WiRO
WorkCover independent review office

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RECOMMENDATION FOLLOWING AN APPLICATION FOR REVIEW OF THE INSURER'S WORK CAPACITY DECISION PURSUANT TO SECTION 44(1)(c) OF THE *WORKERS COMPENSATION ACT* 1987.

1. The injured worker is the applicant for a review of a work capacity decision made by a specialised insurer licensed to operate under the New South Wales workers compensation scheme ("Insurer").

2. The applicant suffered injury to his left shoulder on 11 July 2009 in the course of his employment as a Team Leader with [the employer]. There is no dispute about the injury having occurred in the course of employment.

3. The applicant remains in the same employment, however he is now in a different role with lower wages. Liability was accepted by the Insurer and the applicant was paid for all relevant periods under section 40 of the *Workers Compensation Act* 1987 (1987 Act). Therefore the applicant was a continuing recipient of weekly payments of compensation immediately before 1 October 2012.

4. While the applicant was in receipt of weekly payments of workers compensation the Insurer wrote to him on 8 May 2013 purporting to confirm a telephone conversation of the same date in which it is said that the worker was given an opportunity to provide information to the Insurer to be considered in the course of a proposed review of his work capacity. Specifically he was told:

> In order for us to consider all the available material about your capacity for work, please provide us with any additional information that will assist in the review.[1] Please forward any new information to [the Insurer] within 14 days from the date of this letter.
>
> We note that as per our earlier discussion, the review may lead to a decision that could result in a change to your weekly

[1] "Review" is seemingly used here as a synonymn for "assessment."

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> compensation benefits.[2] Once the review has been completed you will be notified of the work capacity outcome[3] in writing.

5. The Insurer received a letter from the applicant on 17 May 2013 making submissions, but enclosing no new documents. Rather than "submissions" as that term is usually understood by legal practitioners, the applicant appealed to the Insurer to consider his reduced financial position and his family responsibilities when making their decision. He might be thought to be attempting to engage in gentle persuasion, rather than robust, legalistic argument.

6. On 27 May 2013 the Insurer advised the applicant in writing of the work capacity decision. He was advised, *inter alia*, as follows:

> We have conducted a review of your file together with any additional information you may have provided and have assessed you have a capacity to work.[4]

The applicant was also advised of the number of weeks of compensation he had received (54.4 weeks at that time) and that accordingly section 37 would apply to his claim. The algorithm in section 37 was fully set out and explained. Given that the applicant's current weekly earnings exceeded the indexed transitional rate, he was advised that his weekly entitlements would cease as of 12 September 2013. The Insurer thereby fully complied with the notice requirements in section 54.

7. On 19 June 2013 the Insurer received an application for Internal Review. On 17 July 2013 the Insurer wrote to the applicant advising that the Internal reviewer had upheld the original decision.

8. A WorkCover Merit Review was completed and a Statement of Reasons issued on 20 August 2013. The Merit Reviewer upheld the original decision of the insurer. The Merit Reviewer found that the applicant has no entitlement to weekly benefits in accordance with section 37(2)(a).

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[2] No specific reference is made to the possibility of *cessation* of entitlement to weekly benefits.
[3] "Outcome" may refer to the result of the review (or assessment) or it may be a reference to a work capacity decision as defined in section 43 of the 1987 Act. It is not without ambiguity.
[4] A predictable outcome, since he remains working with the same employer where he sustained injury.

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9. On 20 September 2013, the applicant requested the Independent Review Officer to undertake a review of the decision of the Insurer pursuant to Section 44(1)(c) of the 1987 Act. I am satisfied that the applicant has made that application within the time provided by that section.

The Applicant's Stated Grounds for Procedural Review

10. The applicant's grounds for pursuing procedural review might be quoted in full. Speaking in the first person and on his own behalf the applicant made similar submissions to those he made to the Insurer:

> This decision to cease make-up pay is wrong as [I] had healthy earning[s] before my accident. I still have to raise 2 children with plenty of bills to pay. It is not my fault I cannot go back and do my [former] job. It is out of my hands. So at the end of the day I am out of pocket and out of a full[y] functioning shoulder an [in] pain.

Lengthier, but similar, submissions were made to the Merit Review service.

At no stage did the applicant employ the services of a legally trained person to assist. The same cannot be said of the Insurer, which had the benefit of a highly accomplished and very senior legal practitioner who prepared submissions on their behalf.

Submissions by the Insurer

11. The Insurer produced six pages of comprehensive submissions, including a three page chronology which appears to accord with the time-lines evident from the correspondence. It is clear that this Insurer has made more than the usual effort to comply with the legislation, the *Guidelines* and the rules of natural justice. The *Guidelines* are quoted liberally, as is section 54. The Insurer is at pains to emphasize how they have complied with all relevant statutory and other procedural requirements. Where it was not possible to confirm compliance with the non-existent *Best Practice Decision Making Guide*,[5] the Insurer took the

[5] See *WorkCover Work Capacity Guidelines* at 5.1

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trouble to address this want of written guidance by submitting that the available evidence would lead to the conclusion that the Insurer had made an informed, evidence based decision, communicated to the applicant in a transparent, robust-free manner.[6]

In addition to those generalised submissions summarised above, the Insurer made two more, which are unusual.

First, the Insurer submitted that the grounds relied upon by the applicant do not disclose any specific complaint about the procedures adopted by the insurer in making the work capacity decision. The specific wording is as follows:

> [The applicant] is, in effect, seeking further review of the decision of the Merit review Service, which upheld [the Insurer's] work capacity decision, and [this indicates that] he has made no complaint regarding the procedure that [the Insurer] followed in making the work capacity decision.
>
> I therefore submit that there is currently no proper application under section 44(1)(c) before [WIRO] at this time and that the application should be dismissed.

Secondly, the Insurer was bold enough to rely upon a presumed "onus of proof" argument. It was expressed in these terms:

> [The applicant] bears the onus of proving that he has been denied procedural fairness and/or natural justice in relation to the making of the work capacity decision by [the Insurer].
>
> I submit that [the applicant] has not discharged that onus of proof and that his current Application for Review should be dismissed.

[6] "Robust-free" is a term coined by the Insurer. Presumably it comes from *Guideline* 5.1 which says that Insurers should follow "a robust and transparent decision-making process with clear, concise and understandable information provided to the worker giving reasons for decisions." As Dr Samuel Johnson might have put it, in this case the attempt to supply the lack of written guidance was "a task troublesome, without use."

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The Legislative Framework

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

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

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

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

iii. In *Guideline 5.2* a "fair notice provision" sets out the information which must be communicated to a worker "at least two weeks prior to" the work capacity decision.[7] 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:

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

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- inform the worker that a review of their current work capacity is being undertaken and that a work capacity decision is going to be made;
- an explanation that this review may include further discussions with other parties such as their employer, nominated treating doctor or other treatment providers;
- advise the potential outcome of this review and detail the information that has led the insurer to their current position;
- provide an opportunity for the worker to supply any further information to the insurer for further consideration and the date that this information is to be provided by; and
- tell the worker 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 and complex information concerning a workers livelihood over the telephone rather than in writing. Further, in the process of determining whether or not a worker has been afforded procedural fairness, it is impossible for a reviewer to know the adequacy or even the accuracy of any information communicated verbally to a worker by an insurer over the telephone.

iv. In the event of a decision resulting in a variation of the weekly benefits payable to a worker, section 54 requires that the worker be given at least 3 months notice of that proposed variation, which must be notice delivered either in person or by post. I should emphasize here that there is no statutory requirement for a "notice" to be given to a worker of a *decision* under section 43. The notice requirement in section 54 arises from a proposed variation in payments and

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

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

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

Guideline 5.1 says in part:

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

and then goes on to list certain characteristics of what is apparently thought to be "best practice." I advisedly used the word "apparently" in the previous sentence, since it is impossible to check whether or not the items listed in *Guideline 5.1* are "best practice" due to there being in existence no such document as the *Best Practice Decision-Making Guide.*

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

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

Due to the non-existence of the *Best Practice Decision-Making Guide*, I am unable to confirm that the insurer has complied with all relevant *Guidelines* when making its decision. My enquiry is therefore limited to

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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 of the *Guidelines* as may be published and capable of comprehension in the absence of the *Best Practice Decision-Making Guide.*

14. The *Guidelines* which were gazetted on 28 September 2012 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
>
> • 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*.

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> 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 of the word "must" immediately prior to the first bullet point.[8] It would follow that a breach of even a single element of this decalogue similarly 'must' result in invalidity of the notice. This position is fortified by the status of the *Guidelines* as delegated legislation.

Process of the Insurer

15. The decision reached by the Insurer was certainly within the range of available decisions, and may have been inevitable, given the circumstances of the applicant, his current earnings and the transitional rate of weekly earnings to be considered in calculating entitlements under section 37. However, such considerations are of no interest on procedural review where the main relevant consideration is not why a decision is made, but *how* it is made.[9]

16. I am satisfied that the Insurer had regard to relevant medical evidence, including certificates from the applicant's Nominated Treating Doctor and reports from his treating surgeon, a Rehabilitation Closure Report, various payslips and even a statutory declaration from the applicant. I am unaware how many reports or certificates were produced by the doctors, or even the dates of any such documents, since they are listed as "various." This somewhat imprecise listing method appears in both the letter of 27 May 2013 and the letter of 17 July 2013. Of itself, this appears to be a breach of the *Guidelines* which require an insurer to

    - outline the evidence considered in making the decision, noting the author, **the date** and any key information.[10]

My Reasons:

17. The applicant's stated grounds for seeking procedural review do not differ from the grounds he relied upon at earlier stages of review of the

[8] "Must" also qualifies the pentalogue in *Guideline* 5.2.
[9] For a related discussion of the distinction see *Minister for Immigration and Citizenship v Li* (2013) 297 ALR 225 per Gageler, J at 253.
[10] See *Guideline* 5.4.2 – emphasis added.

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work capacity decision, when such reviews were conducted by the Insurer and the Merit Review Service. They do not allege, nor do they disclose, breaches of the *Guidelines*, the legislation or the rules of natural justice. As such, they are irrelevant to the exercise of procedural review and I can have no regard to them. This however is not the end of the road for the applicant, since nowhere in the *Guidelines* or the legislation does any provision appear requiring the applicant to identify grounds of procedural review, which would be a concept understood by lawyers but few others in the community. It is an unrealistic expectation to think that a non-lawyer would be familiar with the distinction to be drawn between broad *ultra vires* and narrow *ultra vires*, or the requirements for the rules of natural justice to be applied, as set down by Lord Reid in *Ridge v Baldwin.*[11] It follows that the submission on behalf of the Insurer that the applicant has "made no complaint" concerning procedure is of no relevance and must fail.

18. The task for a procedural reviewer is to ensure that an insurer has complied with the relevant legislation, *Guidelines* and any rules of natural justice which may apply. This might be an appropriate time to address the submission made on behalf of the Insurer asserting that the applicant bears an onus of proof.[12] Given that the applicant is an injured worker who has continually received weekly benefits since 2009, his entitlement to ongoing benefits can hardly be in dispute, absent the 2012 legislative amendments. In the course of transitioning an existing recipient of weekly payments onto the new system it behoves an insurer to show that it has complied with the relevant statutory provisions and the *Guidelines* and has correctly applied the law to the applicant's individual circumstances. In the event that there is any onus of proof, it would be borne by the Insurer, which stands to obtain a financial advantage at the expense of the applicant and should be put to proof of why the applicant should have his livelihood adversely affected by their decision. It is probably preferable to avoid the concept of an onus or burden of proof in the current circumstances, where all that need be shown is compliance with publicly known legislative provisions and *Guidelines*. The bar is not set high, but it exists.

[11] *Ridge v. Baldwin* (1963) 2 ALL E.R. 66; (1964) A.C. 40
[12] See paragraph 11, page 4 supra.

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19. In addition to the submissions about the nature of the application itself[13] and the onus of proof,[14] the Insurer made lengthy submissions about compliance with the relevant statutory provisions and *Guidelines*. It has to be said that the Insurer took great care to explain every step of the process to the applicant and wrote to him even more often than required by the *Guidelines*. Despite this there are several errors of procedure which, however pettifogging, must result in invalidity for the reason that they constitute breaches of the *Guidelines* or the legislation or both.

- The "fair notice" letter dated 8 May 2013 gave notice that a *review* was to be undertaken, which would have an *outcome*, which could result in *a change* to the applicant's weekly payments. *Guideline* 5.2 says that in insurer *must* "advise the potential outcome of this review and detail the information that has led the insurer to their current position." Nowhere in the letter dated 8 May 2013 is the applicant advised of the potential outcome (termination of his weekly payments) nor is any information referred to which has led the Insurer to their (equally unstated) "current position." In the circumstances it is doubtful that the applicant could have known the gravity of his situation at the time he wrote his letter to the Insurer which they received on 17 May 2013.

- The "fair notice" letter was dated 8 May 2013, and a decision was made on 27 May 2013. While the applicant clearly had 14 days notice[15] of the proposed decision[16] as a result of the telephone conversation with a representative of the Insurer on 8 May 2013, *Guideline* 5.2 does require it to be fair *notice* and therefore the postal service rule in section 76(1)(b) of the *Interpretation Act* 1987 would apply to any such notice delivered by post. Since that requires four clear working days to be added to the date of posting, and since it does not allow for the counting of weekends, it appears that in this case the applicant was only given 13 days notice in writing of the up-coming work capacity decision. 8 May 2013 was a Wednesday, so the fourth clear working day after that date would have been Tuesday 14 May 2013 and the letter

[13] See paragraph 17
[14] See paragraph 18
[15] Such as it was.
[16] Albeit misdescribed as an "outcome."

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outlining the work capacity decision was dated 27 May 2013. Therefore the *Guideline* is breached.

- In the same letter the words “review” and “outcome” are used instead of “assessment” and “decision,” as though they were interchangeable. They are not and the correct wording should be used at all times so that the applicant can understand precisely what is going on. Using the correct wording also assists the applicant in the event that he seeks legal advice.

- The points above highlight the unsatisfactory consequence of the Insurer being encouraged (if not required) by *Guideline* 5.2 to speak to the applicant over the telephone as part of the “fair notice” procedure. There can be no indisputable record of any such conversation and things may be said over the telephone which are omitted in “follow up” correspondence. It is impossible for a reviewer to know what was said by whom.

- In both the letter of 27 May 2013 and the letter of 17 July 2013 the Insurer purports to list “various” certificates and reports from doctors, without giving dates (or even a range of dates) in contravention of *Guideline* 5.4.2.

20. 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 more than one breach of the *Guidelines* which are to be treated as delegated legislation. Accordingly the work capacity decision must be found to be invalid.

My Recommendation:

21. For the reasons set out above I recommend that the Insurer undertake another work capacity assessment and, if it arises, make another work capacity decision, according to the *Guidelines* as gazetted by the Authority and according to the relevant legislation.

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

23. Noting the binding nature of these recommendations[17] I recommend that the Insurer takes my views into account, and I recommend that the Insurer immediately gives effect to them.

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

[17] See section 44(3)(h) of the 1987 Act – recommendations made by the Independent Review Officer are binding on the insurer and the Authority.