. "

and then goes on to list certain characteristics of what is apparently thought to be "best practice." I advisedly used the word "apparently" in the previous sentence, since it is impossible to check whether or not the items listed in *Guideline 5.1* are "best practice" due to there being in

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existence no such document as the *Best Practice Decision-Making Guide.*

The *Guidelines* are made pursuant to section 376(1) of the 1998 Act and section 44A of the 1987 Act. They purport to give guidance and instruction to insurers as to how to conduct work capacity reviews and how to make work capacity decisions. In paragraph 2.3 they say this:

> "All decisions made in relation to a worker's recovery and work capacity should be timely, informed and evidence based. Decisions should be made and communicated in a transparent and robust manner free from preference and prejudice ensuring that effective outcomes are achieved and due process is followed. Decisions should be made in line with the *Best Practice Decision-Making Guide.*"

Due to the non-existence of the *Best Practice Decision-Making Guide*, I am unable to confirm that the insurer has complied with the relevant *Guidelines* when making its decision. My enquiry is therefore limited to an examination of the compliance with the rules of natural justice, procedural fairness, and the timeframes which appear to be set out in relevant sections of the legislation.

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Process of the Insurer

11. The decision reached by the Insurer appears to be appropriate in the circumstances of the case. As far as the process undertaken by the Insurer in reaching the work capacity decision is concerned, I am satisfied that there was no breach of procedural fairness and that the rules of natural justice were fully complied with. The Insurer had regard to (i) a statutory declaration and tax returns produced by the applicant himself; and (ii) medical reports and certificates from Dr Howe, including the notations that (a) the applicant could work with no restrictions, other than to work as a jockey, and (b) that the applicant was fit to work full time in suitable employment.

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12 The last certificate from Dr Howe was dated 27 March 2013. It might therefore be reasonable to conclude that the work capacity assessment was not completed before that date.

My Reasons:

13. The grounds upon which the applicant seeks to rely can be dealt with using the numbering by letter (a-e) appearing in paragraph 8 above:

(a) The term *seriously injured worker* is defined in clear terms in section 32A:

> **"seriously injured worker"** means a worker whose injury has resulted in permanent impairment and:
>
> (a) the degree of permanent impairment has been assessed for the purposes of Division 4 to be more than 30%, or
>
> (b) the degree of permanent impairment has not been assessed because an approved medical specialist has declined to make an assessment until satisfied that the impairment is permanent and the degree of permanent impairment is fully ascertainable, or
>
> (c) the insurer is satisfied that the degree of permanent impairment is likely to be more than 30%.

It is interesting to note that the term *permanent impairment* is used, rather than *whole person impairment*. Prior to 1 January 2002 there was no such concept as *whole person impairment* and there was a clear distinction between those body parts which could sustain *permanent impairment* (back, neck and pelvis) and those which could suffer *permanent loss of efficient use* (limbs, senses) or *scarring and disfigurement* (face, torso).

In section 4 of the 1998 Act the following definition appears:

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"permanent impairment compensation" means compensation for permanent impairment under section 66 of the 1987 Act.

For the sake of completeness, the relevant parts of section 66 are the following terms:

66 Entitlement to compensation for permanent impairment

(1) A worker who receives an injury that results in a degree of permanent impairment greater than 10% is entitled to receive from the worker's employer compensation for that permanent impairment as provided by this section. Permanent impairment compensation is in addition to any other compensation under this Act.

Note: No permanent impairment compensation is payable for a degree of permanent impairment of 10% or less.

(1A) Only one claim can be made under this Act for permanent impairment compensation in respect of the permanent impairment that results from an injury.

....

(3) The amount of permanent impairment compensation is to be calculated under this section as it was in force at the date the injury was received.

It is therefore the case that there is no legislative requirement for a worker to be assessed as having more than 30% ***whole person impairment*** in order to be assessed as a seriously injured worker. This would be impossible in any event for a worker injured prior to 1 January 2002, in light of section 66(3).

In August 2000 the Compensation Court of NSW certified that at the time the applicant suffered from 5% loss of the *full efficient use* of the left arm or the greater part thereof due to

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injuries sustained before 4 pm on 30 June 1987 in addition to a further 10% loss of *efficient use of* the same arm, at/above the elbow and 10% *permanent brain damage* as a result of injuries sustained after 4 pm on 30 June 1987. The applicant has therefore never been certified as suffering from any degree of *permanent impairment* (to use the precise wording of section 32A). It is nonetheless true that he has received lump sum compensation payable under section 66 (as well as section 16 of the 1926 Act).

In my view the applicant would be eligible to be assessed as a *seriously injured worker* if the aggregate of his section 66 assessments exceeded 30% because he was injured prior to 1 January 2002.

The seeming neologism “permanent impairment” may be seen as a portmanteau word, including within it all the modes of assessment of lump sum compensation payable to workers under the various iterations of section 66 of the 1987 Act. It might therefore include the terms “permanent scarring,” “permanent disfigurement,” “permanent loss of efficient use of,” and “whole person impairment.”

In the instant case, the applicant certainly does not comply with s 32A(a) or (b) and it is clear that the insurer does not regard him as suffering more than 30% “permanent impairment”, which therefore also means he does not qualify under s 32A(c).[2]

(b) The Insurer is under an obligation to make a decision in accordance with the legislation and the relevant Guidelines produced from time to time by the Authority. In *WorkCover Work Capacity Guidelines* (see *Gazette* No 101, 28 September 2012) Guideline 4 states in part that a work capacity assessment

[2] Even if the worker had been subject to assessment under the tables in *AMA5* and even if after such assessment the same figures were obtained (i.e. 10%, 10% and 5%) then by virtue of the Combined Values Chart the highest score possible for the applicant would be 24% WPI. No evidence has been produced by the applicant that he has anything like 30% WPI.

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> "considers all available information which may include but is not limited to:
>
> ....
>
> - the worker's self report of their abilities and any other information from the worker
>
> ...."

The applicant argues that this requires an insurer to obtain a report from the worker assessing his own work capacity, since this would comply completely with the clause "considers all available information."

There are at least three reasons for rejecting this submission:

- First, the applicant had in fact provided a statutory declaration and supporting documents to the Insurer prior to the assessment being made.
- Secondly, the insurer wrote to the applicant on 9 April 2013 seeking any further information the applicant sought to reply upon. There was no reply.
- Thirdly, the *Guideline* only requires the consideration of all *available* information. On the applicant's own submission there was no self-report available to the insurer.

(c) There is no evidence produced by the applicant to suggest that the work capacity decision is in any way inconsistent with the findings of the Compensation Court of NSW constituted by Bagnall, CCJ(A). The decision says nothing about the issues of worker, causation, injury, lump sum assessment or liability generally. It does say that as at 24 April 2013 the worker had a capacity to work as a result of which his weekly compensation payments should be reduced to 'nil' from a date in the future. There was no finding by Bagnall, CCJ(A) that the partial incapacity for work was permanent either in extent or duration.

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As the applicant himself asserts, there was a mechanism for terminating awards, for precisely this reason. That mechanism has now changed. This leads in to the next ground of review.

(d) Section 105 of the *Workplace Injury Management and Workers Compensation Act* 1998 (1998 Act) has sometimes been seen as the source of jurisdiction of the Workers Compensation Commission (WCC), which came to replace the former Compensation Court of NSW in 2003. In my view this is erroneous. While it is clear that section 105 allocates jurisdiction between the former Court, the WCC and the District Court, the WCC itself is established and has such jurisdiction as it set out in section 366 of the 1998 Act. The section is in the following terms:

> 366 Establishment of Commission
>
> (1) The Workers Compensation Commission of New South Wales is established by this Act.
>
> (2) The Commission has and may exercise such functions as are conferred or imposed on it by or under the Workers Compensation Acts or any other Act.

It is clear that the WCC does not have any inherent or reserve jurisdiction. All powers exercised by the WCC are conferred by statute (see s 366(2)). Section 105 was discussed by the Court of Appeal in the fairly recent decision of *Speirs v Industrial Relations Commission of New South Wales & Anor* [2011] NSWCA 206 where Giles, JA (with whom Allsop, P [as he then was] and Hodgson, JA agreed) said:

> 34 In general terms s 105 distributes jurisdiction between the Workers Compensation Commission and the District Court, excluding jurisdiction in respect of common law remedies. The District Court's share is coal miner matters. Claims by coal miners have long been treated separately in some respects from claims by other workers. In s 4 of the WIM Act "coal miner

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> matter" is defined as any matter arising under the WC Act and WIM Act "concerning a claim in respect of a worker employed in or about a mine". "Claim" is defined as "a claim for compensation or work injury damages that a person has made or is entitled to make".
>
> ....
>
> 39 When the WIM Act was enacted in 1998, s 105 gave exclusive jurisdiction to the Compensation Court "to examine, hear and determine all matters arising under this Act (except Part 5 of the 1987 Act)". In 2001 there was a bifurcation between new claims and existing claims. The (now) Workers Compensation Commission was established with exclusive jurisdiction to determine "any new claim". The Compensation Court initially retained its jurisdiction to determine "any existing claim", but then was reduced effectively to a residual jurisdiction in relation to claims by coal miners. The later versions of s 105, in two iterations, distributed jurisdiction in similar manner to the present s 105, but in the second iteration "matters" came to be made the descriptor, as in the present s 105, in place of "claim".
>
> 40 The Compensation Court was abolished with effect from 1 January 2004. Provision was made for transfer of pending proceedings in the Compensation Court to the Workers Compensation Commission or the District Court. This brought s 105(4A) into s 105. Perhaps clumsily, the existing reference to the Compensation Court's jurisdiction in s 105(4) was retained, but s 105(4A) operated to give the jurisdiction in coal miner matters to the District Court.

The Court of Appeal was considering a decision by the Full Bench of the Industrial Relations Commission which had found that the WCC had exclusive jurisdiction to deal with the issue

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of "worker" even for the purposes of the *Industrial Relations Act* 1996.

Referring to this case in a later decision, Arbitrator Paul Sweeney of the WCC observed that the Court of Appeal had regard to the intention of the legislature, which anticipated that the majority of workers compensation claims would be resolved without litigation:

> In quashing the decision of the Full Bench of the Industrial Relations Commission, Giles JA, with whom Allsop P and Hodgson JA agreed, pointed out that the great bulk of claims for work injuries were not to be the subject of proceedings in the Commission or in the District Court. The workers compensation legislation recognised and encouraged the payment of claims by employers without the recourse to litigation. The reasoning of the Full Bench would require each injured worker who applied for a reinstatement to commence proceedings in the District Court or the Commission, in order to obtain an award, as a necessary pre-requisite to proceedings in the Industrial Relations Commission. That can hardly have been the intention of the legislature in an Act that promotes early return to work without recourse to litigation (see *Clipper Parcels Proprietary Ltd v Workers Compensation Nominal Insurer by its Scheme Agent Gallagher Bassett Services Pty Ltd and Ors* [2012] NSWWCC 133 (paragraph 29)).

In my view it follows that there are decisions which may be made by parties and entities other than the WCC under the legislation and that the provisions dealing with the WCC are principally concerned with the conduct of litigation.

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Upon the abolition of the Compensation Court of NSW section 105 operated to transfer the jurisdiction of that Court to deal with weekly benefits and the termination of court awards to the WCC. But the WCC only has such jurisdiction as it is granted under legislation. The amendments to section 43 appear to take away from the WCC any primary jurisdiction over weekly benefits, since the wording is unequivocal:

> **43 Work capacity decisions by insurers**
>
> (1) The following decisions of an insurer (referred to in this Division as work capacity decisions) are final and binding on the parties and not subject to appeal or review except review under section 44 or judicial review by the Supreme Court:
>
> (a) a decision about a worker's current work capacity,
>
> (b) a decision about what constitutes suitable employment for a worker,
>
> (c) a decision about the amount an injured worker is able to earn in suitable employment,
>
> (d) a decision about the amount of an injured worker's pre-injury average weekly earnings or current weekly earnings,
>
> (e) a decision about whether a worker is, as a result of injury, unable without substantial risk of further injury to engage in employment of a certain kind because of the nature of that employment,
>
> (f) any other decision of an insurer that affects a worker's entitlement to weekly payments of compensation, including a decision to suspend, discontinue or reduce the amount of the weekly payments of compensation payable to a worker on the basis of any decision referred to in paragraphs (a)-(e).

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> (2) The following decisions are not work capacity decisions:
>
> (a) a decision to dispute liability for weekly payments of compensation,
>
> (b) a decision that can be the subject of a medical dispute under Part 7 of Chapter 7 of the 1998 Act.
>
> (3) The Commission does not have jurisdiction to determine any dispute about a work capacity decision of an insurer and is not to make a decision in respect of a dispute before the Commission that is inconsistent with a work capacity decision of an insurer.

Section 43(1) states that no review is possible “except review under section 44 or judicial review by the Supreme Court.” If the WCC had primary jurisdiction over weekly benefits then it would clearly be able to review work capacity decisions. It follows that this part of the jurisdiction of the WCC has been abolished. Only an insurer can make a work capacity decision.

Section 44(5) prevents the WC determining a weekly benefits dispute while a section 44 review is being undertaken.

> (5) The Commission is not to make a decision in proceedings concerning a dispute about weekly payments of compensation payable to a worker while a work capacity decision by an insurer about those weekly payments is the subject of a review under this section.

Schedule 6, Part 19H Division 2 clause 14 extends section 44(3) and 44(5) to matters “pending in the Commission” when a work capacity decision is made.

> **14 Jurisdiction of Commission**
>
> Sections 43 (3) and 44 (5) as inserted by the 2012 amending Act extend to proceedings

> pending in the Commission when a relevant work capacity decision is made.

As though to emphasize the point, a notation now appears in section 105 between sub-sections (1) and (2) in the following words:

> **Note:** The Commission does not have jurisdiction to determine any dispute about a work capacity decision of an insurer and is not to make a decision in respect of a dispute before the Commission that is inconsistent with a work capacity decision of an insurer. See section 43 of the 1987 Act.

I can identify no basis on which the WCC can be thought to have jurisdiction to deal with a dispute concerning the weekly benefits payable to a worker who is in the process of being transitioned into the new version of the weekly regime.

If it were the case that an award of the Court could never be terminated by an insurer, then it would also be the case that no worker could ever be terminated from an award of the former Court, since the WCC loses jurisdiction once a work capacity decision is made. An insurer could make a work capacity decision concerning a worker currently in receipt of payments pursuant to a Court award, but the worker would have no recourse to the WCC, since a work capacity decision extinguishes any jurisdiction in the WCC concerning weekly benefits.

The better view is that the insurer in making a work capacity decision immediately extinguishes any jurisdiction over that worker's weekly benefits formerly held by the WCC. This must also mean that *a fortiori* court awards are similarly extinguished.

Alternatively if an insurer making a decision or a body reviewing the decision of an insurer were bound by an existing Court award or WCC award, it is likely that any decision made based on such a consideration would be *ultra vires* on the basis of dictation.

(e) The final ground of review is not so easy to dismiss. It is possible that there is some force in the applicant's submission that the Act requires the effluxion of no less than 3 months between the capacity assessment undertaken by an Insurer

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and a work capacity decision being made. Schedule 6 Part 19H Division 2 says in part:

> **Division 2 - Weekly payments**
>
> **6 Application of weekly payments amendments to existing claimants**
>
> An existing recipient of weekly payments remains entitled to compensation under Division 2 of Part 3 of the 1987 Act as if the weekly payments amendments had not been made, but only until the weekly payments amendments apply to the compensation payable to the person as provided by this Division
>
> **9 Weekly payments amendments to apply after work capacity assessment**
>
> (1) On the expiration of a period of 3 months after an insurer first conducts a work capacity assessment of an existing recipient of weekly payments (as required under this Division or otherwise), the weekly payments amendments apply to the compensation payable under Division 2 of Part 3 of the 1987 Act to the worker in respect of any period of incapacity after the expiration of that period.

I note that in this matter the insurer wrote to the applicant seeking any further submissions or evidence on 9 April 2013. I further note that the latest report in the insurer's possession from Dr Howe was dated 27 March 2013. On that basis, on the fair assumption that this report formed part of the evidence on which an assessment was based, I find that it is not possible to accept that 3 months had elapsed between the dates of the the assessment and the decision. Accordingly it may be possible to argue that the amendments did not apply to the applicant as at 24 April 2013 and that therefore the Notice purportedly given under section 43 on that date was void *ab initio*. No other conclusion would be possible if the applicant's interpretation of

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the concluding words of Schedule 6, Part 19H Division 2 clause 9(1) were accepted.

Despite this, it is my view that the amendments do apply to the applicant in the sense that they come into effect no earlier than 3 months following an assessment of work capacity. It naturally follows that a decision cannot be made prior to an assessment[3], but the specific wording in clause 9(1) is not as unequivocal as the applicant asserts. Noting that the clause refers to a 3 month period, the relevant words at the end of the clause are capable of the following emphasis:

> " ... the weekly payments amendments ***apply to the compensation payable*** under Division2 of Part 3 of the 1987 Act to the worker ***in respect of any period of incapacity after the expiration of that period.***"

I take this to mean that at the expiration of 3 months from the date on which a work capacity assessment was first conducted, the compensation payable to the worker can be subject to the amendments. This interpretation actually shortens the time required to give effect to a decision, since (subject to the requirements of section 54) the amendments apply 3 months from the date of assessment, not the (possibly later) date of decision. While it is clearly unsatisfactory to have a situation in which a worker 's rights are subject to change on a date triggered by an assessment rather than a decision, the existence of section 54 and the notice requirements therein do provide a mechanism to ensure that the rights of injured workers are not curtailed without adequate notice being given.

14. In considering the facts and circumstances of this application I have had regard to the provisions of section 44(3)(a) of the 1987 Act which provides a timeframe of 30 days for the worker to seek a review by the merit reviewer of the decision, however the timeframe only commences

[3] But cf s 44A(3): "A work capacity assessment is not necessary for the making of a work capacity decision by an insurer."

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from the receipt by the worker of the insurer's decision on internal review which must be contained in *the form approved by the authority.*

As at the date of this decision there was no such form approved by the Authority and therefore the worker has yet to receive the proper notice of the decision of the internal reviewer and it appears that time has not started to run for him to seek a merit review.

A question of some nicety arises as to whether in that circumstance there was any jurisdiction for the WorkCover Authority to conduct a merit review and therefore whether there was any jurisdiction for me to consider a procedural review.

Given that my role is to make recommendations concerning outcomes in particular matters, this general issue may not arise, but it remains a matter of concern in relation to all applications to the Authority for merit review.

15. Of perhaps greater concern in the present matter, no date is known for the work capacity *assessment* conducted by the Insurer. As quoted in paragraph 13(e) *supra* Schedule 6, Part 19H Division 2 clause 9 of the 1987 Act clearly states the following:

> *On the expiration of a period of 3 months after an insurer first conducts a work capacity assessment* of an existing recipient of weekly payments (as required under this Division or otherwise), the weekly payments amendments apply to the compensation payable under Division 2 of Part 3 of the 1987 Act to the worker in respect of any period of incapacity after the expiration of that period. (Emphasis added.)

Apart from inferential detective work based on the dates of letters and medical reports, it is not possible for me to determine the precise date on which any assessment is said to have been undertaken or completed by the insurer. For that reason, in my view the worker has been denied procedural fairness, since he is unable to determine the precise date upon which the amendments to the legislation begin to apply to his weekly benefits.

16. This recommendation might seem harsh to the Insurer, but I am fortified in this recommendation by the consideration that we are dealing with beneficial legislation, which should always be interpreted in such a way

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as to give the worker the benefit of any doubt about interpretation. I note there was no amendment made to section 9 of the 1987 Act in 2012, and so the following words still remain the law in NSW:

> **9 Liability of employers for injuries received by workers-general**
>
> (cf former s 7 (1) (a))
>
> (1) A worker who has received an injury (and, in the case of the death of the worker, his or her dependants) shall receive compensation from the worker's employer in accordance with this Act.
>
> (2) Compensation is payable whether the injury was received by the worker at or away from the worker's place of employment.

On that basis the legislation remains beneficial in nature despite the 2012 amendments and workers are entitled to the reading most favourable to their continuing to receive compensation.

My Recommendation:

17. I recommend that the Insurer undertake a further Work Capacity Assessment.

18. I recommend that the applicant be given an opportunity to make further submissions prior to any further decision being made and issued.

19. In the issuing of the next decision I recommend that the Insurer advise the applicant of the date of the new work capacity *assessment*, for the purposes of Schedule 6, Part 19H Division 2 clause 9 of the 1987 Act.

20. Since the applicant was an existing recipient as at 1 October 2012, he remains entitled to receive his pre-transition rate of weekly benefits until such time as he is validly transitioned under the Act. This cannot happen until a valid notice under section 54 is issued. Accordingly he remains

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entitled to $66 per week pursuant to the award of Bagnall, CCJ(A) until such time as he is validly transitioned and a section 54 notice issues.

21. I recommend that the insurer take my views into account, and I recommend that the insurer immediately give effect to them.

Wayne Cooper
Delegate of the WorkCover Independent Review Officer
20 August 2013