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 licensed scheme agent of the Workers Compensation Nominal Insurer (Insurer).

2. The applicant suffered injury on or about 19 January 2009 in the course of his employment as a Tiler/Labourer. There is no dispute about the injury having occurred in the course of employment. The applicant worked on for the rest of that day and then never worked in paid employment again.

3. The Insurer accepted liability and made continuing weekly payments for all periods of total or partial incapacity 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 10 April 2013 the Insurer issued a notice of a work capacity decision. 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 10 July 2013.

   Relevantly, the applicant was advised in the following terms:

   > [The Insurer] note[s] that you are not employed and have been paid weekly workers compensation benefits for 185 weeks.[1]
   >
   > ... [The Insurer has] made a work capacity decision that you have no entitlement to payments of weekly workers compensation benefits.
   >
   > ....

[1] But in submissions to the merit review service this was changed to 225 weeks.

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

Therefore you are not entitled to weekly workers compensation.

This decision to reduce/cease payment of workers compensation weekly benefits will be effective 3 months from the date of this letter in accordance with section 54 of the Act.

This means that [the Insurer] will reduce the rate of your workers compensation benefits to $NIL.

Please note that you are still entitled to reasonably necessary medical treatment.

5. On 12 June 2013 the Insurer wrote to the applicant's legal representatives advising of the outcome of an internal review of the decision dated 10 April 2013. The internal review upheld the original decision.

The applicant was informed as follows:

> Under Subdivision 3 of the *Workers Compensation Act* 1987[2] we are obliged to review your work capacity.
>
> A work capacity assessment is a review of all information relating to your ability to return to work and is conducted by [the Insurer].
>
> After carefully considering the documentation on your file, [the Insurer] confirms the original determination that your weekly benefits should cease, under section 38(1) & 38(3)(b)&(c) and section 43(1)(a),(b) & (f) of the 2012 *Workers Compensation Act* 1998[3] as you do not satisfy the special requirements for continuation of weekly payments after the second entitlement period (after 130 weeks) under section 38 of the *Workers Compensation Act* 1987.

[2] Which might be a reference to either ss 43-44B or alternatively ss 154G-154N; unless it is meant to be a reference to Part3, Division 2, Subdivision 3 of the *Workers Compensation Act* 1987, in which case it is a reference to ss 43-44B.
[3] An instrument which does not exist.

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

> This means that:
> You have capacity to work; and
> You are currently unemployed.
>
> Accordingly we will maintain our decision to cease your weekly benefits on 10 July 2013 based on the work capacity assessment.
>
> Compensation for medical or hospital and rehabilitation pursuant to section 60 of the *Workers Compensation Act* 1987 will cease on 1 January 2014.[4]

6. A WorkCover Merit Review was completed and a Statement of Reasons issued, dated 13 August 2013. The Merit Reviewer upheld the determination of the Insurer. The specific finding made by the merit reviewer was in these terms:

> Pursuant to section 38 of the *Workers Compensation Act* 1987, [the applicant] is not entitled to weekly payments of compensation.

7. On 11 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.

Applicant's Stated Grounds of Review

8. The applicant takes issue with the decision of the Insurer on the following grounds:

   1. We refer to *Guidelines for work capacity internal review by insurers and merit reviews by WorkCover Authority* [Review Guidelines] and [the Insurer's] work capacity decision of 12 June 2013.

[4] No authority is quoted for this untrue proposition which completely misconstrues the meaning and effect of section 59A(2) of the 1987 Act, to which no reference is made at any point in the correspondence.

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

(a) [The Insurer] failed to provide findings on material questions of fact, referring to the documents or other material on which those findings were based as required by cl 7.7.2.1

(b) [The Insurer] failed to state reasons for the reasoning process that led the internal reviewer to the decision.

(c) [The Insurer] therefore did not adhere to the requirements of the internal review as set out in the *Guidelines*, and as such we seek a Merit Review[5] of work capacity decision 19 June 2013 accordingly.

(d) Furthermore [the Insurer's] decision of 19 June 2013 fails to consider the evidence of physiotherapist Mr W - a contravention of clause 7.5 of *Review Guidelines* requiring [the Insurer] the "consider all of the material substantively and on its merits as if the original work capacity decision had not been made, and is obliged to make the decision that they think is more likely than not to be correct."

(e) [The Insurer] therefore did not adhere to the requirements of the internal review as set out in the *Guidelines* and as such we seek a Merit Review[6] of work capacity decision of 12 June 2013 accordingly.

2. The duty to provide reasons in *Campbelltown City Council v Vegan & Ors* [2006] NSWCA 284 has been altered favourably for workers in *Wainohu v New South Wales* [2011] HCA 24 and even a legislation which allows any decision maker to give a decision without reasons is invalid and beyond the competence of State Parliament.

(a) The impugned decision of [the Insurer] does not provide reasons why the grounds raised in the injured workers Application for internal review are insufficient to change the impugned work capacity decision of 12 June 2013 and [the Insurer] have not responded in any way to 5 of the grounds raised in our application for internal review.
(b) In light of the above, [the Insurer's] impugned decision is void and must be set aside on the basis of *no reasons have been provided* in response

[5] This is clearly an inappropriate request in an application for *procedural* review.
[6] See previous footnote.

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

to the grounds raised in the injured worker's application for internal review.

Submissions in Reply from Insurer

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

We address the worker's submissions set out in the Application for Review of the Work Capacity Decision dated 11 September 2013 as follows:

1. In regards to the notice dated 12 June 2013 –

   a. The decision was based on the documents listed in the notice. The IDR Panel also reviewed the claim as a whole and considered all documentation on file prior to making its decision.

   b. The reasons were listed. The decision was based on the fact that the worker had received 130 weeks of payments, had current work capacity and was not currently employed. Pursuant to Section 38 of the *Workers Compensation Act 1987* ('the 1987 Act') the worker is not entitled to continuation of his weekly compensation benefits.

   c. All Guidelines were adhered to.

   d. The IDR Panel considered all documentation on file and listed the documents that demonstrated the decision made.

   e. All Guidelines were adhered to.

2. We submit that reasons were provided and the worker's solicitors were notified of the decision of the IDR Panel by telephone on 12 June 2013. On that day I spoke with a person who identified himself as "David" of the worker's solicitors office and explained that the decision was made pursuant to Section 38 and that a notice confirming the decision would be sent to their office. No questions were asked in relation to the decision and to date no correspondence has been received in relation to the decision.

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

The insurer made further submissions in response to earlier submissions made by the applicant to the Merit Review Service, but they are not relevant for the purposes of this application since the applicant has not repeated those submissions here and it follows that submissions in reply to non-existent or withdrawn submissions are otiose.

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. This is not the first applicant who has had legal assistance and it appears to be not much easier for lawyers than it is for their clients to successfully traverse the new legislative terrain. 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[7] (the Regulation) which purports to amend the 1987Act[8] 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*[9] issued by WorkCover.

    The *WorkCover Work Capacity Guidelines* which were gazetted on 28 September 2012[10] 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

[7] See schedule 8, clause 22(1) of the *Regulation*.
[8] See sched 6, Pt 19H Div 1 clause 9 of the 1987 Act.
[9] *Work Capacity Guidelines* and *Review Guidelines*.
[10] 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.

• 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

• 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 jussive temper 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. This position is fortified by the status of the *Guidelines* as delegated legislation.

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 documentary evidence when making the work capacity decision:

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

- Reports from Earning Capacity Assessment[11]
- Workers Compensation medical certificates dated variously from 24 October 2011 to 7 February 2013 (seven in total)[12]
- Print-out showing number of weeks paid[13]

Those are the only documents referred to in the letter dated 10 April 2013 advising the applicant of the work capacity decision. In the letter dated 12 June 2013 advising of the outcome of internal review the Insurer enumerated the following documents in addition to those above:

- Letters requesting review from [the applicant's solicitors] dated 9 and 10 May 2013.

It is of interest that the Insurer nowhere refers to the following reports, all of which were made available to and enumerated by the merit reviewer:

- Status reports by W O dated 29 January 2013 to 28 June 2013 (5 in total)
- Work capacity assessment report by Mr A W [a physiotherapist] dated 20 May 2013
- Fax transmission from the applicant's nominated treating doctor 24 January 2013
- Fax transmission from a Dr O dated 13 November 2012

The merit reviewer also commented that the physiotherapist had referred to the following:

- CT lumbar spine report dated 29 January 2009
- CT Guided facet joint[14] injection report dated 2 October 2009
- MRI lumbar-sacral spine dated 4 January 2013.

The merit reviewer notes that none of these diagnostic reports were referenced in the Earning Capacity Report , which is presumably the same document as is described as the Earning Capacity Assessment in

[11] Neither the author name (or names), nor the dates nor even the number of such reports are specified.
[12] No author specified.
[13] But see footnote 1 *supra*.
[14] For non-Americans, a reference to the zygapophyseal joint.

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

the letter to the applicant from the Insurer dated 10 April 2013.

It is unexpected that the only report which references such diagnostic aids is from a physiotherapist. How the report of the physiotherapist came into existence is not disclosed, but the Insurer did not have the report when the work capacity decision was made on 10 April 2013. Why the report was obtained after that date is not disclose, but it raises the question of when the work capacity assessment process is thought to end. It is also a breach of the *Guidelines*, which require an Insurer to evaluate "all available and relevant evidence" in the course of making a work capacity decision.[15]

"Evaluation" in this context would go beyond mere reference and would require something greater than an enumeration of the documents by title, date and author. The *Guidelines* do not authorise an insurer to simply say "we have carefully considered your claim" then list a series of documents with no commentary on their contents. In the words of Gummow and Hayne, JJ it is

> not enough for the [decision maker] to say in its final determination that it had considered those matters in the sense of having looked at but discarded them.[16]

In the current context the Insurer has not even purported to evaluate the reports of Dr O, whose name only appears in the Merit Review decision, or the medical providers who created the CT and MRI reports. The report of the physiotherapist could not have been considered since it only came into existence on 20 May 2013 and therefore was unavailable at the time of the original assessment and decision being made on 10 April 2013. The ill-described "Reports from Earning Capacity Assessment" referred to in the same letter were the subject of no further discussion by the Insurer than the description appearing in inverted commas in this

---

[15] See the 11th bullet-point in Guideline 5.1 of *WorkCover Work Capacity Guidelines* gazetted 28 September 2012.

[16] *East Australian Pipeline Pty Ltd v Australian Competition and Consumer Commission* (2007) 233 CLR 229 at 256. For this reference I am indebted to Stephen Free who provided me with a copy his paper, co-authored with Richard Lancaster, SC - *The relevancy grounds in environmental and administrative law* (presented to the NSW Bar Association on 30 October 2013).

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

sentence. To say that they were "evaluated" in any way which was communicated to the applicant would not be correct.

My Reasons:

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

(a) Clause 7.7.2.1 of the *Review Guidelines* gazetted on 28 September 2012 requires an Insurer to give a statement of reasons following internal review which includes:

> findings on material questions of fact, referring to the documents or other material on which those findings were based

The Insurer has found that the applicant is unemployed, has received payments for over 130 weeks and, by virtue of not being employed, has not returned to work for at least 15 hours per weeks on suitable duties earning over $155 per week. They have also found he has some work capacity. The documents on which these findings are based are clearly set out in the letter dated 12 June 2013.

(b) The Insurer did not burden the applicant with "the reasons for the reasoning process" leading to the internal review decision, however the applicant was informed that the decision was based on the grounds in sub-paragraph "(a)" above in light of section 38(1) and (3)(b) and (c).[17]

(c) Ground (c) is very broad, alleging breach of the *Review Guidelines*. The Insurer's response is equally terse. See below for more on this.

(d) The Internal reviewer did not consider the evidence of the physiotherapist Mr W. This is said to be a contravention of clause 7.5 of the *Review Guidelines*. Given that this report was sent to the merit review service by the Insurer, it is hard to see why it was not thought relevant by the insurer in the course of internal review. The Insurer strangely replies that it

[17] While this is true, the Insurer described the legislation as "the 2012 Workers Compensation Act 1998." They used the correct name in submissions to the Independent Review Office.

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

considered all documentation on file and listed the documents that demonstrated the decision made

I said the reply was "strange" since it seems to imply that there is a distinction to be made between (i) those documents on file and (ii) those documents "that demonstrate the decision made." Given that clause 7.5 of the *Review Guidelines* requires a consideration of "all the material" and that clause 5.1 of the *Work Capacity Guidelines* requires an Insurer to evaluate "all available evidence," it is unsurprising that clause 5.4.2 of those same *Guidelines* includes this directive in the fourth bullet point concerning a Notice sent to a worker:

> The **Work Capacity Decision Notice** must:
>
> - outline the evidence considered in making the decision, noting the author, the date and any key information. ***All evidence considered should be referred to***,[18] regardless of whether or not it supports the decision

(e) This ground is simply purports to draw a conclusion based on "(d)" above. The Insurer shortly states that all *Guidelines* "were adhered to." This is clearly not the case.

13. To the extent outlined above the Insurer, in making the original work capacity decision, and in making the subsequent decision following internal review partially complied with the relevant legislation and the *Regulation* and the *Guidelines.* The legislation was relevantly referenced and explained in some places, but not in all; the applicant was given reasons for the decision and was told the title, author and date of various documents[19]; and he was advised of his right to seek further review. But with regard to the decalogue in *Guideline* 5.4.2 and the *Guidelines* generally, there are several breaches which cannot be overlooked:

- *Guideline* 5.4.2 requires the Insurer to explain the "impact of the decision on the worker in terms of their entitlement to weekly payments, entitlement to medical and related treatment expenses

[18] Emphasis added
[19] However parsimonious in number and content

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

and return to work obligations." At no time did the Insurer tell the applicant that his entitlement to medical expenses would be affected by operation of section 59A(2) or (3). To the contrary, the applicant was told in the first letter of 10 April 2013 that he would "still" be "entitled to reasonably necessary medical treatment," whereas in the second letter dated 12 June 2013 he was told that his entitlement to medical benefits would cease on 1 January 2014. There is no basis for the latter statement, since section 59A(2) is in clear terms:

> (2) If weekly payments of compensation are or have been paid or payable to the worker, compensation is not payable under this Division in respect of any treatment, service or assistance given or provided more than 12 months after the worker ceased to be entitled to weekly payments of compensation.

Since the applicant was still to be in receipt of weekly payments until at least 10 July 2013,[20] the date of 1 January 2014 can have no relevance to this claim.

- *Guideline* 5.1 requires an evaluation of "all available and relevant evidence." The report of Dr O was available as at the date of the original decision, but was not referred to in the letter of 10 April 2013. Further, no reference was made to the radiology and other diagnostic reports described in paragraph 11 above.

- In the letter dated 10 April 2013 the applicant is advised that his entitlements to weekly payments will cease three months from the date of that letter, that is to say, on 10 July 2013. This date is repeated in the letter dated 12 June 2013. Both letters therefore breach section 54 of the Act which requires three months notice to be given either in person or by post. If given by post (as in this case) then the postal service rule in the *Interpretation Act* 1987 must be complied with. That rule requires that four working days be allowed for service, without counting weekends or public holidays. Accordingly "notice" given on 10 April 2013 under section 54 by letter could not be valid unless it were to say that payments would continue until 17 July 2013, not 10 July 2013. The postal service rule has

[20] But see commentary on section 54 below.

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

been incorporated into more recent iterations of the *Work Capacity Guidelines.* That it was not in the *Guidelines* at the time is no warrant for the insurer to have breached the legislation.

- On 10 April 2013 the applicant was told his weekly payments would reduce to $NIL, but was also told that he would have “no entitlement” to weekly payments. There is a considerable difference between having an “entitlement” to $NIL and having no entitlement. In the former case section 59A(2) would never be activated, in the second it would after 12 months. The letter of 12 June 2013 refers to a cessation of benefits (without referring to a cessation of entitlement). This is confusing and confounding to an applicant and should be expressed clearly as one thing or the other.

- The letter of 10 April 2013 says that the applicant had been in receipt of compensation for 185 weeks, but in submissions to the Merit Review Service the Insurer changed this to 225 weeks[21] and it follows that only one of these can be correct, since the merit review did not take place 40 weeks after the work capacity decision was made. Either the Insurer was wrong in the letter of 10 April 2013 or the Insurer made inaccurate submissions on merit review.

- The internal review letter of 12 June 2013 refers to something described as Subdivision 3 of the *Workers Compensation Act* 1987. There is more than one “Subdivision 3” in the 1987 Act. The proper section should be referenced to avoid a breach of *Guideline* 5.4.2 which requires the Insurer to reference the legislation. Later in the same letter reference is made to “the 2012 *Workers Compensation Act* 1998” which is a fictitious instrument. This is a clear breach of *Guideline* 5.4.2.

- The internal review letter of 12 June 2013 purports to set out the documents relied upon when making the decision and then goes on to list letters from the applicant’s solicitors together with some but not all of the documents listed in the letter of 10 April 2013. There is no reference to the print-out stating how many weeks the applicant had been paid, which may explain the 185/225 weeks confusion referred to above. The letter does not mention a report of physiotherapist Mr W, despite that

[21] See paragraph 20 of the merit review decision

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

report being dated 20 May 2013 and being made available to the merit reviewer.

- The applicant is told in both letters from the Insurer that he as a capacity to work, the only supporting evidence for this coming from medical certificates saying he can work five hours per day five days per week and from "the reports of Earning Capacity Assessment," copies of which were provided to the applicant. This does not explain the reasoning process of the Insurer, nor does it describe the types of suitable employment duties which the applicant might be able to perform.

14. Under the legislation the Insurer can make an assessment of the applicant's work capacity and then a decision about that work capacity, but they must comply with the legislation, the Regulation and the *Guidelines* in order to produce a procedurally correct result. In the current instance there has been a breach the *Guidelines* which are to be treated as delegated legislation.

My Recommendation:

15. 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 43 is issued and the relevant notice period has expired. The applicant should be reinstated to his pre-work capacity assessment/pre-work capacity decision rate of compensation.

16. I recommend that a further work capacity assessment be undertaken, this time taking into consideration all available evidence and in addition more recent medical evidence currently in the Insurer's possession. A further work capacity decision should then be made in accordance with the legislation, *Regulation* and *Guidelines.*

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

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

Wayne Cooper
Delegate of the WorkCover Independent Review Officer
6 November 2013