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*.***

1. The injured worker (IW) is the applicant for a review of the decision made by the Workers Compensation Insurer.

2. The applicant was injured in the course of his employment on or about 17 June 2003. The nature of the injury is described as "major depression, anxiety disorder and post-traumatic stress disorder." There is no dispute about the injury having occurred in the course of employment.

3. The applicant no longer works for the original employer, having had a series of jobs for various employers since the injury, although he has been with his current employer for several years. The insurer has continued to make weekly payments of compensation since 2003.

3. On 12 March 2013 the Insurer completed an assessment of the work capacity of the applicant and purported to issue a notice of a work capacity decision pursuant to Section 43 of the *Workers Compensation Act* 1987 ("1987 Act").

4. The Insurer also purported to give the applicant notice pursuant to Section 54 of the 1987 Act of the reduction of his weekly payments to "nil." This information was contained within a letter to the applicant dated 12 March 2013, which letter also purported to be a notice of a decision pursuant to Section 43 of the 1987 Act.

5. On 8 May 2013 the Insurer wrote to the applicant advising of the outcome of an internal review of the decision dated 12 March 2013. The internal review upheld the original decision.

6. A WorkCover Merit Review was completed and a Statement of Reasons issued on 28 June 2013, received by the applicant on 3 July 2013. The Reviewer upheld the determination of the Insurer.

7. On 30 July 2013, the applicant requested the Independent Review Officer to undertake a review of the decision of the Insurer pursuant to Section 44(1)(c) of the 1987 Act. I am satisfied that the applicant has

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made that application within the 30 day time-limit imposed by the *WorkCover Work Capacity Guidelines*[1] and on the relevant form.

**Applicant's Stated Grounds of Review**

8. The applicant takes issue with both the decisions of insurer and the WorkCover Merit reviewer. My role is only to review the decision of the insurer, however the grounds as set out by the applicant intertwine the two to some extent, and it is no less inconvenient to deal with them together than it would be to deal with one in the absence of the other.

(a) A reference appears in the Merit Reviewer's decision to the name of an employer of whom the applicant has never heard. The Merit Reviewer is said to have been given this name by the insurer. The applicant says of this: "Seeking clarification from WorkCover Merit Review to identify 'P' responded their information came from the Insurer. Upon written request to the Insurer, Internal Review, asking explanation as yet, no response to date." The applicant denies ever being employed by any such entity, asserting that the correct employer would have been D D Pty Ltd.

(b) The applicant disputes the medical evidence provided by the doctor retained by the Insurer, saying that the report of that doctor should be disregarded since it is in conflict with the reports of the applicant's own doctor. The insurer's doctor did not examine or speak with the applicant at any time; however he did have a telephone conversation with the applicant's treating doctor and read various reports from that doctor.

(c) The applicant thinks that his fortnightly psychotherapy treatment should continue, as should the payment of all future medical expenses.

(d) The applicant asserts that his payslips do not accurately reflect his current work capacity, since he takes time off, using his holidays, rather than claiming compensation for all such periods off work. It therefore seems as though he is capable of working 38 hours per week on a perusal of the payslips, whereas in reality this is not the case. The precise way this is put by the applicant (or rather on his behalf by his advocate) is as follows: "IW has for years taken his sick leave from his

[1] There is no statutory basis for guideline 6.4 which appears in the 28 September 2012 iteration of the *WorkCover Work Capacity Guidelines,* later reproduced as guideline 7.4 in the 9 August 2013 version of the same document.

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annual leave entitlements and worked incremental hours to make up for time lost for his numerous absences from the workplace due to exacerbations of his condition. Had he called on all of his entitlements, the formula worked out by the insurer, would show that Iain given the above, would earn less than the $938.30 as he would have exhausted his sick leave."

(e) The applicant disputes that he is in "suitable employment" and has been since December 2005. The advocate puts it this way: "IW has not been in suitable employment. Medical reports obtained by Insurer state that IW held responsible senior management positions previously. He is in a blue-collar shift-working job, without autonomy, and for which he has still not adjusted, but feels hopeless to change his circumstances due to his depression. How this can be seen as 'suitable' employment is a false statement. He has limited earning capacity, has had huge lifestyle adjustments due to this factor, and it is challenging for him to hold down this job at times. "H" is a job, not a career path, and part of IW's inability to reach optimum improvement is because he is unsuited to his job and has to work at a level below his capacity due to his prognosis. Furthermore it is a matter of opinion whether one's perception is that Iain has progressed in the company from bus driving to that of a supervisor. Iain's stopped bus driving due to the responsibility, he could no longer perform his duties due to lack of concentration and to a position available within the company with less responsibility and less hourly pay. This is not progressing in the company. A false statement."

(f) The applicant sums up the grounds on which he seeks to rely thus: "Given the inaccuracy of identification of the company, the inaccuracy of Dr P's report, lack of acknowledgement of the true facts in this case, based on inaccurate information i.e. payslips – we believe warrants further scrutiny."

**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. There are no less than four steps in the transition process, all of them mandatory. There is also a clause in the *Workers*

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*Compensation Regulation* 2010[2] which purports to amend the Act[3] in a way which is both confusing and most probably invalid.

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. A work capacity decision may be made at any time according to *Guideline 5* and a work capacity decision is any decision as described within section 43 of the 1987 Act.

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 the applicant's claim), *Guideline 5* states in part:

> "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.[4] 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:

[2] See schedule 8, clause 22(1) of the Regulation.
[3] See sched 6, Pt 19H Div 1 clause 9 of the 1987 Act.
[4] 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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- 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."

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

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therefore the issue of "notice" may not arise in circumstances where no variation in payments results from a work capacity decision.

10. The Regulation at schedule 8, clause 22(1) seeks to modify the 1987 Act in a very peculiar way. The wording of schedule 8, clause 22(1) of the Regulation is worded thus (with emphasis added):

> **22 Application of weekly payments amendments to existing recipients of weekly payments**
>
> (1) On the expiration of a period of 3 months ***after an insurer makes a work capacity decision arising from the first work capacity assessment*** (as required by Division 2 of Part 19H of Schedule 6 to the 1987 Act) of an existing recipient of weekly payments, 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.
>
> **Note:** Clause 9 (1) of Part 19H of Schedule 6 to the 1987 Act provides that the weekly payments amendments apply to an existing recipient of weekly payments 3 months after an insurer first conducts a work capacity assessment of the worker. Subclause (1) provides instead for the amendments to apply to such a worker 3 months ***after the insurer makes a work capacity decision in respect of the worker***.

This is peculiar on two grounds. First, the highlighted words in clause 22(1) are not identical to the highlighted words in the Note to the clause. Secondly, what clause 22(1) refers to is only that class of decisions made "**arising from the first work capacity assessment**." As noted at paragraph 9 (i) and (ii) *supra*, a work capacity decision may be made *at any time* and under section 44A(3) an assessment is not necessary for the making of a work capacity decision. It can only be thought that those who drafted the Regulation were of the view that this would provide clarity or even certainty for workers and insurers. But as a result of the proposed amendment it is still necessary for the worker to be subject of an assessment, something which is not required by the Act in section 44A(3). It will also be necessary for the insurer to advise the worker of of the date of the assessment which preceded the decision in order for

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the worker to be able to be satisfied that this decision was in fact "arising from the first work capacity assessment."[5]

11. 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 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*."

[5] Since this clause in the Regulation is clearly inconsistent with Schedule 6, Pt 19H Div 2 cl 9 of the 1987 Act, the only thing which might save it is a valid "Henry VIII" clause. It is possible that Schedule 6 Pt 19H Div 1 cl 5(4) is such a clause. The High Court is yet to determine this question in the case of *Goudappel v ADCO Constructions Pty Ltd*, which remains subject to a pending application for special leave to appeal.

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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 together with such *Guidelines* as are published, accessible, within power and comprehensible in the absence of the *Best Practice Decision-Making Guide*.

**Process of the Insurer**

12. The decision reached by the Insurer appears to be appropriate in the circumstances of the case. The decision maker had regard to medical evidence including certificates from Dr H and Dr K, in addition to submissions made on behalf of the applicant, and payslips provided by the applicant. The insurer had access to payslips going back as far as 2009 in assessing the applicant's post-injury earnings. The Insurer also had a report from a Dr P who did not examine the applicant, but who had access to medical certificates and reports and spoke with the applicant's treating doctor. 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. This was rendered more difficult than usual in the present case, because the applicant had a certificate from his treating doctor (Dr H, consultant psychiatrist) stating that it would be injurious to his mental health if he had to communicate directly in person with the Insurer. It is also the very likely cause of the applicant not being examined by Dr P. Further, at the insistence of the applicant's wife, who assumed the role of his advocate, the Insurer was told to have no contact with the applicant's current employer.

**My Reasons:**

13. The lengthy reasons given by the applicant for seeking procedural review (as set out in paragraph 8(a)-(f) *supra*) are in almost every instance issues going to the merits of the decision reached. To the extent that they canvas the merits of the insurer's decision, I can have no regard to

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them. Similarly I can have no regard to the process of merit review. The grounds can be dealt with under the lettering used in paragraph 8:

(a) The Insurer seems to have wrongly named a former employer (D D Pty Ltd) as P in submissions to the Merit Reviewer. Little seems to turn on this error and the applicant, apart from complaining that it took place, does not explain in what way it prejudices his claim.

(b) The issue of the relative merits of medical reports is not a matter for procedural review.

(c) The continuation or cessation of the applicant's medical treatment is a question of law which will follow automatically from any work capacity decision ceasing his payments. Accordingly, there is no "decision" involved in this question.

(d) The assertion that the applicant has not "called on all of his entitlements" and that therefore his payslips are inaccurate raises the unanswered question of why it is that he has not "called on all his entitlements." Clearly the current employer has regard for the applicant's illness/injury, since he allows the applicant considerable leeway to perform his duties at unusual times. Both this and the next ground raise a further issue in this matter about representation.

(e) The relative position of the applicant within his employer company is a matter which might have been more easily addressed by the Insurer had the applicant's advocate not prevented the Insurer from contacting the employer directly. This "no direct contact" directive would also have not assisted the Insurer in ascertaining the accuracy or otherwise of the payslips referred to in ground (d). While it is certainly the case that Dr H has said that it is potentially injurious to the mental health of the applicant to have direct contact with the Insurer, it is hard to see a credible reason for preventing contact between the Insurer and current employer. There is no basis of which I know which allows a worker or his/her representative to dictate to an Insurer the way in which an assessment may be undertaken or at which a decision may be arrived. If it transpires that as a result certain information cannot be confirmed by the Insurer it is scarcely a failing of the Insurer's procedures which has produced the error.

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(f) In any event I find that all of the grounds (a)-(g) go to the merits of the work capacity decision and are of no relevance on procedural review.

13. The Insurer wrote to the applicant's advocate wife on 12 March 2013 and said, *inter alia*, this:

"On 19/02/2013 I contacted you to advise our intention to make a decision about your husband's work capacity in 14 days and invited you to provide me with additional information you believe I should consider when making this decision."

The Insurer did the right thing in this respect[6] and the applicant did provide further information and documents. The letter goes on to set out the medical and other evidence relied upon when coming to the work capacity decision. The Insurer also set out the relevant legislative provisions and explained the basis on which the transition process resulted in the application of the transitional rate, since the applicant was an existing recipient of weekly payments as at 1 October 2012. The insurer also quoted from some of the documents relied upon to show their reasoning process in coming to the conclusion that the applicant's entitlements should be reduced to "nil."

14. To the extent outlined in paragraph 13, the Insurer has complied with the relevant legislation and the regulation and the *Guidelines*; but there are some respects in which compliance with the legislation, regulation and *Guidelines* was not as rigid as it might have been.

(i) While the worker was told that the decision was made on 12 March 2013, he was not told when the *assessment* was conducted. Even assuming that Schedule 8, clause 22(1) of the Regulation is valid, the applicant does not know the date on which the assessment was made from which this decision is said to "arise." He needs to know this.

(ii) Since the applicant is working in suitable duties, he might have been forgiven for being somewhat alarmed at getting a letter with the following words in the heading: "... notice of reduction or cessation of

[6] In compliance with *Guideline 5.2* the Insurer is to give the worker two weeks "fair notice" of an impending decision.

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wages under section 54 of the *Workers Compensation Act* 1987." The true heading of section 54 is in the following terms: "Notice required before termination or reduction of payment of weekly compensation." The applicant might not have been reassured when the text of the letter went on to say: "The decision will mean your husband's ongoing entitlement to wages will cease as at 12/6/2013." While it may be true that his weekly payments of workers compensation would be ceasing, it is not the case that the applicant's employer would stop paying his wages for work performed. Given the extremely fragile mental state of this applicant, the impact of the words "entitlement to wages will cease" can only be imagined.

(iii) The Insurer also committed the solecism of saying in a letter dated 12 March 2013 that the weekly payments (however described) would cease of 12 June 2013, exactly three months from the date of the letter. This is not correct, since the postal service rule requires four working days to be added to the date of the letter for delivery by post. In the updated *Guidelines* dated 9 August 2013 (not in force at the time) WorkCover has now said that 7 days should be added to the three month period to allow for postal delivery.[7]

(iv) While not a breach of the legislation, regulation or guidelines, I note that the Insurer has referred to the 2012 Amending legislation, even referring to Schedule 12, part 19H, Division 1, part 2of the *Workers Compensation Legislation Amendment Act* 2012. This correctly identifies the legislation as it was introduced, however that Act has now been incorporated into the 1987 Act and thereby repealed and the references in correspondence to workers should now be to the *Workers Compensation Act* 1987.

(v) The letter to the applicant advising of the outcome of internal review, dated 8 May 2013 makes a considerably better fist of complying with the legislation, regulation and *Guidelines*. First, there is a reference to "benefits" rather than wages. Secondly, the correct (indexed) transition amount of $938.30 is quoted. However, there remain two glaring difficulties which cannot be overcome: (a) while the insurer notes that WorkCover requires a further seven day period to be added to notice of cessation of payments to comply with the postal

[7] See *Guideline 6.*

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service rule, they purport to add the seven days to the date contained in the original notice dated 12 March 2013, so purporting to extend that notice from 12 June 2013, rather than giving another 3 months and seven days from 8 may 2013; and (b) the applicant remains uninformed of the date on which the "first work capacity assessment" was made, from which the decision was said to "arise." In my view this is a breach of both the 1987 Act (Schedule 6, Pt 19H, Div2, Clause 9) and the Regulation (Schedule 8, clause 22(1)) both of which require an assessment to have been undertaken. I the case of the Act it is said that the amendments will apply to the applicant's weekly payments three months from the date of the initial assessment, whereas in the Regulation it requires three months to elapse from the date of the *decision* arising out of the first assessment. Clearly in both cases, the applicant should be informed of the date of the relevant assessment.

14. It is clear that the *Guidelines* have been breached in more than one respect. In *Guideline 5.4.2* insurers are given a decalogue of bullet points to comply with when sending out a notice of a work capacity decision, including but not limited to:

- reference the relevant legislation
- advise when the decision will take effect

There is nothing in the legislation which permits the description of weekly benefits or weekly payments of workers compensation to include the word "wages." Using that term in the context in which it arose in the letter dated 12 March 2013 was a clear breach of section 54. The advice that payments would cease on 12 June 2013 was also incorrect, as was the later advice that payments would cease on 19 June 2013. The latter was incorrect because the date of that letter was 8 May 2013, and so the date for the expiry of a new section 54 notice would have been 15 August 2013.

15. The question which arises is whether strict compliance with the provision of the proper notice under section 54 is required such as to render a non compliant notice invalid. In my view strict compliance is required for three reasons:

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(a) The effect of a Work Capacity Decision to reduce weekly benefits payable to the injured worker has the potential to impact on that worker's ability to meet financial obligations and the time period was important to ensure that the worker could reorganise his or her affairs.

(b) Failure to give the proper notice is regarded so seriously in the legislation that it is an offence.

(c) There is no provision in the legislation which enables an insurer to amend the notice.

**My Recommendation:**

16. I recommend that the Insurer issue a valid section 54 notice, which gives the applicant three clear months notice of variation of his weekly benefits. Such notice should include four clear working days for service by post.

17. The applicant should be advised of the date on which his initial work capacity assessment took place.

18. 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 and the relevant period has expired. The applicant should be reinstated to his pre-work capacity assessment/pre-work capacity decision rate of compensation.

19. 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
3 September 2013