WiRO
WorkCover independent review office

Level 4, 1 Oxford Street, Darlinghurst NSW 2010
T: 13 9476
contact@wiro.nsw.gov.au
www.wiro.nsw.gov.au

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 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 to her neck[1] in the course of her employment as a store person on or about 25 January 2010. There is no dispute about the injury having occurred in the course of employment.

3. The applicant no longer works for the original employer, although she did perform light duties until 25 March 2010. She has not resumed employment since. The insurer accepted liability and made continuing weekly payments for all periods until 2013. Accordingly the applicant was an "existing recipient of weekly payments" of compensation (as that term is defined in Schedule 6, Part 19H Division 1 of the *Workers Compensation Act* 1987 [1987 Act]) immediately prior to 1 October 2012.

4. On 21 March 2013 the Insurer, having completed an assessment of the work capacity of the applicant, purported to issue a notice of a work capacity decision pursuant to Section 43 of the 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."

   Relevantly, the applicant was advised in the following terms:

   > We have carefully considered your claim and after an internal review, we have made a work capacity decision that **will take effect from 21/03/2013.**
   >
   > In line with the notice period [the Insurer] is required to give under section 54, your weekly benefits will continue at the current rate until 21/06/2013.

[1] Or as the *WorkCover Guides for the Assessment of Permanent Impairment* would have it, the "spine."

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> This decision is only related to weekly benefit compensation payments on your claim. However, under section 59 entitlement to medical treatment only extends for a 12 month period after weekly benefit payment ceases 21/06/2013.
>
> Approval for any medical treatment should be requested from [the Insurer] via a referral from your Nominated Treating Doctor or specialist.

5. On 16 May 2013 the Insurer wrote to the applicant advising of the outcome of an internal review of the decision dated 21 March 2013. The internal review upheld the original decision.

   Relevantly, the applicant was further advised in the following terms:

> In accordance with Schedule 12, Part 19H, Divison2(8)(1) we are required to conduct a work capacity assessment for the purposes of facilitating the application of the weekly benefit amendments to a worker in line with the *Workers Compensation Amendment Act* 2012.
>
> After careful consideration of your application, pursuant to section 43(1)(f) of the *Workers Compensation Act* 1987 we wish to advise that a work capacity decision has been made resulting in discontinuation of weekly benefits.
>
> Pursuant to Clause 20,Schedule 1 of the *Amendment* (sic) *Workers Compensation Regulation* 2010 we wish to advise you, that you no longer meet the criteria set out under Section 38 of the Act.
>
> Due to the reasons detailed above, <u>your entitlement to weekly benefits will be reduced from $250 per week to $0 effective from 28/06/2013.</u>
>
> Please be advised that the date has been amended from the original date of 22/06/2013 in accordance with WorkCover guidelines.

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We can confirm that the work capacity decision **only relates to your entitlements to weekly benefits and does not affect other entitlements that you may be entitled to under the Act.**

6. A WorkCover Merit Review was completed and a Statement of Reasons issued, dated 2 July 2013. The Reviewer upheld the determination of the Insurer. WorkCover says that the Merit Review decision was posted to the applicant on 2 July 2013, but the applicant denies ever receiving the decision in the post and says that the first time she became aware of the decision was on 22 August 2013 when a copy was emailed to her solicitor.

7. On 2 September 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* and on the relevant form. Section 44(3)(a) requires the application to the Independent Review Officer to be made "within 30 days after the worker receives notice in the form approved by the Authority of ... the Authority's decision on a review..." Since the applicant and her solicitor were first alerted to the Authority's decision via an email dated 22 August 2013 and the application to the Independent Review Officer was made ten days later, the section has been complied with.

Applicant's Stated Grounds of Review

8. The applicant takes issue with both the decision of the insurer and the WorkCover merit review, thus:

(a) The Insurer did not give sufficient notice of the decision.

(b) The Insurer based its decision in large part on documents and information which were out of date. As an illustrative example, the applicant cites reliance on a functional capacity assessment conducted on 7 November 2011. This is so out of date that it actually predates resolution of proceedings in the Workers Compensation Commission which were the subject of consent orders entered in January 2012. As a

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result of those orders, the Insurer was to continue paying the applicant $250 per week.

(c) The applicant says that she never received a copy of the merit review decision in the post, despite being told that it had been sent via post on 2 July 2013.

Submissions in Reply from Insurer

9. In response to the application, the Insurer makes the following submissions:

(a) The insurer acknowledges that 3 months notice was given, with no time allowed for service. In accordance with Section 54(2)(b), they say they have paid the worker an additional one week and two days. They therefore believe that they have "adhered to and given sufficient notice of the decision."

(b) The Insurer acknowledges that the functional assessment is more than 12 months in arrears from when the decision was issued. Having said that, this is not the basis for their decision. They have more recent information from the applicant's nominated treating doctor that is within the 12 months who states that she has a capacity for full hours with restrictions. It further states that she has reached maximum medical improvement and therefore the Insurer remains of the belief that she has capacity for suitable employment.

(c) The Insurer has no control over any decision from the merit review service and therefore they request that this reason be excluded from any procedural review decision.

The Legislative Framework

10. 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] (the Regulation) which purports to amend the 1987Act[3] in a way which is both confusing and most probably invalid. A person hoping to fully comprehend the process requires an understanding of the 1987 Act, the *Workplace Injury Management and Workers Compensation Act* 1998 (1998 Act), the Regulation and up to three iterations of two separate sets of *Guidelines*[4] issued by WorkCover.

The *WorkCover Work Capacity Guidelines* which were gazetted on 28 September 2012[5] set out the necessary requirements of a *Work Capacity Decision Notice* at 5.4.2 thus:

> **5.4.2. Requirements of a Work Capacity Decision Notice**
>
> The **Work Capacity Decision Notice** must:
>
> • reference the relevant legislation
>
> • explain the relevant entitlement periods
>
> • state the decision and give brief reasons for making the decision
>
> • outline the evidence considered in making the decision, noting the author, the date and any key information. All evidence considered should be referred to, regardless of whether or not it supports the decision.
>
> • clearly explain the line of reasoning for the decision
>
> • 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
>
> • advise when the decision will take effect
>
> • detail any support, such as job seeking support, which will continue to be provided during the notice period

[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] *Work Capacity Guidelines* and *Review Guidelines*.
[5] Now replaced by the *WorkCover Work Capacity Guidelines* gazetted on 8 October 2013. In this case the relevant version remains those *Guidelines* gazetted 28 September 2012.

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• advise that any documents or information that have not already been provided to the worker can be provided to the worker on request to the insurer

• advise of the process available for requesting review of the decision and how to access the required form, *Application for review of a work capacity decision by insurer*.

There is a great deal of ground covered in those ten points, which may lead to difficulties with compliance. A particular difficulty is caused by the subjunctive mood induced by the word "must" immediately prior to the first bullet point. It would follow that a breach of even a single element of this decalogue similarly 'must' result in invalidity.

Process of the Insurer

11. The decision reached by the Insurer appears to be within the range of available decisions and was upheld on merit review. The Insurer had regard to the following documents:

- WorkCover medical certificates[6] issued by the applicant's nominated treating doctor between 12/05/2010 and 18/07/2012
- Report from Dr T dated 20/12/2011
- AOHS closure report dated 01/12/2011
- Earning Capacity Assessment from AOHS dated 24/11/2011
- Functional Capacity Evaluation report from AOHS dated 18/11/2011

I note that apart from medical certificates issued by the applicant's nominated treating doctor, none of the documents relied upon post-date the settlement reached between the parties in January 2012.

My Reasons:

[6] As they were then known.

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12. The reasons given by the applicant for seeking procedural review can be dealt with under the lettering used in paragraph 8:

(a) There can be no dispute that the Insurer gave inadequate notice under section 54. The Insurer concedes this in submissions, but says in response that they have remedied the problem by paying the applicant for an "extra" one week and two days. This is said to comply with section 54(2)(a) of the 1987 Act. In the letter of 16 May 2013 advising the applicant of the outcome of internal review the Insurer changed the operative date of their decision from 21June 2013 to 28 June 2013 in an attempt to remedy the error in the original notice.

On this ground the applicant must succeed. The Insurer has purported to extend the earlier notice by giving an extra seven days from the original date given, but does not give three months and seven days notice from the date of the *new* notice, which is the only way to remedy an error in the original notice. In order to successfully overcome the original error, the Insurer would have had to give the applicant notice of three months and seven days (according to *Guidelines* dated 9 August 2013) or three months and four days (according to *Guidelines* dated 8 October 2013) or more correctly three months and four working days (according to section 76(1)(b) of the *Interpretation Act* 1987) from the date of the letter giving that new notice, i.e. from 16 May 2013. Therefore in order to overcome the original error, notice should have been given in a letter dated 16 May 2013 that payments would cease on 23 August 2013, not 28 June 2013.

The original notice cannot be remedied or in any way validly altered by correspondence, in the same way a subpoena or a bankruptcy notice cannot be remedied or altered by correspondence. It is therefore necessary to serve a new notice.

(b) The applicant notes that the documents relied upon by the Insurer pre-date a settlement of her claim, which had resulted in the Insurer agreeing to pay $250 per week. In response the Insurer says that they obtained more recent documents from the applicant's nominated treating doctor, but these all appear to be WorkCover medical certificates rather than medical reports as that term is normally understood.

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On this ground the applicant may have a point, especially since work capacity certificates[7] only have a currency of between 28 days and "up to" 90 days, depending entirely upon the attitude of the Insurer. Exactly how far this line of argument can take the applicant is unknown, since if it were only possible to uphold a work capacity decision based on strictly current documents, no such decision would survive internal review conducted more than 28 days following the date of the most recent work capacity certificate. On the same basis it is impossible to see how any work capacity decision could survive merit review following an internal review. The current matter concerns a decision made on or about 21 March 2013. Therefore no work capacity certificate relied upon by the Insurer in making a work capacity decision on or before that date could be current at the present time, even if extended to 90 days with the Insurer's concurrence. It must follow that currency of medical evidence is not a determinative consideration when examining the processes of the Insurer, although it may be a relevant consideration in cases where all the evidence relied upon (including non-medical evidence) is so old as to result in an unfairness to the applicant.

It is likely that the applicant is surprised and disappointed by the decision of the Insurer in light of the consent orders entered into in the Workers Compensation Commission in January 2012. Nothing has changed as far as the applicant is concerned, but this lack of change works in the Insurer's favour, since it renders the functional capacity assessment and earning capacity assessment still current despite having been obtained prior to January 2012.[8]

(c) The failure of the postal service to deliver a hard copy of the merit review decision to the applicant does not reflect on the conduct of the Insurer in any way, although it does explain why the applicant did not approach the Independent Review Officer for a procedural review until late August 2013 when the merit review decision was dated 2 July 2013. The applicant was obviously in no position to apply to the Independent Review Officer prior to receipt of the merit review decision, and on that basis procedural review should be permitted despite the application being out of time.

[7] As the former *WorkCover medical certificates* are now called.
[8] See further at paragraph 15 *infra*.

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13. To the extent outlined in paragraphs 11 and 12(b), 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 21 March 2013, she 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." She 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*. She 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 21 March 2013 says no more than this: "We have carefully considered your claim and after an internal review[9] we have made a work capacity decision that will take effect from 21/03/2013." 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**

[9] An odd choice of words, given that the worker's only immediate redress is to seek "internal review."
[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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such a worker 3 months after the insurer makes a work capacity decision in respect of the worker.

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 "arising from" the first work capacity assessment. Being unaware of the date of the assessment, she 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:

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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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> [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 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

[13] At [36]-[37]

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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 *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[14], 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 21 March 2013 the following breaches occur:

- A work capacity decision resulting in a cessation of weekly payments dated 21 March 2013 is said to "take effect" on that same date. This is a clear breach of section 54 and the Guideline requiring notification of when the decision will take effect.
- Notice purportedly given under section 54 is given to 21 June 2013, not 28 June 2013. This is a breach of section 54 and the same *Guideline.*
- The applicant is told that the decision "is only related to weekly compensation payments" but is then told that "under section 59 entitlement to medical treatment only extends for a 12 month period after weekly benefit payment ceases 21/06/2013." This is a breach of the *Guideline* requiring advice of the impact of the decision, since section 59A(2) and (3) are nowhere referred to, no

[14] See fully set out at paragraph 10 *supra*.

Level 4, 1 Oxford Street, Darlinghurst NSW 2010
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mention is made that the right to have medical and related expenses paid may arise again if weekly benefits are ever resumed, and the applicant is told that her entitlement to "medical treatment" ceases, rather than that her entitlement to have medical treatment expenses paid for by the Insurer ceases. This is also a breach of the *Guideline* requiring reference to the relevant legislation.

- The applicant is told she should seek "approval for any medical treatment" from the Insurer, without being told that this is a current statutory requirement rather than a consequence of the work capacity decision.

In the letter dated 16 May 2013 the following breaches occur:

- The applicant is told that a work capacity assessment must be undertaken by virtue of "schedule 12, Part 19H, Division 2 (8)(1) of the *Workers Compensation Amendment Act* 2012. The applicant would have no prospect of finding this, since it was repealed upon assent and the relevant provisions now appear in Schedule 6 Part 19H Division 2 clause 8(1) of the 1987 Act.
- In a similar vein the applicant is advised "pursuant to Clause 20, Schedule 1 of the *Amendment* (sic) *Workers Compensation Regulation* 2010" that she no longer meets the criteria for payment under section 38 of the 1987 Act. While there is something called Clause 20, Schedule 1 of the *Workers Compensation (Amendment) Regulation* 2012 and there is also a Clause 20 of Schedule 8 of the *Workers Compensation Regulation* 2010, the instrument described in the letter does not exist. This is therefore a clear breach of the *Guideline* requiring the legislation to be referenced.
- The letter erroneously purported to extend the time for notice under section 54 to 28 June 2013.
- The applicant was told the following: "We can confirm that the work capacity decision only relates to your entitlements to weekly benefits and does not affect other entitlements that you may be entitled to under the Act." The applicant might have understood the letter of 21 March 2013 to be telling her that a consequence of the work capacity decision was that her entitlement to payment for medical and related expenses was adversely affected, and

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therefore a proleptic irony arises in the incorrect wording used in the second letter misleading a person who had deduced the correct position from the incorrect wording used in the first letter. This does not comply with the *Guideline* requiring the Insurer to state the impact of the decision.

14. 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 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.

15. The applicant had her work capacity assessed under a legislative regime which differs substantially from the version in place at the time of the compromise settlement reached with the Insurer in the WCC in January 2012. Under the current legislation the Insurer can unilaterally decide that agreements and even awards from the WCC may be varied following an assessment of the applicant's work capacity, but they must comply with the legislation, the Regulation and the *Guidelines* in order to produce a fair result. In the current instance there has been a multiplicity of breaches of both the legislation and the *Guidelines*.

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 her weekly payments. Such notice should now comply with *WorkCover Work Capacity Guideline* 6 (as gazetted on 8 October 2013).

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17. The applicant should be advised of the date on which her first work capacity assessment was completed.

18. Since the applicant was an existing recipient as at 1 October 2012, she remains entitled to receive her 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 her pre-work capacity assessment/pre-work capacity decision rate of compensation of $250 per week.

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
15 October 2013