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

2. The applicant suffered injury to his left foot on or about 16 November 2004 while working as a truck driver. There is no dispute about the injury having occurred in the course of employment.

3. The applicant resumed work and currently works as a taxi driver for more than 15 hours per week and earning approximately $200 per week. He was paid weekly benefits for all relevant periods and therefore was an existing recipient of weekly payments of compensation immediately prior to 1 October 2012.

4. On 31 May 2013 the Insurer advised the applicant in writing of a work capacity decision which had been made on that date. He was advised that his entitlement to ongoing weekly payments of workers compensation would be terminated since he was found to have no entitlement under section 38 of the *Workers Compensation Act* 1987 (1987 Act). He was told the following things:

   - Based on the number of weekly benefits paid to the applicant[1] his claim fell within the "Special Requirements Entitlement Period"[2] in section 38

   - In accordance with section 38 of the Act the weekly entitlement was calculated using this formula:

     (Transitional Rate x 80%) – (Earnings + Deductions) = Entitlement.
   - The following information was used to calculate the "actual benefit"[3]

[1] The number of weeks was not specified.
[2] This expression was not otherwise explained.
[3] A term which does not appear in the legislation or *Guidelines*.

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(a) You are currently engaged in suitable employment for 38 hours/week, average earnings your actual weekly earnings are $193.55.[4]

(b) Labour Market Research/Current Job Report completed on 31/5/2013 which reported, based on current pay rates in the open labour market, earnings for this occupation are considered to be $811.66 (gross) based on 38 hours per week. Based on the above assessment we have calculated your weekly entitlement as follows:

($938.30 x 80%) – ($811.66) = $0.[5]

5. In addition to what appears above, the applicant was given the following further insight into the decision-making processes of the insurer:

> **What legislation and guidelines were used to make the decision?**
>
> We considered the meaning of **current work capacity** and **suitable employment** under section 32A of the Act.[6]

We determined your weekly entitlements based on the following section/s of the Act:

a) s 35 Factors to determine rate of weekly payments.[7]

b) s 38 Special requirements for continuation of weekly payments after the second entitlement period (after 130 weeks).[8]

In making our determination we have also complied with the WorkCover work capacity guidelines.[9]

The Insurer then enumerated the various reports and other documents on which it relied in making the decision, including one report dated 31

[4] *Sic.* This was the "actual" wording used.
[5] This despite the "actual" figures being ($938.30 x 80% i.e. $750.64) – ($193.55) = $557.09. No explanation was given for using the $811.66 figure in preference to $193.55.
[6] Without telling the applicant what the Insurer believes these terms to mean, or how they apply to his case.
[7] No "factors" are identified, nor is section 35 otherwise explained.
[8] No reference is made to the first entitlement period or to the length of any entitlement period beyond what appears in this sentence.
[9] See below.

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May 2013, being the very date of the letter advising the applicant of the work capacity decision. That report was called "Labour Market Research" and included three estimates (all different) of the average earnings of a taxi driver, all based in Sydney. The estimated earnings from two companies ranged between $150 - $200 per day, but there is no reference to hours worked. A third company said a driver might earn "$20 per hour for a day shift," again without specifying the hours required in a day shift. Despite the report writer stating that the earnings would be averaged out at $811.66 per week "for a 38 hour week" not one of the companies is quoted as saying that their drivers could or would work a 38 hour week.

No attempt was made to enquire as to the average earnings of a taxi driver in the Central Coast, where the applicant lives and currently works as a taxi driver, nor was any effort made to ascertain the average shift length, either in the Central Coast or in Sydney.[10]

6. On 17 July 2013 the Insurer wrote to the applicant advising that an Internal Review had upheld the original decision. In this letter the Insurer reiterated the sections of the Act on which it relied and made more of an effort to explain the medical evidence in the case and how it affected their decision. For unexplained reasons they substituted the role of a mini-bus driver for the role of a taxi driver as "suitable employment," relying on a report from 2012. The average weekly earnings of a mini-bus driver were said to be $859.18, being more than $40 above the supposedly average hours of a taxi driver working a 38 hour week. While the letter referenced a report of 2012, the column in the letter setting out the documents and "key information" relied upon included this:

   - Other (type of document). Author: Compensation Assistance Services. Date – 09/07/2013.[11] Key information: Labour market report. Average earnings for a mini bus driver over the age of 45 in Australia is $1,054. A role as a mini bus driver with Strathfield Council working 38 hours per week (currently advertised) pays $859.18 per week.

[10] See *Work Capacity Guideline* 2.4 which requires an insurer to tailor a work capacity decision to the worker.
[11] That is, the report post-dates the original work capacity decision by more than five weeks.

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Despite being based on new evidence, the Insurer purported to uphold the original decision. They described it as "a new decision" but (in a letter dated 17 July 2013) confirmed that the applicant's entitlement to weekly payments would cease "from 7/09/2013."[12] This at least partially explains paragraph 7, *infra*.

7. On 19 August 2013 the Insurer wrote to the applicant once again, this time to extend the notice period wrongly quoted in the earlier letters. The Insurer said that the reason for the letter was "that you were not provided with the appropriate notice period. As such your period of three months and one week starts from the date of this letter."[13] In this letter the notice period was said to expire on 26 November 2013. It is therefore assumed that the applicant continued to be paid his pre-transition rate of weekly benefits ($250.00 per week) until that date.

8. Interestingly (in light of paragraph 7, *supra*) the applicant had applied to the WorkCover Authority for a Merit Review of the Insurer's decision on 28 July 2013. The Insurer had filed a Reply to that application with the Merit Review Service on 12 August 2013. A WorkCover Merit Review was completed and a Statement of Reasons issued on 27 September 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(7)(a) of the 1987 Act.

9. On 14 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 made that application within the time provided by that section and on the correct form.

## The Applicant's Stated Grounds for Procedural Review

10. The applicant's grounds for pursuing procedural review are as follows:

[12] See s 54(2)(a), *contra*.
[13] Between 9 August 2013 and 7 October 2013 the correct notice period according to *WorkCover Work Capacity Guidelines* was the three months in section 54(2)(a), plus one week for postage (see *Work Capacity Guideline* 6). Since 8 October 2013 they have specified 4 days rather than one week. This conflicts with section 76(1)(b) of the *Interpretation Act* 1987 which says that service is taken to have been effected on the fourth ***working day*** after the letter was posted, thereby exempting weekends and holidays from the days counted.

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(i) The figures used by the Insurer for a taxi driver are inaccurate since they base the figures on a 5 day, 38 hour week. All taxi drivers work 10 or 12 hour shifts, with a normal week being 5 x 12 hours to a total of 60 hours per week. He would have no prospect of doing those hours, given his physical limitations.

(ii) The applicant's taxi licence only applies to the Central Coast. Working in Sydney would require a 3 or 4 hour commute each day plus working 12 hour shifts, which would mean a 15-16 hour working day. He is certain that even WorkCover would agree that this would pose an unacceptable risk of injury both to himself and to his passengers.[14]

(iii) The applicant says that the Insurer changed its position at Internal Review to base their decision on possible earnings as a mini-bus driver, contrary to the evidence. He goes on to observe that the only time he had ever driven a mini-bus was "intermittently on a manual vehicle, on a voluntary basis" prior to his in jury when he was "fitter, thinner and more agile."

(iv) The amount of $250 per week paid from 27 April 2010 (when the applicant commenced driving taxis) was supposed to offset part of the salary reduction suffered by the applicant, who had earned in excess of $1,200 weekly prior to his injury. He says he has no prospect of earning that amount now.

**Submissions by the Insurer**

11. The Insurer made no submissions in response to the application.

**Legislation**

12. Section 44(1)(c) of the 1987 Act limits the scope of procedural review to a review only of:

[14] No mention is made of the risk posed to other road users, although this might be inherent in the submission.

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> 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.[15]

Therefore while it remains the case that no discretion is unreviewable,[16] the Insurer's discretion when making a work capacity decision 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*.[17] 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**

13. 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 therefore section 38 is the applicable section of the Act to calculate entitlement. 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.[18]

**My Reasons:**

14. The applicant's stated grounds for seeking procedural review can be dealt with using the numbering in paragraph 10 (i)-(iv) above:

[15] Judgement is misspelt in the Act as "judgment."
[16] See *Padfield v Minister of Agriculture, Fisheries and Food.* [1968] AC 997
[17] A short-hand name for *Guidelines for Work Capacity Decision Internal Reviews by Insurers and Merit Reviews by the Authority.*
[18] 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) The hours typically worked by taxi drivers might go to the merits of the case but they are not a relevant consideration for procedural review.

(ii) The obvious risks posed to the community by having an injured taxi driver or mini-bus driver on the road for extended hours, while concerning, do not constitute relevant considerations for procedural review.

(iii) The change by the Insurer between the original work capacity decision where reliance was placed on the average weekly earnings of taxi drivers, and the Internal Review where the average weekly earnings of mini-bus drivers were relied upon does raise a substantial question of procedure, not least because it calls into question whether the assessment process had truly ended as at the date of the work capacity decision (31 May 2013). It is clear that the applicant had no opportunity to make submissions in reply to any report which was dated the same day as the original work capacity decision, or to a report enclosed with the Internal Review letter and which post-dated the work capacity decision by more than five weeks.

(iv) The potential earnings of the applicant are not grounds for procedural review.

Grounds (i), (ii) and (iv) are all relevant to merit review, but cannot be considered for present purposes.

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

Since procedural review requires a scrutiny of the decision-making processes of the Insurer, including an examination of compliance with legislation and *Guidelines*, rather than a consideration of submissions made by either party, the review process may proceed despite the absence of relevant submissions.

16. 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.

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- The work capacity decision letter of 31 May 2013 did not advise the applicant of the number of weeks of weekly payments he had received.

- The expression "Special Requirements Entitlement Period" was used in connexion with a reference to section 38, with no attempt made to explain what this term means. The capitalised words in inverted comas operate to some extent like a snowclone, purporting to convey information while at the same time conveying nothing.

- The work capacity decision letter did not explain why the applicant's current weekly earnings ($193.55) were not used in the calculation of his entitlement, rather than the amount of $811.66 (a figure arrived at in unusual circumstances).[19]

- The words "Transitional Rate" were used with no attempt made to define the term or explain why it applied in this case.

- Section 32A and section 35 were both referred to, but not explained. The Insurer assured the applicant that they had "considered the meaning of"[20] terms appearing in section 32A, without giving the applicant the benefit of their views on what those meanings were. The relevant terms were "current work capacity" and "suitable employment," the understanding of which is a fundamental requirement for anyone trying to come to grips with the concept of a work capacity decision.

- The Insurer's attention to detail was questionable. For instance, in the letter dated 31 May 2013 the applicant was told: "You are 55 years of age." On 17 July 2013 he was told: "You are 60 years of age." Somewhat confusingly, the Merit Reviewer described the applicant as being 59 years old.[21]

- The work capacity decision letter was accompanied by a report of the same date, which purported to show the average weekly earnings of

[19] See footnote 5 *supra*.
[20] This phrase is a paradigm example of a snowclone, referred to *supra.*
[21] Perhaps the WorkCover forms for workers seeking internal, merit and/or procedural review could include a box for "date of birth."

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a taxi driver working 38 hours per week. It is trite to say that the applicant could have had no prospect of making any submissions in respect to this prior to a decision being made.

- When advising the applicant of the outcome of internal review the Insurer enclosed a copy of another report, which post-dated the work capacity decision, this time purporting to show the average weekly earnings of a mini-bus driver. Again, the applicant had no prospect of making any contribution to the decision-making process in relation to the earnings of mini-bus drivers prior to the decision being made.

- The only references to medical and related treatment expenses appearing in the correspondence say that the applicant is "entitled to claim medical and other treatment expenses until 12 months after weekly payments cease." There is no reference to the relevant legislative provision (section 59A(2)), nor is there any suggestion that the applicant might be able to claim medical expenses during the course of any further incapacity (see section 59A(3)).

Each of these bullet points is a breach of the *Work Capacity Guidelines*. Those *Guidelines* require the Insurer to reference the legislation, explain the relevant entitlement periods and give the worker an opportunity to "contribute additional information" – see *Guidelines* 5.4.2 and 5.1. There is nothing in the *Guidelines* which allows an Insurer to obtain new information in its own interests in the course of internal review. *Guideline* 2.4 requires the decision to be "tailored to the worker" – hard to do when the Insurer does not even know the applicant's age. *Guideline* 5.4.2 also requires the 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." On any view of it, the impact of the decision on weekly payments and medical expenses has not been clearly and fully explained.

The Insurer did not advise the date of the work capacity assessment. Schedule 6, part 19H, clause 9 of the 1987 Act says that the weekly payment statutory amendments of 2012 apply to the weekly payments of a worker three months after an Insurer first conducts a work capacity assessment. Clause 22 of Schedule 8 of the *Workers Compensation Regulation* 2010 provides that the relevant date is three months after a

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decision "arising from the first work capacity assessment." Either way, the date of assessment is relevant and this applicant was not advised of it. This is at least a breach of procedural fairness, and after 8 October 2013 when the *Guidelines* were updated, it would constitute a breach of *Guideline* 5.3.2.[22]

17. 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:**

18. 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.

19. 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.

20. Because the review process does not operate as a stay of the original decision, the applicant has not received weekly payments since 26 November 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 and back-dated to

[22] As the former *Guideline* 5.4.2 has been re-numbered

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26 November 2013, since there is no need for the effluxion of any notice period.[23]

21. Noting the binding nature of these recommendations[24] 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
10 December 2013

[23] 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*.
[24] See section 44(3)(h) of the 1987 Act – recommendations made by the Independent Review Officer are binding on the insurer and the Authority.