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 licensed self-insurer under the New South Wales workers compensation scheme ("Insurer").

2. The applicant suffered injury to his right shoulder before and on 14 July 2006 due to the nature and conditions of his employment as a train guard. There is no dispute about the injury having occurred in the course of his employment.

3. The applicant was retired "medically unfit" by the Insurer (*qua* employer) in 2009. The applicant was told that he would be paid compensation until the age of 66 and on this basis he says that he changed his superannuation arrangements so as to maximise his entitlements. He was paid weekly benefits for all relevant periods and therefore he was a continuing recipient of weekly payments of compensation immediately prior to 1 October 2012.

4. While the applicant was in receipt of weekly payments of workers compensation the Insurer contacted him via telephone on 6 May 2013 advising that they proposed to assess his work capacity and to make a work capacity decision in the near future. The applicant was given an opportunity to provide further "relevant documentation" within 21 days and on 10 May 2013 he wrote to the Insurer making submissions, but not providing any further documentation beyond his own submissions.

5. On 30 May 2013 the Insurer advised the applicant in writing of a work capacity decision which had been made on 29 May 2013. He was advised that his entitlement to ongoing weekly payments of workers compensation would reduce to "$Nil" as of 11 September 2013. He was also told this:

> Your entitlement to benefits for medical or related expenses will continue in accordance with the provisions of the Act.[1]

[1] He was not told *which* "provisions of the Act."

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In the same letter the Insurer noted that they had twice written to the applicant's nominated treating doctor (on 11 and 28 February 2013) seeking his comments on an earnings capacity assessment, but had received no reply. It is therefore slightly surprising that in the list of documents said to constitute "Evidence considered in making the decision" the following entry appears:

- Letters dated 11.02.13 and 28.02.13 addressed to [the applicant's nominated treating doctor].

In the same letter the applicant was advised that he had to apply for internal review "within 30 days of you receiving this notice."[2]

6. On 22 June 2013 the Insurer wrote to the applicant advising that an Internal Reviewer had upheld the original decision. Once again the Insurer listed the following documents, this time under the heading "DOCUMENTS CONSIDERED IN MAKING THE DECISION":

   - Letters dated 11.02.13 and 28.02.13 addressed to [the applicant's nominated treating doctor].

   On this occasion, there was no reference of any kind to the effect this decision would have on the applicant's entitlement to reasonably incurred medical and related treatment expenses.[3]

7. On 5 August 2013 the applicant applied to the WorkCover Authority for a Merit Review of the Insurer's decision. A WorkCover Merit Review was completed and a Statement of Reasons issued on 4 October 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 38 of the 1987 Act.

8. On 16 October 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

[2] This requirement appeared in the first iteration of the *Work Capacity Guidelines* at 6.2.2 and in the *Review Guidelines* at 6.5 and 6.6 and was clearly based on a misunderstanding of section 44(1)(a) of the 1987 Act. The *Guidelines* have since been corrected.
[3] This is a breach of *Work Capacity Guideline* 5.4.2.

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made that application within the time provided by that section and on the correct form.

The Applicant's Stated Grounds for Procedural Review

9. The applicant's grounds for pursuing procedural review are repeated in paraphrase thus:

(i) The applicant was medically retired in 2009 due to coronary disease. At the time he was informed that his self-insured employer would continue to make weekly payments of workers compensation until the age of 66. On this assurance he surrendered his lump sum superannuation entitlements in favour of a defined benefit pension. He would not have made this decision had he been aware that the weekly payments could be terminated.

(ii) Due to his age and his many health problems the applicant believes it is "extremely unlikely" that he could obtain employment.

(iii) It is unfair that no consideration has been given to the medical conditions suffered by the applicant which are unrelated to work. This is particularly unfair since the medical retirement of the applicant in 2009 was based primarily on these very conditions.

Submissions by the Insurer

10. The Insurer made no submissions in reply to the application for procedural review.

Legislation

11. Section 44(1)(c) of the 1987 Act limits the range of procedural review to a review:

> only of the insurer's procedures in making the work capacity decision and not of any judg[e]ment or discretion exercised by the insurer in making the decision.[4]

Therefore while it remains the case that no discretion is unreviewable,[5]

[4] Judgement is misspelt in the Act as "judgment."

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in this case the Insurer's discretion appears only to be reviewable in the course of merit review or Judicial review. The procedures to be followed by the Insurer are set out in *WorkCover Work Capacity Guidelines* and *WorkCover Review Guidelines*.[6] Both sets of *Guidelines* are said to be delegated legislation and therefore must be complied with in order for a work capacity decision to be validly made. Given the overall beneficial nature of the 1987 Act and the serious consequences to workers if decisions are made incorrectly, strict compliance with the Guidelines is required.

Process of the Insurer

12. The decision reached by the Insurer was certainly within the range of available decisions, and was upheld by the merit review service. The applicant has been paid for more than 130 weeks, and has retired from work. Being an existing recipient of weekly payments immediately prior to 1 October 2012, the applicant is subject to the transitional rate in Schedule 6, Part 19H, clause 2 of the 1987 Act. 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.[7]

The Insurer had medically retired the applicant more than four years ago and had in its possession a recent work capacity certificate from the applicant's nominated treating doctor certifying him fit for only 12 hours per week of suitable duties. Since the applicant had received weekly payments for more than 200 weeks it was unlikely that the applicant could on any basis qualify for continuing payments under section 38. Despite this, the Insurer proceeded to make a decision in a way which was contrary to the *Guidelines* and therefore invalid.

My Reasons:

13. The applicant's stated grounds for seeking procedural review can be dealt with using the numbering in paragraph 9 (i)-(iii) above:

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[5] See *Padfield v Minister of Agriculture, Fisheries and Food.* [1968] AC 997
[6] A short-hand name for *Guidelines for Work Capacity Decision Internal Reviews by Insurers and Merit Reviews by the Authority.*
[7] For a related discussion of the distinction see *Minister for Immigration and Citizenship v Li* (2013) 297 ALR 225 per Gageler, J at 253.

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(i) My only power is to review the procedures of the insurer in making the work capacity decision and does not extend to an examination of any potential equitable remedies the applicant might be able to seek against his former employer on the basis of representations which may have induced him to act to his detriment.

(ii) The likelihood of the applicant being able to find suitable employment is likewise an irrelevant consideration in the course of procedural review.

(iii) It is clear that the self-insured employer, while acting as the employer, was happy to certify the applicant as medically unfit to continue in employment in 2009, whereas in the course of the work capacity decision the same self-insured employer saw no problem with asserting that the applicant was fit to work for 38 hours per week in suitable employment. On that basis it is easy to see the point the applicant is trying to make, namely that it suited the employer to get him off the books in 2009 by finding him medically unfit for work, and it now suits the employer (while acting in the guise of Insurer) in getting him off their books again by this time saying he can work. However inequitable this may be, it is a consideration which goes to the merits of the case rather than to the procedure and accordingly I can have no regard to it.

None of the grounds specified by the applicant would suffice to overturn the Insurer's work capacity decision.

14. The Insurer made no submissions about compliance with the relevant statutory provisions and *Guidelines*.

15. There are in my view several breaches of the *Guidelines* which either individually or taken together are sufficient to invalidate the work capacity decision made by the Insurer.

- *Guideline* 5.4.2 of the *Work Capacity Guidelines*[8] requires the Insurer to "reference the relevant legislation." It is not sufficient to say (as the Insurer did in this case) that a worker's entitlements will continue "in

[8] A gazetted 28 September 2012.

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accordance with the provisions of the Act"[9] without stating which provisions are thought to be relevant.

- The same *Guideline* requires and Insurer to:

  > 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.

  It is clear that the impact on the applicant's ongoing entitlement to medical and related treatment expenses was never explained by the Insurer. The glancing reference made in the letter advising of the work capacity decision was followed up by no reference to these entitlements in the letter advising the outcome of Internal Review.

- *Guideline* 5.1 requires the Insurer to list all relevant evidence considered in the making of a work capacity decision. In the current instance the Insurer purported to rely on two letters it wrote to the applicant's nominated treating doctor, neither of which received a reply. These were listed as relevant documents in both the letter advising of the work capacity decision and the letter advising the outcome of Internal review. It is hard to see the probative value of such documents and in my view they cannot be relied upon by an Insurer as proof of anything. Accordingly it is a breach of *Guideline* 5.1 for an Insurer to purport to rely on such self-created documents.

16. 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:

17. For the reasons set out above I recommend that the Insurer undertake

[9] This was the wording used in the letter advising of the work capacity decision.

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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.

18. Since the applicant was an existing recipient as at 1 October 2012, he remains entitled to receive his pre-transition rate of weekly benefits until such time as he is validly transitioned under the Act. This cannot happen until a valid notice under section 54 is issued. 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.

19. Because the review process does not operate as a stay of the original decision, the applicant has not received weekly payments since 11 September 2013. Therefore it cannot be said that he "is receiving" compensation. This means that clause 21 of schedule 8 to the *Workers Compensation Regulation* 2010 cannot apply. It follows that he may be restored to the correct pre-transition amount forthwith, since there is no need for the effluxion of any notice period.[10]

20. Noting the binding nature of these recommendations[11] 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
2 December 2013

[10] To the extent that clause 21 of schedule 8 of the *Regulation* conflicts with both section 9 ("A worker ... shall receive compensation") and section 38(2) ("A worker ... is entitled to compensation"), it is *ultra vires*.
[11] See section 44(3)(h) of the 1987 Act – recommendations made by the Independent Review Officer are binding on the insurer and the Authority.