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. An injured worker is the applicant for procedural review of a work capacity decision made by a scheme agent of the Workers Compensation Nominal Insurer ("Insurer").

2. The applicant suffered injury in the course of his employment as a courier on or about 27 January 2010 when he was lifting a box containing a barbeque, which resulted in injury to the lower back.[1] 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 his employment terminated. The insurer made weekly payments of compensation from early 2010 until 2013. Accordingly the applicant was an "existing recipient of weekly payments" as at 1 October 2012.

4. On 1 March 2013 the Insurer, having completed an assessment of the work capacity of the applicant, purported to issue a notice[2] of a work capacity decision pursuant to Section 43 of the *Workers Compensation Act* 1987 ("1987 Act"). 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." The cessation of weekly payments was said to be effective "from 1 June 2013."

5. On 2 May 2013 the Insurer wrote to the applicant advising of the outcome of an internal review of the decision dated 1 March 2013. The internal review upheld the original decision.

6. A WorkCover Merit Review was completed and a Statement of Reasons issued on 8 July 2013. The Reviewer upheld the determination of the Insurer.

[1] Or as the *WorkCover Guides for the Assessment of Permanent Impairment* would have it, the "spine." Cf: s 66(2A) of the 1987 Act which still refers to "permanent impairment of the back."
[2] See *WorkCover Work Capacity Guidelines* 5.4.2

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7. On 5 August 2013, application was made to 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 made that application within the 30 day time-limit imposed by section 44(3)(a), and the *WorkCover Work Capacity Guidelines*[3] and on the relevant form.

Applicant's Stated Grounds of Review

8. The applicant takes issue with both the decisions of the insurer and the WorkCover Merit reviewer. I can have no regard to the processes undertaken on Merit Review. The applicant also makes reference to material which could not have been before the Insurer as at the date of either their original decision of 1 March 2013 or their subsequent review on 2 May 2013. I can have no regard to that material. The applicant makes the following submissions:

(a) His medical condition has deteriorated "since Easter". A nerve conduction test done on 1 July 2013 apparently confirms this deterioration, but was "ignored" by the Merit Reviewer.

(b) A WorkCover NSW certificate of capacity issued by his treating doctor (Dr K) on 2 August 2013 says: "Back pain(mild)/pins and needles from buttocks to ankles have increased since Easter/nerve conduction study confirms this." The same certificate reduces the applicant's daily working hours from 8 to 6 (five days per week) and reduced his sitting time tolerance from 30 minutes to 20 minutes and driving time tolerance from 2 hours to 1.5 hours. He is still allowed to stand for one hour at a time with a five minute break each hour and to lift up to 10 kilograms.

(c) The applicant disputes some assertions appearing in the letter of 1 March 2013. Specifically, he seeks to "clarify" the assertion that he has gained employment on three occasions since leaving his former employer. The first job involved delivering brochures to letterboxes and paid $3.50 per hour; the second job involved lifting more than 10 kilograms and caused him back pain; and the third job (as a maintenance

[3] 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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officer) was ideal, until he suffered an injury to his shoulder while changing a light bulb and he was subsequently sacked. The applicant therefore thinks it misleading to describe him as having "gained employment" on three occasions as stated, since the first job did not pay adequate wages, the second job did not meet the restrictions imposed by his doctor and the third job caused a further injury. I note that despite the circumstances in which the third job ended for the applicant, he has continued to seek employment as a maintenance officer.

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 Compensation Regulation* 2010[4] which purports to amend the Act[5] 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

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

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> 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.[6] 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 when 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

[6] 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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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.[7] 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 existence no such document as the *Best Practice Decision-Making Guide.*

[7] But cf: footnote 2 *supra*.

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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 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

11. The decision reached by the Insurer appears to be appropriate in the circumstances of the case. The insurer has carefully set out all the documents on which their decision was based. The documents were first enumerated in the "fair notice" letter[8] dated 14 February 2013, and an expanded list appeared in the letter notifying the worker of the outcome of internal review, dated 2 May 2013. The latter refers to such documents as the worker provided in response to the letters of 14 February 2013 and 1 March 2013 and documents obtained by the Insurer in reply. The documents might be listed in 3 categories: (a) being documents on which the original decision was based; (b) documents submitted by the applicant in response to the original decision; and (c) documents acquired by the Insurer for the purposes of internal review. The insurer sets these out as follows in the letter dated 2 May 2013:

[8] See *Guideline* 5.2

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a. Documents/evidence on which the Insurer relied in making the work capacity decision

- Worker Injury Claim form 3 March 2010
- Employer Injury Claim Form 3 March 2010
- MRI of Lumbar Spine report 10 March 2010
- Medical report Dr Ml 1 April 2010
- Medical report Dr H 21 April 2010
- Rehabilitation report of R 23 April 2010
- Medical report Dr M 10 May 2010
- Rehabilitation report of R 21 May 2010
- Return to Work Plan of R 28 May 2010
- Medical report Dr H 31 May 2010
- Report of P C 15 June 2010
- Report of P C 5 July 2010
- Report of P C 20 July 2010
- Medical report Dr M 28 July 2010
- Report of P C 6 August 2010
- Medical report Dr M 20 September 2010
- Nerve Conduction Studies report of Dr Sc 9 October 2010
- Injury Management Consultation report of Dr Sa Perla 9 November 2010
- Report of T C A R 17 November 2010
- Rehabilitation progress report of R 27 January 2011
- Rehabilitation report of R 31 January 2011
- Injury Management Consultation report of Dr S P 28 February 2011
- Correspondence from K M of R to J A of A E 2 March 2011
- Rehabilitation report of R 21 March 2011
- Report of T C A R dated 11 May 2011
- Medical report Dr G 6 September 2011
- Letter from M B Lawyers 13 September 2011
- Correspondence from S C of recover to A L of A 4 January 2012
- Correspondence from T B of W to A L of A 23 March 2012
- Employability Assessment Report of Wo dated 11 April 2012
- Earning Capacity Assesment of ECA 25 May 2012
- Correspondence from the applicant to V R of A 6 September 2012, 10 October 2012 and 19 November 2012

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- Medical report of Dr K 2 May 2013**
- J job logs and independent job seeking diaries
- WorkCover medical Certificates of Dr H and Dr G
- Payslips

b. documents submitted by the applicant in response to the original decision
   - Medical report Dr G 18 March 2013

c. Documents acquired by the Insurer for the purposes of internal review
   - Medical report of Dr K 2 May 2013** (note, also listed under "a" above – a copy was enclosed with the letter to the applicant of the same date)

12. It can be seen from the list above that the Insurer had regard to well over 30 documents, including reports from treating doctors, non-treating doctors, W, ECA, R, P C, T C A R, an injury management consultant, payslips, radiology, and correspondence from the applicant and even correspondence from his solicitors. The decision is to be made by the insurer on the basis of all available information. It is clear that the reports described in paragraph 11 (b) and (c) above were not available to the insurer as at 1 March 2013, although they were considered in the making of the internal review decision on 2 May 2013. Since the nerve conduction test (1 July 2013) and the subsequent WorkCover certificate of capacity from Dr K (2 August 2013)[9] did not even come into existence until some months following the internal review, I can have no regard to them and no criticism can be made of the Insurer for not having considered them.

My Reasons:

13. The reasons given by the applicant for seeking procedural review (as set out in paragraph 8(a)-(c) *supra*) are in 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 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:

[9] See paragraph 8(a) and (b) *supra*.

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(a) The applicant alleges that his condition has recently deteriorated and he refers to a nerve conduction study dated 1 July 2013 and a WorkCover capacity certificate dated 2 August 2013. Both of these reports/documents post-date the work capacity assessment and decision process. They may have some relevance to the merits of the case, but even if they do I cannot consider them.

(b) See (a) above.

(c) In the letter dated 1 March 2013 the Insurer sets out the history of the claim and reasons for the decision. On page five they state the following: "You continue to independently job seek and have demonstrated the ability to seek and gain alternative employment. More specifically, since the completion of occupational rehabilitation, you have applied for and gained employment on 3 occasions." The applicant concedes that this is strictly true, but cavils that the employment he has gained is inappropriate as to remuneration, lifting requirements, or being the cause of further injury. Anomalously, it is the third type of employment, which caused actual injury, which the applicant continues to seek. This ground also goes to the merits of the work capacity decision and I cannot consider it.

Accordingly, none of the grounds sought to be relied upon by the applicant will assist his cause on procedural review.

14. To the extent outlined in paragraphs 11 and 12, the Insurer has complied with the relevant legislation and the *Regulation* and the *Guidelines*; but there are some further respects in which compliance with the legislation, *Regulation* and *Guidelines* was questionable.

(i) While the worker was told that the decision was made on 1 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 date in order to be able to make coherent submissions about compliance with the requirements of both the legislation and the *Guidelines*. He needs to be able to be satisfied that the work capacity decision follows and arises from the "first" work capacity assessment undertaken by the Insurer. The letter dated 1 March 2013 says no

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more than this: “Following an assessment of your work capacity, a decision has been made...” The applicant is not told that it was the first such assessment, nor the date on which it occurred. I do not see how it is possible for the Insurer to comply with Schedule 6 Part 19H Division 2 Clause 9 of the 1987 Act, or Schedule 8 Clause 22(1) of the *Regulation* in the absence of this information being provided to the applicant.

(ii) It might be thought that nothing prejudicial follows from this omission by the Insurer, in the sense that there is no “practical injustice”[10] in the worker not knowing precisely when an assessment occurs, particularly in light of the wording now appearing in a “Note” to clause 22(1) in Schedule 8 of the *Regulation*. The Note says this:

> **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.**

Of course subclause (1) says considerably more than what appears above in bold type. The critical words in subclause (1) of clause 22 are the words appearing below in bold type:

> (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.

(iii) Without any notification that the assessment is the *first* such assessment, the applicant cannot know that the ensuing decision is

[10] See comment by Gleeson, CJ in *Minister for Immigration and Multicultural and Indigenous Affairs v Lam* (2003) 214 CLR 1 at [37].

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"arising from" the first work capacity assessment. Being unaware of the date of the assessment, he cannot know that the insurer has complied with the requirement that a decision be made "as soon as practicable" after the first work capacity assessment is completed.[11] In this respect, there is a crucial difference between a worker not being told the date of an assessment and situation in the High Court decision of *Lam.*[12] In the latter case the Chief Justice made the following observations:

> [36] The more fundamental problem facing the applicant, however, relates to the matter of unfairness. A statement of intention, made in the course of decision-making, as to a procedural step to be taken, is said to give rise to an expectation of such a kind that the decision-maker, in fairness, must either take that step or give notice of a change in intention. Yet no attempt is made to show that the applicant held any subjective expectation in consequence of which he did, or omitted to do, anything. Nor is it shown that he lost an opportunity to put any information or argument to the decision-maker, or otherwise suffered any detriment.
>
> [37] A common form of detriment suffered where a decision-maker has failed to take a procedural step is loss of an opportunity to make representations..... A particular example of such detriment is a case where the statement of intention has been relied upon and, acting on the faith of it, a person has refrained from putting material before a decision-maker. In a case of that particular kind, it is the existence of a subjective

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[11] See Schedule 8, clause 23 of the *Regulation*:

"**23 Work capacity decision to be made as soon as practicable after assessment**

An insurer must, for the purposes of Division 2 of Part 19H of Schedule 6 to the 1987 Act, make a work capacity decision in respect of an existing recipient of weekly payments as soon as practicable after the first work capacity assessment of the worker is conducted by the insurer as required by that Division."

[12] See footnote 10 *supra*

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> expectation, and reliance, that results in unfairness. Fairness is not an abstract concept. It is essentially practical. Whether one talks in terms of procedural fairness or natural justice, the concern of the law is to avoid practical injustice.[13]

(iv) In *Lam* the High Court was unable to be satisfied that a person involved in a dispute with the Minister for Immigration and Multicultural and Indigenous Affairs had been deprived of "fairness" due to a procedural failing on the basis that no "practical injustice" could be identified. But in workers compensation cases where a worker is at peril of losing their income (or a substantial part of it) "fairness" is shown by strict adherence to the set of procedures laid down in legislation, the *Regulation* and the *Guidelines*. In this light, "fairness" might be thought no more relevant to an Insurer's interests than it is to the creditors of a person fighting a bankruptcy notice. The letter of the law must be adhered to in the latter case, because of the devastating consequences for anyone against whom a sequestration order might be made, and it is my view that a worker in circumstances like those of the applicant should be similarly protected by a requirement of strict adherence to the legislation, the *Regulation* and the *Guidelines*. Fairness, in this context, might be thought to go more in one direction than the other, but in cases involving beneficial legislation and the livelihood of injured workers, it is not unreasonable to expect Insurers to comply fully and accurately with all procedural requirements.

(v) Even if it were accepted that the approach taken by the High Court in *Lam* might be appropriate in workers compensation cases, it is clear that this Insurer has failed to avoid a practical injustice. In the letter dated 2 May 2013, the Insurer has included as an enclosure a copy of a report by Dr K, also dated 2 May 2013. There is no prospect that the applicant could have made submissions or obtained any reports from his own medical providers in answer to this report. Further, this report appears to be new evidence which was obtained by the Insurer, after the applicant made submissions and provided further information in answer to the original decision. I cannot see anywhere in the *Guidelines* where this is allowed. Relevantly, the *Guidelines for*

[13] At [36]-[37]

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work capacity decision Internal Reviews by Insurers and Merit Reviews by the WorkCover Authority (Internal Review Guidelines) [14] state at *Guideline* 7.4:

> The internal reviewer may request additional information from the worker, and if doing so should allow the worker no less than 7 days to supply any such information.

(vi) This follows on from the earlier *Guideline* concerning acknowledgement of the application for internal review which says at 7.1.3 the Insurer should do the following:

> 7.1.3 confirm that the worker may provide any new or additional information relevant to the work capacity decision and advising when that information is due to be received.

(vii) Nowhere in the *Internal Review Guidelines* does it say that an Insurer may obtain further medical reports in the course of internal review.

(viii) This has wider implications, since the consideration of newly acquired medical evidence obtained by the Insurer in answer to submissions by the applicant takes the Insurer back to the stage of assessment. It is no longer an internal review of a decision already made; it is now another decision made based on a further assessment of the applicant's work capacity. How this decision can then be said to "arise from the first work capacity assessment" as required by clause 22(1) of Schedule 8 of the *Regulation* is unknown.

(ix) In order for the decision-making process to be comprehensible, the assessment process must have an end-point. But when an Insurer relies on a report dated the same day as the notice of outcome of an internal review, it is clear that the assessment process has either (a) continued beyond the date of the original "decision" or (b) become confused and conflated in the mind of the Insurer with the decision-making process. As the *WorkCover Work Capacity Guidelines* say at *Guideline* 5:

[14] *NSW Government Gazette* No 126, 7 December 2012

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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.

Work capacity decisions should be made in line with the *Best Practice Decision-Making Guide.*[15]

(x) 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
- 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

In the letter to the applicant dated 1 March 2013 reference was correctly made to sections 43 and 54 of the 1987 Act. The applicant was wrongly told that his weekly payments would be reduced to nil from 1 June 2013, since this did not allow for the postal service rule and the correct date of 8 June 2013 should have been given. Perhaps more interestingly the following elliptical, not to say eccentric, sentence appeared:

- any entitlement you have to pre-approved reasonable and necessary medical and other expenses, until 1 June 2014 will not be affected.

I have no doubt that the applicant was pleased to hear this. I also have no doubt that he was not properly informed, or informed at all, that his entitlements to medical expenses, whether reasonable or not,

[15] See paragraph 10 generally.

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would cease being approved 12 months after his weekly payments ceased, in accordance with section 59A of the 1987 Act. This is a clear breach of the *Guidelines*.

(xi) As already noted, the Insurer committed the further solecism of saying in a letter dated 1 March 2013 that the weekly payments would cease as of 1 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.[16] Both errors (omission of explanation of cessation of medical expenses under section 59A and incorrect date for cessation of weekly payments under section 54) were repeated in the letter of 2 May 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:

(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.

16. It might be argued that if an insurer pays a worker compensation for the extra time between the wrongly given earlier date and the correct date the worker will have suffered no loss and the problem will have been overcome. This is to misconstrue section 54(3), which is a penalty

[16] See *Guideline 6.*

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clause, not a remedial clause. Section 54(3) only applies following the commission of an offence (whether prosecuted or not) and does not overcome the slightly awkward fact that the 1987 Act has no provision enabling an insurer to issue an amended notice. If the notice is invalid due to the wrong date being given because no time was allowed for service in contravention of section 76(1)(b) of the *Interpretation Act* 1987, it must be re-issued, with a further three month period (plus time for service) given to the worker.

17. In the course of reading the correspondence between the applicant and the Insurer I noticed some comments which I would not normally expect to see. Included in this class of comment was this: "... the evidence on file suggests that assistance with motivation was also required as you were identified as being 'picky' with the positions you applied for."[17] In the paragraph immediately following that effort, this appeared: " ... a functional assessment was not able to be carried out as your blood pressure was too high at the time of the assessment on 2 February 2012 and again on 23 March 2012. As a result, the Employability Assessment report dated 11 April 2012 was based on your vocational assessment and written medical approval from Dr G."[18] I gather from this that no functional assessment was carried out because the illness of the worker did not happen to suit the convenience of the Insurer. This attitude towards the rights of the applicant is mirrored in the way additional medical evidence was obtained in the insurer's interests in the course of an internal review. In the *WorkCover Work Capacity Guidelines* at 2.4 it clearly states:

> Work capacity assessments should be tailored to the worker. An understanding of the worker's circumstances and their injury ensures the right approach at the right time.

It appears that this applicant had his work capacity assessed in the absence of a functional assessment precisely because the Insurer chose to ignore *Guideline* 2.4 and preferred their own convenience to his.

My Recommendation:

[17] Letter from Insurer to Applicant dated 2 May 2013.
[18] *Ibid.*

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18. I recommend that the insurer conduct a functional assessment of the applicant before making a new work capacity decision in accordance with the legislation, *Regulation* and *Guidelines.*

19. If required, I recommend that the Insurer issue a valid section 54 notice, which gives the applicant three clear months notice of variation of his weekly payments. Such notice should now comply with *WorkCover Work Capacity Guideline* 6 (as gazetted on 9 August 2013).

20. The applicant should be advised of the date or dates on which his first work capacity assessment is or was completed.

21. 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.

22. 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
11 September 2013