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 (the applicant) seeks procedural review of a work capacity decision made by a licensed scheme agent of the Workers Compensation Nominal Insurer (the Insurer).

2. The applicant was employed as a vehicle inspector and suffered injury to his back and left wrist on or about 5 November 1999. There is no dispute about the injury having occurred in the course of employment. He returned to work on suitable duties but these were withdrawn by the employer in 2006 and he has not been employed since that time. The Insure paid weekly benefits for all relevant periods and therefore the applicant was an existing recipient of weekly payments of compensation immediately prior to 1 October 2012.

3. On 8 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:

- The relevant entitlement periods in the legislation were clearly and correctly explained.

- It was noted that the applicant does not currently work and has received weekly payments for considerably longer than 130 weeks.[1]

- "As a result of your work capacity assessment, a decision has been made that you are no longer entitled to weekly payments under the new section 38 of the Workers Compensaiton Act 1987."[2]

[1] 379.2 weeks, to be precise.
[2] No date or range of dates was given for any "assessment" - Cf: *Workers Compensation Regulation* 2010, schedule 8, clauses 22-23 and 1987 Act, schedule 6, Part 19H, clauses 6 and 9.

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- "Any entitlement you may have to payment of pre-approved reasonable and necessary medical and other expenses, until 15 August 2014, will not be affected."[3]

- "Your entitlement to weekly payments at your current rate must cease within three months of this decision – please refer to section 54(2)(a)."[4]

4. On 5 July 2013 the Insurer wrote to the applicant advising that an Internal Review had upheld the original decision. This letter made no reference whatsoever to the effect of the decision on medical benefits, did not refer to any date of assessment and (a point in its favour) avoided repeating the error of misrepresenting section 54(2)(a).

5. The applicant applied to the WorkCover Authority for a Merit Review of the Insurer's decision on 3 August 2013 and in a recommendation dated 9 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.

6. On 23 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

7. The applicant's grounds for pursuing procedural review are:

(i) One of the reports relied on by the Insurer in reaching its decision wrongly named another person instead of the applicant. The applicant understandably has little faith in the accuracy of this report and believes it may have prejudicially influenced other providers who have (he says wrongly) concluded that he has work capacity.

[3] A classic example of antenantiosis, where a proposition appears in the negation of its opposite.
[4] Precisely the opposite of what the section says.

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(ii) The Insurer arranged no training, even though this was recommended by a doctor retained by the Insurer.

(iii) The merit reviewer incorrectly described the requirements of a job for which it was thought the applicant had work capacity.

(iv) The applicant's "transferable skills" in valuation are neither recognised noir mentioned in the merit review decision.

Submissions by the Insurer

8. The Insurer made the following submissions in response to the application.

> We refer to [the applicant's] application for procedural review and provide our submissions as follows:
>
> 1. The grounds for seeking a review as stated by [the applicant] in the Application for Review of Work Capacity Decision ("the form") dated 23 October 2013 are dealing with the merits of decision rather than any procedural errors identified. Therefore the grounds as stated by [the applicant] fall outside of the procedural review by WIRO.
>
> 2. In any event in the response to [the applicant's] submissions the Insurer submits that irrespective of his view of the assessment conducted by Ms J, there is nevertheless enough evidence to rely on to come to the same conclusion that [the applicant] has current work capacity even without the mentioned report.
>
> 3. *The Workers Compensation Act 1987* s 44(2) states (emphasis added):
>
> - **An application for review of a work capacity decision must be made in the form approved by the Authority** and specify the grounds on which the review is sought. **The worker must notify the insurer in a form approved by the Authority** of an application made by the worker for review by the Authority or the Independent Review Officer.
>
> To date, there is no form approved by the Authority for an

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> application for review of a work capacity decision by the WorkCover Independent Review Officer ("WIRO").
>
> Therefore, the Insurer submits that it has not received the required legislative notice of the review and [the applicant] has not made an application for internal review.

Legislation

9. Section 44(1)(c) of the 1987 Act limits the scope 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.[5]

Therefore while it remains the case that no discretion is unreviewable,[6] 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*.[7] 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

10. 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

[5] Judgement is misspelt in the Act as "judgment."
[6] See *Padfield v Minister of Agriculture, Fisheries and Food.* [1968] AC 997
[7] A short-hand name for *Guidelines for Work Capacity Decision Internal Reviews by Insurers and Merit Reviews by the Authority.*

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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.[8]

My Reasons:

11. The applicant's stated grounds for seeking procedural review can be dealt with shortly.

While the erroneous naming of another person (rather than the applicant) in a report is a sign of a lack of attention to detail and poor proof-reading and is highly regrettable, it does not of itself invalidate the entire assessment and decision-making process. The Insurer is entitled to consider a variety of reports, with no single report being conclusive.

The remainder of the issues raised by the applicant go to the merits of the case and are not appropriate for procedural review.

12. The grounds of the Insurer can be addressed as follows:

(i) The Insurer is correct to characterize the majority of the applicant's submissions as non-procedural and therefore irrelevant.

(ii) The Insurer is also correct to say that the report of the provider which used the incorrect name is not fatal to the assessment process, due to the existence of other evidence which was sufficient to ground an assessment and decision.

(iii) The Insurer is incorrect to assert that "to date there is no form approved by the Authority for an application for review of a work capacity decision by [WIRO]." This is obvious due to their own first submission which referred to the shortcomings of the applicant's grounds for review as set out on ***the form*** dated 23 October 2013.

(iv) The Insurer enters nonsensical territory with its final submission that "therefore [it] has not received the required legislative notice of the

[8] For a related and recent 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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review and [the applicant] has not made an application for Internal Review." This would be news to the person employed by the Insurer who purported to conduct an internal review on 5 July 2013.

13. 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 from either party. Any demonstrable error[9] on the part of the Insurer may invalidate the decision.

14. 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.

- The work capacity decision letter made no reference to the true impact of the decision on the applicant's entitlement to medical and related treatment expenses. The only reference was a statement ostensibly seeking to reassure the applicant that his entitlements would remain unaffected until a date in 2014. This is did not say that the effect of the decision is that 12 months after the last payment of weekly benefits, the entitlement to medical benefits would automatically come to an end under section 59A(2). Similarly there was no reference to section 59A(3).

- The same can be said of the letter advising the outcome of internal review, which made no reference to medical benefits.

- Neither letter referred to section 59A(2) and (3).

- Collectively this constitutes four errors on the part of the Insurer, since each instance of failure to explain the impact of the decision and reference the legislation is duplicated.

- The description of the effect of section 54(2)(a) in the first letter is a complete misrepresentation of the notice provision, and incorrectly

[9] For a recent examination of "demonstrable error" see *New South Wales Police Force v Registrar of the Workers Compensation Commission of New South Wales* [2013] NSWSC 1792 (11 December 2013) at paragraphs 39-56.

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states that payments must cease "within 3 months" of the work capacity decision, whereas the true effect of the section is to say that the payments ***may not cease*** until three months have elapsed following the provision of notice. That is, the Insurer has styled the section as a maximum payment provision, rather than a minimum notice provision.

- This was compounded by no mention being made of section 54 in the letter advising the outcome of Internal Review. It is therefore another duplicated error.

- The relevant *Guideline* is 5.4.2 which requires the Insurer to:

    - Reference the relevant legislation

    - 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.

- There is no indication of the date on which the assessment was conducted. While this was not a requirement of the *Guidelines* at the date of the work capacity decision, it has subsequently been added to the 8 October 2013 iteration.[10] Despite this it constitutes an unfairness to the applicant, since the Insurer is required to make a decision "as soon as practicable" after a work capacity assessment[11] and absent being told of the date of assessment the applicant cannot know whether or not this has been done.

15. 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.

[10] In the *Guidelines* gazetted on 8 October 2013 such an omission would be a breach of the dodecalogue now appearing in the newly numbered *Guideline* 5.4.3.

[11] See cl 23, schedule 8 of the *Regulation*.

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Immediacy of Entitlement

16. A worker who has satisfied the provisions of the 1987 Act has an immediate entitlement to compensation. In *Speirs v Industrial Relations Commission (NSW)* (2011) 81 NSWLR 348 Giles, JA (Allsop, P and Hodgson JA agreeing) reviewed the various references to entitlement in the 1987 Act and arrived at the following conclusion [at paragraph 85]:

> [I]n my opinion 'entitled to' in the definition in s 240(2) of the [1987 Act] does not mean entitlement established by a determination of the Workers Compensation Commission or the District Court, or by decision of the Board. The entitlement is **a right subsisting in law** when there has been injury satisfying s 4 and s 9A of the [1987 Act]. It may be recognised and given effect without tribunal or court determinations, as will commonly be the case.

Since the immediate entitlement to compensation is a right subsisting in law, it is hard to see on what basis clause 21 of Schedule 8 to the *Workers Compensation Regulation* 2010 presumes to impose a three month "notice period" prior to a worker receiving an increase in payments to which they would otherwise be immediately entitled. By "otherwise" I mean that anyone other than an existing recipient is entitled to an increase in benefits without the preclusion period in clause 21. I note also that section 33 of the 1987 Act requires compensation to be paid "during the incapacity" rather than at some later date. There is no Henry VIII clause making reference to an amendment to section 33 of the 1987 Act and it follows that clause 21 must be *ultra vires* to the extent that it conflicts with the section.

My Recommendation:

17. 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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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 15 August 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 the date when the last payment was made, since there is no need for the effluxion of any notice period.[12]

20. Noting the binding nature of these recommendations[13] 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
18 December 2013

[12] To the extent that clause 21 of schedule 8 of the *Regulation* conflicts with section 9 ("A worker ... shall receive compensation") section 33 ("compensation... shall include a weekly payment ***during the incapacity***") and section 38(2) ("A worker ... is entitled to compensation"), it is *ultra vires*.
[13] See section 44(3)(h) of the 1987 Act – recommendations made by the Independent Review Officer are binding on the insurer and the Authority.