Submission No 61

FIRST REVIEW OF THE WORKERS COMPENSATION SCHEME

Organisation: CFMEU

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1. Introduction

The Construction, Forestry, Mining and Energy Union (**CFMEU**) welcomes the opportunity to make a submission to this inquiry. In addition to these submissions the CFMEU supports the submissions filed by Unions NSW.

The CFMEU represents approximately 16,000 members in the building and construction industry. The industry is characterised by heavy manual work, with workers working long hours, generally six days per week and in some cases far from home or in difficult environments. The safety and wellbeing of our members is our primary concern. The CFMEU is extremely committed to ensuring that where possible our members are working in safe environments. Despite the CFMEU efforts to ensure safety, accidents still happen and people can still get hurt.

The work of our CFMEU members is hazardous and high risk. Our members regularly face the risks and consequences that inevitably come their way as a result of:

1. working at heights or in confined spaces or with electricity and gas;
2. operating or being near heavy moving plant and equipment;
3. exposure to fumes, asbestos and other highly toxic materials; and
4. the grind of heavy and repetitive manual work year after year.

When our CFMEU members are hurt at work they typically suffer serious physical injuries, which often result in workers having to leave the industry and losing their trade or occupation of many years. Above all, it often results in a worker losing some or all of their ability to earn a living and the dignity this provides him or her in being able to look after themselves and their family.

A large proportion of our members are workers who come from non-English speaking backgrounds with little or no education beyond the age of 15. A huge proportion of our workers have very few transferable skills and qualifications outside their industry. More often than not, once these workers are injured they cannot secure alternative employment because they lack the ability to read and write in English. Many of our members can testify that if all you have done since coming to Australia is work for

decades on construction sites doing concrete pours or demolition or formwork and then one day you suddenly find you cannot do this work, it is no easy task making a new life when the best years of your working life are already behind you.

1.1 Construction Industry Profile

The construction industry employs 9% of the workforce, an increase of approximately 37% over the last decade.[1] NSW alone recorded a 12% increase in construction workers in this period.

Nationwide the construction industry records 12, 600 serious claims per year. A work related survey for the year 2009-10 found 156 construction workers are injured every day representing approximately 5.9% of all construction workers.[2] The construction industry has the highest proportion of lost time injuries compared to other industries. The proportion of injured workers who had not returned to work following injury was four times that of all other industries.[3] These figures indicate that injuries suffered by construction workers are likely to be more severe.

Safe Work Australia statistics show that 42% of all claims in the construction industry involved traumatic joint/ligament and muscle/tendon injuries, most being for musculoskeletal and connective tissue injuries, accounting for 13% of all serious claims. Lower back injuries account for 15% of all claims. Interestingly the statistics show that mental stress injuries have the highest median time off work at 17.2 weeks off work.[4] Back injuries are the most common in both 35-54 and 55 and over age groups, accounting for more serious claims than any other part of the body.[5]

The sad truth about these statistics is that while these types of injuries represent a lifelong disability the chances of these workers being declared a "worker with high needs" or a "worker with the highest needs" are very slim. In many cases, these injuries are unlikely to reach the threshold for lump sum compensation or meet the requirements to receive medical benefits beyond 2 years after weekly benefits cease.

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[1] Safe Work Australia 'Work-related injuries and fatalities in construction in Australia 2003-2013', June 2015.
[2] Ibid.
[3] Ibid 28.
[4] Ibid 35.
[5] Construction Industry Profile, Safe Work Australia

1.2 A Fair, Just and Effective Workers Compensation System

A fair, just and effective workers compensation system must have a guiding set of principles. The CFMEU submits that the NSW workers compensation system should be based on the following set of principles:

1. Workers compensation should be available on a no-fault basis where an injury "arises out of or in the course of employment", even where it is the aggravation of an existing injury or disease.

2. Premiums must recover the costs of the system as well as encourage safe work practices.

3. The regulator must be properly resourced to carry out its functions properly including an increased emphasis on prevention and compliance.

4. Meaningful tripartite consultation must be a central part of the system.

5. The system of scheme agents and self-insurers should be abolished and all workers compensation functions should be internalised within an appropriate government entity.

6. Trade unions must have the power to enforce non-compliance with workers compensation law together with rights of entry, inspection and other investigative powers.

7. The Workers Compensation Commission should provide a quick, easy, effective and legally binding mechanism to resolve disputes about all aspects of the workers compensation system.

8. Return to work should be elevated as a central tenant of workers compensation by:

   8.1. placing an absolute obligation on employers to provide suitable duties;

   8.2. preventing termination unless the injury management plan states that the return to work goal is a different job and a different employer; and

   8.3. incentivising the employment of injured workers.

9. Journey claims and recess claims should be covered by the system.

10. Weekly payments should be set at a level equivalent to an injured worker's pre-injury average weekly earnings irrespective of their fitness for work and should not be subject to any caps or step-downs.

11. Costs associated with medical and all related treatment should be covered for workers compensation purposes with no arbitrary caps or limits.

12. Work Capacity Reviews and Decisions should be removed from the workers compensation legislation. Consideration of a worker's functionality is properly addressed as part of their rehabilitation plan.

Currently the workers compensation system is overly complex, inaccessible, unjust and unfair towards injured workers, confusing and uncertain.

2. Background

Since the 2012 announcement by the then O'Farrell government to introduce amendments to the workers compensation system, there have been several inquiries into the impact of the amendments on injured workers. Additionally, SIRA has issued several discussion papers on specific issues since the announcement of the *Workers Compensation Amendment Act 2015* (**Amending Act**). The CFMEU has made submissions in connection with the following:

1. Joint Select Committee on the NSW Workers Compensation Scheme 2012
2. Review of the exercise of the functions of the WorkCover Authority – Legislative Council Standing Committee on Law and Justice
3. Statutory review of the Workers Compensation Legislation Amendment Act 2012 – The Centre for International Economics
4. Parkes Project – WIRO
5. Return to Work Assistance Discussion Paper – SIRA
6. Claiming compensation Guidelines – SIRA
7. Regulation of legal costs for work capacity decisions Discussion Paper – SIRA
8. Regulation of pre-injury average weekly earnings Discussion Paper – SIRA

Despite the number of inquiries and submissions little progress has been made towards

creating a fair and just workers compensation system for injured workers. Some of the reforms announced as part of the Amending Act are yet to be realised with no indication of expected time frames.

These submissions will not address every aspect of the workers compensation system. These submissions will focus on the following areas:

1. Case Management
2. Calculation of Weekly Payments
3. Work Capacity decisions
4. Pre-injury average weekly earnings
5. Legal representation
6. Medical Expenses
7. Industrial Deafness Claims

We ask this Honourable Committee to draw upon findings made in previous inquiries and note that the CFMEU is happy to provide this Honourable Committee with copies of the above submissions to assist this Honourable Committee is reaching its conclusions.

3. Case Management

3.1 Victorian Ombudsman's report

In June 2014, following an increase in complaints concerning claims management processes, the Victorian Ombudsman's office commenced an investigation into WorkSafe and its agents' claims management processes. An analysis of the complaints received by the Ombudsman in the 2014-15 period showed that 55% of those complaints related to claims decisions and processes with the second most common complaint relating to payments including delays and poor decision making.[6] Case management had been an ongoing concern in Victoria as evidenced by two previous reports which raised concerns about the focus on liability management at the expense of quality case management.[7]

[6] Victorian Ombudsman 'Investigation into management of complex workers compensation claims and WorkSafe oversight' September 2016, 14.
[7] Ibid.

In September 2016, the Victorian Ombudsman released its report on *"Investigation into the management of complex workers compensation claims and WorkSafe oversight."* The Investigation uncovered unreasonable decision making from all scheme agents including:

- Unreasonably using evidence in decision making;
- Maintaining unreasonable decisions at conciliation;
- Making decisions contrary to binding Medical Panel opinions;
- Allowing employers to improperly influence their decision-making;
- Providing inadequate internal review processes.

The investigation revealed poor behaviour on behalf of all five scheme agents indicating a system wide problem. The evidence showed injured workers had suffered genuine hardship and distress as a result of poor behaviour. The evidence also uncovered systematic "gaming of the system" by all scheme agents. Those most at risk of falling victim to this behaviour are injured workers with incapacity or a need for long term medical treatment.

The report is littered with emotional and harrowing stories of the impact poor case management can have on injured workers. There are many stories of injured workers suffering serious psychological injuries as a result of the case management process including stories of attempted suicide.

The final report is a damning examination of a broken system as indicated by the following extract:

> *"While we also saw instances of good decision-making and practices by some agent staff, the fact that the case studies revealed poor behaviour by all five agents indicated forcefully that the system does not work well at the complex end of the spectrum. Agents are responsible for their decision-making – they should be adhering to the agreed standards and held to account when they do not – but they are also motivated by incentives in the scheme which must be recalibrated to address the issues my investigation raises."*[8]

[8] Ibid 156.

The report also highlighted deficiencies in WorkSafe's oversight of the system. The evidence showed a reliance on financial incentives to focus on return to work outcomes, without adequate attention paid to long term claims or whether that return to work was durable; a failure to follow up on claims and decisions that failed the auditing processes; failure to monitor complaints to identify systemic failures; and, a reluctance to intervene where insurers had made poor decisions.[9]

The failure on behalf of WorkSafe to conduct appropriate oversight led to the following recommendation:

> *Consider how the overall operation of the scheme can better target its resources and oversight to ensure quality decision-making in the cohort of complex cases where disputes frequently arise.*[10]

3.2 NSW Experience

The experience in Victoria is not so removed from that of injured workers in the NSW workers compensation system.

In this Honourable Committee's final report on the Review of the Exercise of the functions of the WorkCover Authority, this Honourable Committee made the following comments:

> *The Committee is concerned that a number of review participants have reported poor treatment from insurer's under the workers compensation scheme. We are optimistic that the recommendations made in this report will improve the experiences of injured workers. We also encourage all participants in the scheme to behave respectfully and transparently towards each other.*
>
> *Many injured workers are inevitably in a vulnerable position when they engage with the WorkCover scheme. This means there must be robust measures in place to ensure their rights are protected and they are treated with dignity and respect by*

[9] Ibid 11-12.
[10] Ibid 162.

all parties in the scheme from insurers, to WorkCover and medical and rehabilitation specialists.[11]

Following the announcement of the 2015 Benefits "reforms" and the legislated split of the Nominal Insurer and Regulator, CFMEU members have experienced an increase in aggression, incompetence and antipathy from insurers and their case managers. There are legitimate concerns about the training that case managers receiving prior to being allocated claims.

John is 30 and a single father who suffered an injury to his lower back. After a successful PIAWE review application John reported increased scrutiny and pressure from his employer and insurer to return to work in his substantive role. John agreed to a trial return to work however the work he was required to perform aggravated his lower back and he struggled to walk as a result. John notified his employer that he was going to see his nominated treating doctor about his increased pain. The employer reported this to the insurer who cancelled John's doctor's appointment without cause. When John contacted the insurer to find out why he was told by his case manager that he couldn't see the doctor inside the period of his certificate and that John was required to provide 24 hours' notice before seeing his doctor and he would not be paid benefits for attending the doctor without permission.

John contacted the union for assistance. When the union rang the insurer, the case manager confirmed the advice that was given to John. The union asked the case manager which section of the Acts or Guidelines he was relying upon and he could not answer. The union pointed the insurer to the Guidelines which specifically stated that visits to the nominated treating doctor were exempt from the pre-approval requirements.

John was then informed by his case manager, that he was not permitted to attend a doctor's appointment without his rehabilitation provider and employer being present. The insurer organised a case conference with the nominated treating doctor with 24 hours' notice and without providing John with written confirmation of the

[11] Legislative Council Standing Committee on Law and Justice, Parliament of NSW, *Review into the exercise of the functions of the WorkCover* Authority (2014) 58 [4.101]-[4.102].

appointment, a copy of the proposed injury management plan or a case conference agenda. The matter was reported to WIRO for assistance and the insurer failed to return WIRO phone calls.

John complained to the union that he felt like the rehabilitation provider, insurer and employer were "ganging up" on him and his doctor and nobody was paying attention to the pain in his back. He was receiving constant text messages from his employer and emails from his insurer accusing John of doing the wrong thing. John had been trying to email his case manager for information but his case manager did not respond to any correspondence from John. The Union contacted the case manager on John's behalf. During the conversation the case manager admitted he hadn't spoken to John, admitted that he had based his decisions on information provided by the employer only, told John that he was not permitted to seek gainful employment elsewhere whilst still employed by his employer and that the rehabilitation provider was a representative of the employer rather than a representative for the injured worker. Meanwhile, the case manager was refusing to approve a change of rehabilitation provider.

The union complained to the team leader and was given a commitment that the matter would be "looked into." The team leader tried to negotiate an outcome whereby the case manager was retained but a new rehabilitation provider was approved. The union noted that the case manager was providing incorrect information to John and that some of the information was inconsistent with the legislation and guidelines. The union received no further feedback from the team leader. The union escalated the complaint to SIRA who assisted in getting the new rehabilitation provider approved and getting a change in case manager. The process of resolution took approximately 5 weeks from the initial complaint.

Greg is a 33 construction worker who suffered a back injury. Due to the intervention of an IMC, Greg's nominated treating doctor certified Greg fit for suitable employment despite Greg being on strong narcotic patches. Greg was unable to drive due to his

injury and was forced to catch public transport to site. Greg complained to his doctor that the pain in his back was so severe that he was forced to lie on the floor of the train carriage to get some relief. Greg's doctor would not alter the certificate of capacity because "the insurer's doctor said he had to go to work." During this time the employer notified Greg that there was no suitable employment available on site and he would have to work at the employer's compound. This would have increased Greg's travel time by an hour and a half. The long travel was already having a negative impact on Greg's back and recovery.

Greg chose to change his nominated treating doctor to someone he believed would have his best interests at heart. The new doctor saw the danger in sending a heavily medicated worker into a high risk workplace. The doctor was concerned about Greg travelling long distances while on narcotics patches. A new certificate of capacity was issued stating Greg had no capacity for work.

The insurer decided to withdraw provisional liability, and consequently weekly benefits, while "investigating" the downgrade in capacity. The workers compensation acts and guidelines do not provide a basis for withdrawing provisional liability once payments have commenced unless the insurer chooses to deny liability. Relevantly there is no option to reasonably excuse payments once they have commenced.

The insurer did not provide any documentation to support the withdrawal of provisional liability and weekly benefits. The insurer did not send a letter announcing its intention rather it relied upon a telephone call to Greg.

The union contacted the insurer on Greg's behalf. The legal officer asked the case manager what part of the Acts or Guidelines the insurer was relying upon to withdraw provisional liability. The insurer put the legal officer on hold for 10 minutes while she looked into it. When the case manager returned she could not provide an answer and stated that a more senior officer would contact the union the following day with an answer. The following day the union received a letter which stated the insurer was exercising its right to take 21 days to determine liability. The union made extensive submissions regarding provisional liability and the fact that the system

does not allow it to be withdrawn. In the meantime Greg was not receiving any weekly benefits. The insurer failed to respond to the union's email so the matter was referred to WIRO for intervention.

Greg was without weekly benefits for a period of three weeks while the union and WIRO made submissions to the insurer on Greg's behalf. Eventually the insurer agreed to accept the downgrade and back paid Greg for the missing payments.

During the review of the *Guidelines for Claiming Workers Compensation* (**Claims Guide**), the CFMEU made several requests that SIRA conduct education programs with both case managers and their supervisors. The concern was that the adversarial culture cannot change if education and training is targeted at one group over the other. The CFMEU also called for close monitoring of the impact of the education. The system currently has too few monitoring programs and case managers are getting away with questionable behaviour and aggressive communication tactics. While SIRA has advised that an education program was rolled out, there appears to be no change in the behaviour and it unclear how closely, if it all, SIRA and/or icare are monitoring case management practices.

Too often insurers are defending their actions, or inactions, by claiming it was merely "an oversight." Injured workers are vulnerable people who rely on the insurer to apply the law correctly and to meet their obligations under the law. When the insurer fails to account for their actions and refuses to acknowledge the pleas and advice from the injured worker, the injured worker has no choice but to escalate the complaint to their union and/or WIRO.

Sam, 56, has managed to find alternate employment following his injuries for which he is paid on a fortnightly basis. Sam dutifully forwards his payslips to his insurer as they are received. Recently the insurer has failed to pass on the full benefit owed to Sam stating that Sam had worked "fulltime" and was not entitled to a benefit for that period. Sam's partner contacted the insurer about the missing payments and reminded the insurer that the payslips provided reflect a fortnight's work. The

insurer refused to make the missing payments relying on their misreading of the payslips.

Sam contacted the union who made a complaint to WIRO on Sam's behalf. After three days the insurer agreed to pay the missing payment claiming it was "an oversight." The insurer had only made payment for one of the missing weeks. The union notified WIRO that another week was missing. After another three days the insurer confirmed it would make the missing payment.

Sam has been providing fortnightly payslips for a period of approximately 2 years. There is no excuse for the insurer suddenly reading the payslips as weekly. The issue could have been resolved had the insurer paid attention to the information provided by Sam's partner. Instead the injured worker was forced to rely upon WIRO and the union to rectify a situation that should not have occurred in the first place.

The CFMEU has noticed a worrying trend in the way insurers interact with injured workers and their representatives. On more than one occasion the CFMEU has been required to inform case managers of their legal obligations in order to secure fairness for its members.

Richard asked his employer what would happen to his weekly benefits during the two week Christmas shutdown period and whether he would be paid or need to take annual leave. Richard received a letter from the insurer reducing his weekly benefits on the basis that he was capable of earning a certain amount in suitable employment. The letter did not purport to be a work capacity decision despite fitting the definition of work capacity decision in s 43 of the 1987 Act. The insurer and employer also advised that Richard would not be permitted to be paid annual leave and weekly benefits over the shutdown period.

The union contacted the insurer and advised that despite not being called a work capacity decision, in practice a work capacity decision had been made and the required notice period had not been met. The insurer denied it had made a work capacity decision and asserted they were just giving effect to the certificate of

capacity. The union also advised the insurer that by virtue of s 49 of the 1987 Act, Richard was permitted to be paid weekly benefits and annual leave simultaneously. The insurer disputed that fact.

The union filed an application for internal review of a work capacity decision and made submissions concerning s 49 of the 1987 Act. The insurer responded that no work capacity decision had been made and that it would not be conducting an internal review. It maintained its position on s 49 of the 1987 Act.

The union filed an application for merit review of a work capacity decision and again raised the s 49 arguments. The Merit Review Service conducted a merit review and found that the insurer was required to pay weekly benefits for some of the shutdown period and confirmed the correct interpretation of s 49 being that annual leave and weekly benefits could be paid simultaneously.

The CFMEU and its members have also experienced an increase in hostility from insurers. Where the CFMEU has provided an appropriate authority and contacted the insurer for information, it is not uncommon for case managers to contact injured workers and demand to know why the union has become involved. That behaviour leaves the injured worker feeling intimidated and has the potential to coerce injured workers not to make legitimate enquiries about their claim.

This hostility is also evident in circumstances where the union is merely trying to facilitate communication between the injured worker and insurer to avoid the ongoing involvement of the union.

Aiden had been trying to contact his case manager to update his telephone number. The insurer then issued a notice stating that they had not been able to get in contact with Aiden and were going to close his file. Aiden contacted the union for advice. The union rang the case manager on Aiden's behalf. The case manager was hostile during the conversation and kept repeating that they did not have authority to speak to the union and would contact Aiden directly. The union reiterated that the case manager would not be able to get hold of Aiden on the number on their file and just wanted to

provide the new phone number. The union was not seeking any information was just trying to update Aiden's details. The case manager then rang Aiden and questioned him for a period of approximately 10 minutes about why he got the union involved.

Some injured workers try to resolve their issues directly with the insurer to no avail. There appears to be a common trend of insurers delaying in providing requested information where the injured worker has questioned the reasoning for certain decisions. The insurer will agree to pass on the information and then fail to send the documents. In some circumstances the insurer will merely respond that the matter is under review and then will fail to update the injured worker on the outcome of that review. The injured worker then has no other recourse than to seek the intervention of their union and/or WIRO.

Brian is 55 who injured his right wrist and right shoulder. In September the insurer made a work capacity decision calculating Brian's PIAWE. In October the insurer made another work capacity decision increasing Brian's PIAWE by approximately $15 per week. Brian asked for his PIAWE to be recalculated and asked for the documentation relied upon by the insurer to reach its PIAWE figure. Brian repeated his request for documentation on a monthly basis. Over time Brian noticed a reduction in his weekly benefits and contacted his payroll and insurer to find out what was happening. Brian told his insurer that he believed he was being paid the initial PIAWE figure not the October PIAWE figure. He was told that his PIAWE was being recalculated and the insurer would advise him of the outcome in due course. Brian asked about indexation and was told that after indexation his weekly benefits would decrease.

Due to the insurers continued failure to provide the requested documentation Brian sought assistance from the union. The union identified a number of problems with Brian's payments. The union struggled to get information from the insurer and reported the matter to WIRO for assistance. The insurer asserted that Brian had requested a recalculation of his PIAWE which had resulted in a reduction in his PIAWE calculation. The insurer had not provided a work capacity decision confirming the new calculation and as such the decision to reduce the PIAWE was not valid and

the October decision was the current PIAWE decision. The insurer then tried to issue a letter accepting liability and backdated the change in PIAWE to a period 5 months prior to the complaint to WIRO. After further intervention from WIRO the insurer agreed to reimburse Brian in accordance with the previous PIAWE decision.

During this time Brian and the union complained to WIRO about the employer underpaying Brian by approximately $200 a week for a period of approximately 5 weeks. The insurer insisted that the employer had received full reimbursement and it was then up to Brian to recover that underpayment from the employer directly. By the time Brian received this advice his employment had ceased. WIRO asked the insurer to raise the underpayment with the employer directly. After several weeks the insurer agreed to pay the shortfall.

After resolving the two underpayment issues it became apparent that the insurer had failed to apply indexation and after two weeks of waiting Brian was still waiting for his back pay from the insurer. The matter has again been referred to WIRO for assistance in resolving these matters.

Ray's son is acting as his father's day to day representative in relation to his workers compensation claim. He is the person who contacts the insurer when information is not provided. Michael is still seeking documentation from the insurer. He has raised concerns about the rehabilitation provider and the fact that the rehabilitation report relied upon by the insurer actually applies to another injured worker. In response to that complaint Michael was told he would need to lodge a formal written complaint before any action can be taken. Due to the complacency and lack of communication from the insurer

Ray's nominated treating doctor suggested referring Ray to a Spanish speaking psychologist for a secondary psychological injury. Before the referral has even occurred the insurer has notified Michael that it will be declined. Michael describes

his interactions with the insurer as a full time job which is interfering with his own life.

WIRO's Annual report and performance reports corroborate the experiences of the CFMEU and its members. WIRO's July 2015 to June 2016 Performance Review shows that the majority of complaints received relate to either Allianz or QBE, with both recording complaints almost double that of the other scheme agents, Allianz accounted for 1006 complaints while QBE accounted for 911 complaints.[12] It is important to note that neither of these figures comprise complaints regarding TMF. WIRO's 2015 Annual Report replicated this pattern with WIRO receiving 2670 complaints about Allianz and 2709 complaints against QBE, again almost double that of the next closest scheme agent.[13]

The complaints received by WIRO generally fall into two categories weekly benefits and medical expenses. WIRO notes that disputes about weekly benefits are the major issue raised with WIRO including incorrect calculations, failure to index, PIAWE generally and withdrawal of weekly benefits.[14] WIRO also noted delays in approving medical benefits or refusing to approve medical benefits as a significant issue.

Injured workers are not the only stakeholders dismayed at the case management practices of the scheme agents. WIRO noting that the main concern raised by employers was the management of claims by scheme agents.[15]

The case studies contained in WIRO's 2015 Annual Report also establish a worrying pattern of misbehaviour and complacency. The case studies include examples of insurers overlooking claims for months; punishing workers for circumstances beyond their control even after providing supporting documentation; failure to pay benefits for a period of 4 months due to administrative oversight; and, failure to understand EBA

[12] WIRO Performance Review July 2015-June 2016.
[13] WIRO Annual Report 2015.
[14] WIRO Performance Review July 2015 to Dec 2015.
[15] Ibid.

entitlements. The evidence shows that despite case managers not being industrial experts, insurers are taking it upon themselves to make industrial decisions.

Ben was an adult apprentice with limited English language skills who relied on his partner to make representations on his behalf. After a long period of intensive work Ben suffered an injury to his shoulder and a psychological injury. In declining liability for both injuries the insurer made a finding that Ben had not been overworked or underpaid despite having no documentation to that effect nor knowledge of the relevant industrial award of industry. Further proof of the insurer's failure to fully investigate the matter

Ben has since been reimbursed his underpayments from his previous employer.

3.3 Interference of Employers and lack of oversight

The interference of employers has become a major issue in the workers compensation process with many injured workers being punished through liability denials based on the personal opinions of the employer or delaying tactics by the employer. Rather than being a system which compensates and rehabilitates injured workers it has become a system that focuses on placating employers with a view to managing potential premium increases. Injured workers are being denied required treatment or diagnostic tests on the back of employer requests or opinions. This was a concern raised in the Victorian Ombudsman's report.

Fred was originally injured in 2011. After a graduated return to work he was given permanently modified duties at his employer. Those duties comprised mostly office work but given his experience he was often instructed to work outside of his restrictions in the factory. Fred was worried that if he refused he would be sacked and because he had a workers compensation injury he knew he would struggle to find alternate employment.

His employer increased the frequency in which Fred would be required to work outside of his physical restrictions and eventually Fred suffered a secondary injury to

his shoulder. Fred's nominated treating doctor believed that the injury was as a result of the employer's requirement that Fred work outside of his restrictions. The employer seemed to run interference between Fred and the insurer. Fred could not get information from the insurer and he was entirely reliant on the employer to provide him all the information. The employer told Fred he was not allowed to "re-open" his claim because the time frame had expired, despite the doctor stating it was a new injury.

This back and forth through the employer to the insurer lasted for approximately 3 months before the insurer finally granted approval for surgery under the secondary surgery provisions. The matter could have been resolved earlier had the insurer spoken to Fred directly instead of the employer interfering at every step of the process. The employer's interference delayed the process and caused Fred to suffer unnecessary pain as a result.

Tony 38 suffered an injury to his back. His employer has an internal workers compensation manager who liaises with the worker and the insurer as a de facto rehabilitation officer. The workers compensation manager decided that Tony had not suffered a work-related injury and diagnosed Tony with scoliosis despite no medical training, and reported this to the insurer who decided to investigate the claim on that basis.

The union contacted the insurer on Tony's behalf to enquire into the delay for approving an MRI. The case manager admitted to the union that she was taking her cues from the employer and admitted that the insurer was waiting on the employer to tell them whether they could approve the MRI. The nominated treating doctor told the union that he had been contacted by the employers doctor, was told to change a certificate of capacity and withdraw the referral for the MRI. The nominated treating doctor complained that he felt intimidated. When the union raised this issue with the

insurer, the union was told that the employer had engaged an IMC and the insurer was relying on the information from the employers IMC.

The CFMEU is also concerned about the lack of accountability where employers fail in their obligations to notify the insurer of serious injuries, pass on workers compensation claims or pass on insurers information when requested.

The employer refused to lodge a workers compensation claim on Chris' behalf. The employer believed that the injury wasn't work related despite no evidence to support their assessment. After 6 months of no payments and being unable to afford physiotherapy appointments, Chris contacted the union for advice. The union rang the employer to get the insurer details and received hostility but no information. The union contacted Icare to get the policy details and was told that the employer did not have a current policy.

The union was finally able to get the insurance information with the assistance of the company delegate.

Jason received a right leg injury. Jason texted his employer and stated that he had suffered a work injury and would be going to the doctor. The employer told him to go to the doctor under Medicare because they would "take care of him." Jason continued to attend the doctor and get medical certificates. During this time Jason paid all his own medical expenses. When he could no longer afford physiotherapy he contacted the union for help. The employer failed to comply with its obligation to notify the insurer of the injury.

In the construction industry it is not uncommon for employers to require their workers to make a claim under medicare rather than workers compensation with a promise to cover all medical expenses if they promise not to make a claim. The threat of being dismissed for making a workers compensation claim is a real risk to many in the industry. The CFMEU constantly hears from its members phrases like "but the boss is a good man" or "they promised they will take care of me." Unfortunately, once the injured worker reaches the magic 6 month mark, the employer terminates the injured workers

employment and refuses to pay the ongoing medical costs. By this stage the insurer is unwilling to accept provisional liability until such time as they are able to conduct a thorough investigation. In most cases these types of claims result in a denial of liability. The injured worker is punished because they were either unaware of their rights or their employer coerced them into not exercising those rights. The CFMEU is yet to see an employer penalised for a failure to abide by the notification obligations under the 1998 Act which allows this kind of behaviour to continue without risk of penalty.

SIRA needs make employers more accountable for their actions to ensure that injured workers are not further disadvantaged by the bad behaviour of their employer. This is particularly important where employers have failed to pass on the weekly benefits owed to the injured worker. The insurer passes on the full benefit to the employer who fails to pass that money on to the injured worker. The injured worker is then told it is their responsibility to chase up the payment with the employer. The employer is not punished for its failure to pass on the weekly benefit rather the injured worker is punished through lack of support or intervention from the insurer and/or regulator.

Liam 19 suffered a left ankle injury during his apprenticeship. The claim was accepted by the insurer and the employer was allocated the full weekly benefit. The employer believed that Liam should not receive overtime and failed to pass on the full amount of the weekly benefit. The union contacted the insurer and was told that the insurer had complied with its obligations and Liam would need to pursue the employer for the underpayment. The union was unable to locate the employer and the employer was refusing to return phone calls. The union reported the matter to WorkCover. The matter failed to resolve in the first tier of the complaint process. The insurer refused to compensate Liam for the underpayment and refused to pursue the employer despite evidence that the employer had fraudulently retained money and had stolen Liam's tools. During the second tier of the complaint process the insurer agreed to pursue the employer but was not minded to pay Liam until it had received the money back from the insurer. The union was told that Liam would need to wait until legal proceedings had commenced and settled.

After approximately 6 weeks of negotiations with the insurer, they finally agreed to pay Liam the $6200 owed without waiting for the employer.

More needs to be done to ensure the system does not further disadvantage injured workers for the bad behaviour of insurers and employers. Injured workers are already vulnerable and are reliant on the insurer, employer and regulator to fulfil their obligations. In its final report on Review of the Exercise of the Functions of WorkCover this Honourable Committee made the following comment:

> *We also encourage all participants in the scheme to behave respectfully and transparently towards each other.*

The evidence shows that some of the participants in the system have failed to take that advice on board and its business as usual with injured workers being treated inappropriately because they have been injure at work, have lodged a workers compensation claim, questioned a decision of the insurer, or sought the assistance of their union.

The CFMEU calls for an independent investigation into the management of workers compensation claims similar to that conducted by the Victorian Ombudsman.

When an employer has refused to pass on the insurer's information, the CFMEU assists the injured worker in obtaining that information from icare through the designated telephone number. On at least 4 occasions icare has been unable to locate a policy for a particular employer on their system. The CFMEU has then made other enquiries to try and locate an applicable workers compensation policy and has been successful in getting that information. The CFMEU suggests that icare look into its processes to determine whether there are any issues in identifying policies where a valid policy does exist and make the necessary changes to ensure the correct information is being provided to injured workers.

4. Calculation of weekly payments

4.1 Definitions

Sections 33-38 of the 1987 Act explain how weekly compensation is to be calculated for each of the entitlement periods. For an injured worker who has no work capacity weekly

compensation is calculated as a percentage of the injured workers pre injury average weekly earnings. For example, for a person with partial capacity within the first entitlement period, being weeks 1-13, the relevant algorithm as outlined in s 36 of the 1987 Act is **(AWE x 95%) – E**. The variable **E** is defined in s 35 of the 1987 Act as:

> *"E means the amount to be taken into account as the worker's earnings after the injury, calculated as whichever of the following is the greater amount:*
>
> *(a) the amount the worker is able to earn in suitable employment,*
>
> *(b) the workers current weekly earnings."*

Under the pre 2012 system, weekly payments for partial incapacity could only be reduced in circumstances where an injured worker had returned to some form of employment and was earning an income. In those circumstances the wages earned were deducted from the payment made by the relevant insurer.

The current system does not require an injured worker to have returned to work in order to make deductions to their weekly payments. It is sufficient for the injured worker to have some capacity to earn. The rationale behind this new approach to weekly payments is to encourage people to return to work. This reasoning is flawed as it assumes that the reason an injured worker has not returned to work is entirely the fault of the injured worker. This approach ignores reality, in that it fails to recognise that the labour market has a bias against employing workers who have had a workers compensation claim.

The mere fact that a worker has had a claim in the past is often a deterrent for a prospective employer. There is a perception that injured workers are a health and safety risk and that these injured workers will be more likely to make a subsequent workers compensation claim against the prospective employer. That is why we have a high incidence of injured workers applying for hundreds of jobs and not being able to break back into the workforce.

This new approach to calculating weekly payments does little to change the reality of the labour market and instead has the effect of pushing injured workers and their families further towards poverty, an approach described as many to be an attempt "to starve them out".

If the insurer has decided that an injured worker is fit for suitable employment and that injured worker is not actually working, the money that could potentially be earned in that role will be deducted from their weekly compensation. The purpose of this calculation is to encourage injured workers to return to some form of employment in order to continue to receive a decent income from the system. However, the system fails to account for the actions of employers.

4.2 Suitable employment

The definition of suitable employment was inserted into the 1987 Act as part of a raft of amendments apparently intended to improve return to work outcomes. However, there was no consideration of the impact that this new concept would have on injured workers and their families.

Under the previous system there was an understanding that any injured worker would not be penalised where their employer was unable to provide light or suitable duties in the workplace. The primary goal was to return to pre-injury employment. The goal posts have now changed and the primary goal appears to be return to any job anywhere as soon as possible.

Suitable employment is defined by s 32A of the WCA as:

> *"suitable employment, in relation to a worker, means employment in work for which the worker is currently suited:*
>
> *a) having regard to:*
>
> *i) the nature of the worker's incapacity and the details provided in medical information including, but not limited to, any certificate of capacity supplied by the worker (under section 44B), and*
>
> *ii) the worker's age, education, skills and work experience, and*
>
> *iii) any plan or document prepared as part of the return to work planning process, including an injury management plan under Chapter 3 of the 1998 Act, and*
>
> *iv) any occupational rehabilitation services that are being, or have been,*

provided to or for the worker, and

v) such other matters as the WorkCover Guidelines may specify, and

b) regardless of:

i) whether the work or the employment is available, and

ii) whether the work or the employment is of a type or nature that is generally available in the employment market, and

iii) the nature of the worker's pre-injury employment, and

iv) the worker's place of residence."

When we combine this extraordinarily broad definition with the algorithm discussed above, the combined impact on an injured worker can be devastating.

If the insurer has decided that an injured worker is fit for suitable employment and that injured worker is not actually working, the money that could potentially be earned in that theoretical role will be deducted from their weekly compensation. The intention of this calculation is to encourage injured workers to return to some form of employment, in fact any form of employment, in order to continue to receive some level of income from the system. However, the system fails to account for the actions of employers.

In September 2013, Andrew, a 17 year old apprentice, suffered a work related injury when his employer instructed him to lift a 60kg air compressor off a truck and to carry it through the site. Andrew suffered a titled pelvis and 2 bulging discs. As a result of the injury Andrew was told he would need surgery on his pelvis and back.

Andrew was initially told he had no capacity for work and his employer refused to lodge the workers compensation claim. Andrew has since been certified as having some capacity and has been trying to get back to work. Andrew has made several attempts to talk to his employer about suitable duties as has the union

on Andrew's behalf, however Andrew's employer refuses to even discuss the prospect of suitable employment.

In March 2014, Josh, a 23 year old apprentice, suffered a work related injury causing soft tissue damage to his chest wall. Josh's employer refused to notify the workers compensation insurer of the injury.

Josh has since been certified as having capacity for some form of employment. While Josh was using his sick leave the employer was able to provide suitable employment. Once Josh lodged a claim for workers compensation, Josh's employer withdrew suitable employment. The employer has since refused to discuss any suitable employment options. Several union officials have attempted to discuss the possibility of suitable employment with the employer to no avail. The union contacted the State Training Authority on Josh's behalf and was notified that the State Training Authority does not get involved in such disputes. Josh has since been terminated from his employment.

Timothy suffered an injury to his left ankle when he fell off a brick wall at work. After a short time off work, Timothy's NTD issued a certificate of capacity that certified him capable of returning to work for 40 hours per week with physical restrictions including limited lifting capacity, limited standing capacity, inability to push/pull, avoid driving, no ladder work and avoid uneven ground. The employer was unable to provide suitable employment matching Timothy's restrictions and eventually terminated Timothy's employment. Applying the correct algorithm, Timothy is not entitled to receive any income because he is capable of earning more than the insurer's liability. Timothy is now without a job, and because he tried to return to work, is now without an income.

Since the calculations take into account potential earning capacity not just actual earnings, it is the injured worker who suffers when suitable employment

is not on offer. Timothy tried to return to work; he had his certificate altered so he could return to work, and yet it is Timothy who is being penalised for his employer not having any suitable employment to offer. The system is punishing the injured worker for trying to get back to work, but there is no penalty for an employer who fails to provide suitable employment.

This is particularly harrowing when we consider the increase in terminations since the introduction of the 2012 amendments. Companies who have had a history of providing long term suitable employment for their injured workers have availed themselves of the opportunity to terminate those very same injured workers. The CFMEU has seen this effect with at least two major companies, each terminating up to a dozen injured workers. Not only do these injured workers lose their employment, but potentially they will lose their weekly compensation as well.

Employers no longer feel obliged to keep injured workers employed. The system provides no incentive to employers and it is the employees who bear all the risk, especially when we consider that the insurer is not required to take into account the reason why a person is currently not engaged in some form of employment.

The current definition of suitable employment was adapted from the definition in South Australian jurisdiction, except that the South Australian definition does not contain limb (b) of the definition. The government made the decision to empower insurers to make decisions without any requirement for that decision to be just or fair. There is no logical basis for including the second limb in the definition beyond making it easier for insurer to remove injured workers from the system through the work capacity regime.

The CFMEU submits that the definition of suitable employment must be replaced with a definition that ensures just and fair outcomes. A new definition of suitable employment must take into account the following:

1. Limb (b) of the current definition must be removed;
2. Suitable employment must be based on actual jobs not theoretical jobs – requiring an injured worker to negotiate their job description with their new employer to remove certain tasks cannot be described as suitable employment;

3. The nominated treating doctor's assessment of capacity must be the paramount consideration – insurer must not be permitted to deviate from that assessment without sufficient cause;
4. An injured workers entire capacity must be taken into account – currently the insurer only considers the compensable injury for which they are responsible ignoring other ailments which may prevent a job from being suitable employment;
5. It must be as close to the injured workers pre-injury duties as possible.

A definition which fails to take into account the above principles cannot result in actual and meaningful return to work outcomes and can only be described as an instrument of punishment.

5. Work Capacity

A system of work capacity assessments and work capacity decisions was introduced as a result of the 2012 legislative amendments to the workers compensation system. The system did not exist in NSW prior to the amendments. Previously South Australia was the only state or territory to utilise a work capacity system to determine an injured workers level of capacity. The rationale for the introduction of the system was the idea that there needed to be an increase in the return to work rate among injured workers. However, like the South Australian system, work capacity assessments and work capacity decisions are used as a mechanism for pushing people off the workers compensation system or pressuring injured workers to remove themselves from the system voluntarily rather than being constantly subject to the whim of the work capacity process.

The definition of a work capacity decision is extraordinarily broad and can encompass a large majority of decisions made by a claims officer during the life of a workers compensation claim. A work capacity decision is defined by s 43 of the 1987 Act as follows:

> *43 Work capacity decisions by insurers*
>
> *1) The following decisions of an insurer (referred to in this Division as work capacity decisions) are final and binding on the parties and not subject to*

appeal or review except review under section 44 or judicial review by the Supreme Court:

a) *a decision about a worker's current work capacity,*
b) *a decision about what constitutes suitable employment for a worker,*
c) *a decision about the amount an injured worker is able to earn in suitable employment,*
d) *a decision about the amount of an injured worker's pre-injury average weekly earnings or current weekly earnings,*
e) *a decision about whether a worker is, as a result of injury, unable without substantial risk of further injury to engage in employment of a certain kind because of the nature of that employment,*
f) *any other decision of an insurer that affects a worker's entitlement to weekly payments of compensation, including a decision to suspend, discontinue or reduce the amount of the weekly payments of compensation payable to a worker on the basis of any decision referred to in paragraphs (a)–(e).*

2) *The following decisions are not work capacity decisions:*
   a) *a decision to dispute liability for weekly payments of compensation,*
   b) *a decision that can be the subject of a medical dispute under Part 7 of Chapter 7 of the 1998 Act.*
3) *The Commission does not have jurisdiction to determine any dispute about a work capacity decision of an insurer and is not to make a decision in respect of a dispute before the Commission that is inconsistent with a work capacity decision of an insurer*

The work capacity system fails to function in a rational, efficient or effective manner. The work capacity system is flawed in many respects and is a burden for both insurers and injured workers alike. The work capacity system works on a theoretical basis with little recognition of the reality of the labour market or the demands on workers within the labour market. The work capacity system does not function efficiently, effectively, fairly or even logically.

Insurers see the work capacity process as a means to an end. They no longer need to deny liability to discontinue weekly payments or worry about potentially facing the wrath of

the Workers Compensation Commission (WCC). The work capacity process allows insurers to use the injured workers' rehabilitation efforts against them in order to remove them from the system, without the worker having any recourse to the WCC. WCD's are binding and in order to challenge their validity and merit the injured worker must conquer many hurdles, not least the insurer itself.

An insurer is permitted to make a WCD based on the evidence already in an injured worker's file. This is problematic for many reasons, not least because a decision is being made by a case manager who has no medical training and who has most likely never seen the injured worker. There is no requirement that the case manager consider all the evidence on an injured workers file and in reality the CFMEU has found that case managers have become quite good at ignoring sound medical advice in favour of documentation that allows them to achieve their end, that is the discontinuation of weekly benefits.

Currently, if an injured worker's certificate of capacity is inconsistent with the insurer's opinion or that expressed in a functional assessment, the insurer may place greater emphasis on the findings of the rehabilitation report, thereby ignoring the sound medical advice of the nominated treating doctor. Life altering decisions are being made by unqualified case managers with no legal training and who have a vested interest in finding that an individual workers has capacity to work.

The work capacity system cannot achieve the aims for which it was created. Rather, the work capacity system works to increase poverty among the disadvantage in our society further widening the gap between the different classes in our population. The system creates a new class where people who have ongoing injuries are unable to earn an income, pay for adequate medical expenses, receive social security benefits and are forced to use their superannuation to cover mortgage payments.

The CFMEU submits that the work capacity system must be abandoned to protect those who need protecting and provide adequate support to the disadvantaged members of society.

5.1 Stay Provisions

During the Review into the Functions of WorkCover, this Honourable Committee heard evidence that Merit Review Service was taking on average 61.9 days to make a merit review decision with some decisions taking up to 200 days.[16] The legislation at the time did not allow for the stay of a work capacity decision which resulted in many injured workers having their weekly benefits discontinued while awaiting for the review to be completed.

As a consequence of evidence led before this Honourable Committee as to the financial impact of delays in the merit review process, the government introduced a stay on work capacity decisions to operate in certain circumstances. While the provisions largely achieve their desired purpose, they are an additional layer of complexity in the already complex work capacity process.

While on the surface the stay provisions seem to address the inadequacy of the review process they are still designed to confuse and exclude injured workers.

Section 44BC prohibits an insurer from taking action on a work capacity decision while the decision is the subject of a review where the application for review has been made within 30 days of the decision being notified or the date on which the injured worker is required to be notified. That is where the issue lies. Injured workers presume that insurers and review officers will make decisions within the required time frames, however where a review officer fails to make a decision with the legislated time frame the injured worker is still bound by the time frame in order to take advantage of the stay provisions. This is best illustrated by way of example:

The injured worker applies for an internal review. Section 44BB requires the insurer to make an internal review decision within 30 days. The insurer fails to make the decision within that 30 day period and in fact takes 40 days. The period by which the next application must be made in order to claim the protection of s 44BC is then 20 days instead of 30 days because the provision operates based on the date on which the

[16] Legislative Council Standing Committee on Law and Justice, Parliament of NSW, *Review into the exercise of the functions of the WorkCover* Authority (2014) 63 [5.13] – [5.14].

injured worker was required to be notified. The injured worker loses 10 days grace due to the actions of the insurer.

Admittedly the injured worker can make an application for merit review from the date that they were required to be notified but in practice most injured workers will wait for the internal review decision before deciding whether to take the next step in the process.

Section 44BD attempts to explain the effect of the review decision on notice period but is convoluted to the point of nonsense. Section 44BD states:

44BD Effect of review decision on notice period

1) *In the application of section 54 to a discontinuation, or reduction of the amount, of payments of compensation as a result of a review decision (whether or not the review decision is less favourable to the worker than the original decision):*
    a) *no regard is to be had to any period of notice given to the worker in respect of any discontinuation or reduction before the date on which the worker is notified of the review decision, and*
    b) *the required period of notice commences on that date.*
2) *This section does not apply to a discontinuation or reduction as a result of a review decision that affirms an original decision with respect to the discontinuation or reduction.*

Note: See section 44BE for the effect of the affirmation of an original decision on the required period of notice.

This section is not written for injured workers to understand. An injured worker reading this section is none the wiser about the effect of the review decision on the notice period. The Claims Guide offers no explanation about this impact of this section. The original draft for the new guidelines did provide a table which would have offered some assistance but that was not included in the final guide. The only certainty that an injured worker, without legal training, can ascertain from this section is that the notice period does not change where the review decision affirms the previous decision to

discontinue or reduce weekly benefits.

Section 44BE is clearer in its intention. Where the review decision affirms the original decision, or where the injured worker withdraws the application for review, there will be no change to the notice period.

5.2 Merit Review

The Merit Review Service has been problematic since the inception of the work capacity process. For a long period the Merit Review Service was unable to make decisions within the required time frame with some workers being forced to wait in excess of 100 days to receive a merit review decision. This led to the introduction of the stay provisions.

When WorkCover was split into SIRA and icare, merit review became part of the regulatory regime. This does raise some questions about whether or not the conflict of interest that existed under the previous regime has been appropriately addressed. The regulator is still responsible for ensuring the regulator exercises its merit review powers appropriately. This is particularly concerning when considering the Merit Review User Guide which was published on 17 June 2016 to take effect from 1 August 2016.

The creation of the Merit Review User Guide coincided with SIRA's consolidation of a number of key guidelines. During this process, the *WorkCover Work Capacity Guidelines* and the *Guidelines for Work Capacity Decision Internal Reviews by Insurers and Merit Reviews by the Authority* were condensed and inserted into the new Claims Guide. The section relating to merit review decisions was not included in the new Claims Guide. SIRA conducted a number of meetings regarding the creation of the new Claims Guide and at each meeting the unions requested an update on the merit review guide and requested to be consulted on the creation of the merit review guide. Unions have a significant experience in navigating the work capacity process and have experience with the Merit Review Service, not to call on that expertise was a lost opportunity.

Without consultation the Merit Review User Guide was created and published. The Merit Review User Guide is not a gazetted guide and it is unclear how and whether injured workers can enforce the guide in the event that the Merit Review Service fails to adhere to its own rules. The Merit Review User Guide is flawed and is not user friendly. The guide

appears to be written by lawyers for lawyers, curious given lawyers are not yet a part of the work capacity or merit review process.

The Merit Review User guide:

- Is longer than the entire work capacity section of the new Claims Guide;
- Does not set time frames for the making of decisions and where time frames are set allows the MRS to extend those time frames as necessary (excluding legislative time frames which all apply to injured workers);
- Allows merit review to rely on documentation that had not previously been provided to the injured worker such as surveillance footage;
- Adds additional requirements about the content of applications for merit review;
- Allows the merit review officer to determine their own process and procedure.

The CFMEU provided feedback to SIRA about the content of the user guide and questioned why SIRA did not consult on its content despite several offers and requests from the unions. A full copy of the comments provided to SIRA are Attachment A of these submissions. To date the CFMEU has not received any feedback about its comments and notes at the time of lodging these submissions there have been no amendments to the Merit Review User Guide.

Additionally, the Merit Review User Guide and accompanying background paper both state "the Authority publishes on its website a suite of complementary supporting information and materials to assist and inform workers, insurers and their representatives." It is not clear to what "suite of supporting information" this refers since the only available information on the website is the user guide, background paper and application form.

5.2.1 Posting of Notable decisions

The Merit Review Service has recently commenced publishing notable merit review decisions on the website. The CFMEU has no dispute with this approach in principle, however the decisions should be printed in full (absent any identifying information) and report the full truth. The CFMEU is aware that at least one decision published on the website belongs to one of its members and was drafted by the CFMEU. The decision itself is held up as an example about how the PIAWE provisions should be interpreted. This is

misleading. That particular decision was subject to a subsequent Judicial Review application which alleged:

1. Error in the determination of ordinary earnings;
2. Error in relying on s 44G to exclude certain monetary amounts;
3. Error in applying s 44G to overtime calculations;
4. Jurisdictional errors of fact.

The matter was ultimately settled on a commercial basis and those issues were never legally determined. The failure of SIRA to note that this particular merit review decision, which is being held as a shining example, was not subject to further proceedings is misleading. The CFMEU has contacted SIRA regarding this decision and requested that the decision either be removed or that a note be made that the decision was subject to judicial review.

If these decisions are being held up as a standard for how injured workers can expect merit review decisions to be decided in the future, SIRA must ensure that all the relevant information is made available. The fact that the CFMEU was able to identify this particular decision and is aware of its misleading nature, raises concerns about whether the other decisions available on the website are also misleading.

5.2.2 Increasing Demands

There appears to be a new trend within the Merit Review Service to review aspects of a claim that may not be necessary for the determination of the particular application. The merit review officers are requesting more and more information and submissions, dragging out the merit review process.

> Dennis was subject to a third work capacity decision since his transition to the new system. In approximately June the CFMEU assisted Dennis in applying for a merit review of a work capacity decision on the basis that the insurer has incorrectly assessed Dennis as being an existing recipient and therefore only entitled to receive the transitional rate. At the time the Merit Review Service agreed with the CFMEU that Dennis was not an existing recipient since he was not receiving weekly benefits 1 October 2012.

In approximately March, the insurer made a work capacity decision to reduce Dennis' weekly benefits on the basis that he had capacity for suitable employment. The CFMEU again assisted Dennis with an internal review and then an application for merit review. Three weeks after lodging the application for merit review, the merit review officer began exploring the issuing of whether Dennis was an existing recipient and both the CFMEU and insurer were required to make submissions and provide information on this point. The existing recipient issue had been resolved in November 2015 and was not relevant to the work capacity decision that was the subject of the application. By requiring information and submissions on this irrelevant point the merit review decision took an additional 2 weeks to complete, meaning the decision was made outside of the 30 day period required by the then Guidelines.

While the CFMEU has no issue with the Merit Review Service requesting additional information where it is relevant to the application at hand, when requests are made towards the end of the 30 days period and extend to matters that have already been decided the constant need to make submissions becomes oppressive. This kind of behaviour is likely to result in more and more injured workers opting not to apply for a merit review of their WCD because they are not equipped to make submissions on legal concepts and it is highly unlikely that they have such intimate knowledge of previous decisions so as to make the necessary submissions.

This is additionally worrisome because of the potential impact of no providing additional information. Section 44BB(3)(c) states:

> *(c) the reviewer may decline to review a decision because the application for review is frivolous or vexatious or because the worker has failed to provide information requested by the reviewer,*[17]

There are no parameters for the request for information and the Merit Review User Guide does not offer injured workers a reasonable excuse for failure to provide information. An injured worker may not have the information, the information may be irrelevant, the injured worker may not understand the request, or the request is unreasonable. Neither

[17] See also Chapter 8 Merit Review User Guide.

the 1987 Act nor the User Guide take into account the myriad of reasons why the information may be requested, they merely punish an injured worker for failure to provide.

6. Pre-Injury Average Weekly Earnings – PIAWE

The PIAWE system is complex, inaccessible, poorly understood and costly. Workers, insurers, unions and merit review officers struggle to understand the system, which leads to differing interpretations and incorrect PIAWE decisions.

On 12 August 2016 the government introduced the *Workers Compensation Amendment Act 2015* (assented to on 21 August 2015). The Amending Act contained a specific reference to PIAWE. The proposed s 58A states:

> *58A Regulations*
>
> *The regulations may make provision for or with respect to the following:*
>
> *a) varying the method by which pre-injury average weekly earnings are to be calculated under this Subdivision in respect of a worker or class of workers,*
> *b) prescribing a benefit, or class of benefit, as a non-pecuniary benefit for the purposes of this Division,*
> *c) prescribing a payment, allowance, commission or other amount, or class of amount, as a base rate of pay exclusion for the purposes of this Division.*

On 24 February 2016, SIRA released the *'Regulation of pre-injury average weekly earnings (PIAWE) – Discussion Paper'* calling for submissions on the highly complex PIAWE system. On 5 April 2016 submissions closed and on 5 May 2016 SIRA published a summary of the submissions. Little to no progress has been made in this area since the closing of submissions and little feedback has been provided as to the expected time frames.

The CFMEU is aware that SIRA has recently engaged the services of an academic to assess the issue. It would appear that a second round of consultation is on the horizon and injured workers can expect further delays in this area. It is unclear how long this secondary process will take which is disappointing since this topic had been canvassed quite extensively during the Parkes Project. Again a significant component of the 2015

benefits reform has not been carried through to fruition and injured workers are still suffering at the hands of the PIAWE calculation process which is further compounded by the continued lack of legal representation.

The CFMEU has been a prolific contributor on the topic of PIAWE through its internal processes and experience, and through a number of submissions on the topic. Rather than replicating the same arguments we attach for this Honourable Committee a copy of the submissions made to SIRA in response to the discussion paper on the regulation. While there have been some amendments to the Claims Guidelines since these submissions are attached as Attachment B were made, the bulk of the arguments are still relevant.

6.1 Applying the definition

The current system of PIAWE is broken. Insurers do not understand PIAWE or how to calculate it and injured workers do not understand their entitlements. A PIAWE decision is ultimately a matter of interpretation more than calculation. The insurer must interpret the legislative provisions, the relevant industrial instrument and payslips to determine what is actually included in the scope of PIAWE prior to commencing the actual calculation. Insurers and merit reviews officers are ill-equipped to the task, not having sufficient (if any) legal or industrial experience.

PIAWE is not defined by one section but by the combination of 7 sections (section 44C to 44I) and has to be read with the exclusions contained in Schedule 3 of the 1987 Act. The provisions cannot be read in isolation. To do so would result in anomalous, incorrect and unfair decisions.

The CFMEU's experience of the 7 sections making up the definition is that s 44G is the most inappropriately, incorrectly and unfairly applied. Section 44G defines "base rate of pay" and sets out a number of exclusions to what constitutes "base rate of pay". Without fail, s 44G is applied to exclude certain loadings and allowances from the calculation of PIAWE. The difficult with this is that s 44G does not apply in all circumstances.

Section 44G is only relevant in the context of base rate of pay. Base rate of pay under the regime finds its origins in s 44E in the definition of "ordinary earnings". Ordinary earnings is calculated by reference to one of two categories:

1. if the worker's base rate of pay is calculated on the basis of ordinary hours worked, or
2. in any other case.

In order to determine which of the two categories an injured worker falls into, the insurer must refer to the definition of "ordinary hours" in s 44H of the 1987 Act. Section 44H requires the insurer to decide whether a worker is covered by a fair work instrument and whether that instrument sets out the ordinary hours of work. Where there is no instrument or the instrument does not provide for ordinary hours of work, the injured worker cannot fall into the first of the categories contained in s 44E. In that case "base rate of pay" has no relevance. "Base of rate of pay" is also not relevant to injured workers who fall into the category "in any other case." In those circumstances, s 44G has no role and the insurer's application of s 44G and insistence on excluding particular payments on the basis of s 44G is plainly wrong. The flowchart, as attached to the PIAWE submissions at Attachment B of these submissions, attempts to explain the relationship between the different sections in simple terms.

Section 44G appears to protect against the very rarer circumstance of 'double-dipping' – specifically including incentive based payments, loadings, monetary allowances, piece rates or commissions etc where those very payments have been included in ordinary hours of work payments. It appears it is not about excluding the s 44G exclusions from the calculation, which is how the insurers and merit review officers repeatedly apply the section. This incorrect application unfairly deprives a worker of compensation under the system.

This is particularly concerning in the context of casual employment. It is unusual for a fair work instrument to set out the ordinary hours of a casual employee. If there are no ordinary hours, there is no need to address the question of base rate of pay and there is clearly no legitimate reason for applying s 44G of the 1987 Act. Currently, there are waves of casual employees receiving PIAWE decisions which show their loading is not calculated as part of their PIAWE on the basis of s 44G. As outlined, that interpretation cannot be correct given that casual employees do not have ordinary hours of work. Injured workers are being denied proper compensation on the basis of a lazy and/or

mistaken interpretation of the PIAWE regime. – most of whom would not necessarily question the convoluted workings of PIAWE.

The CFMEU calls for the complete overhaul of the PIAWE system. The current 7 provision definition should be replaced with one simple definition:

> *"the average of an employee's pre-injury earnings during the 52 week period prior to injury or where an employee has not been employed for 52 weeks, the period of continuous service prior to injury."*

The fact that a PIAWE decision is a work capacity decision means that there is unlikely to be a judicial determination of the correct interpretation of these provisions. A PIAWE decision is reviewed through the work capacity review process which is largely administrative. This is why the conflict in this area continues to exist four years on from the legislation taking effect. The only means by which these sections may come before the court is through a judicial review application to the Supreme Court, however the costs of pursuing such a claim outweigh the likely remedy. The CFMEU did commence proceedings for judicial review on behalf of one of its members in the hopes of finally resolving the ongoing issues regarding interpretation, however that matter was settled for an amount equal to the alleged underpayment and hence did not proceed to determination.

This of course raises the issue of legal representation which will be addressed later.

6.2 Calculating Pre-Injury Award Weekly Earnings form (PIAWE Form)

The PIAWE form is an administrative burden for employers, injured workers and insurers. An employer is required to complete the form and return it to the insurer to calculate the injured workers PIAWE. In practice the role of the injured worker in this process is minimal. The insurer relies entirely on the information provided by the employer, which in some circumstances may not be accurate information. The first time an injured worker will be permitted to have a say in the calculation of their PIAWE is after the decision has been communicated to them, by which time their only option is to seek a review of the decision.

The CFMEU has been critical of the form in the past and has made submissions on the adequacy of the form to ensure accurate information has been provided. The CFMEU has argued that the form does not accurately reflect the legislation and does not provide enough guidance to the employer or injured worker. The most significant issue is that it places all the power in the hands of the employer.

The inadequacies of the form and how to resolve any issues were matters raised during the consultation for the PIAWE regulation. The CFMEU has since become aware that a new PIAWE form has come into existence, however that form is not available on the SIRA/WorkCover website and is therefore not readily available to injured workers or their representatives. The CFMEU has now been notified that the form is available on the icare website. Regardless, the accessibility of the form is a concern since injured workers are more inclined to search the SIRA/WorkCover website where they can access every other form.

The CFMEU became aware of the form after one of its members complained to the insurer about their PIAWE figure. The insurer then sent the member a copy of this new form to complete. The new form is three times the length of the initial PIAWE form and is far more complicated. The CFMEU spoke to an employer who was struggling to complete the form because it required too much information. The employer just wanted to provide a copy of the payroll records but was told that they were required to complete the form.

As stated, the form is not readily available and the injured worker is entirely reliant on the insurer to provide a copy of the form. The new form appears to be the creation of icare given the branding. When the CFMEU raised the issue of this new form with SIRA, they were unaware of its existence.

The CFMEU is concerned about the implications of the insurer relying on one set of forms and injured workers relying on another set of forms. The CFMEU is also concerned about the lack of consultation on the content of the forms; the fact that the forms are not readily available; whether the new forms are approved forms for the purposes of the 1987 Act; the lack of announcement about the existence of the new forms; and, the overall secrecy of the issue.

The CFMEU submits that SIRA and icare do away with the forms and that PIAWE be calculated on payroll records to be provided by the employer. Employers can readily produce reports and payslips for the relevant period without the necessity of completely a complex and largely unnecessary form.

Section 535 of the *Fair Work Act 2009* states: *"An employer must make, and keep for 7 years, employee records of the kind prescribed by the regulations in relation to each of its employees."* The *Fair Work Regulations 2009* require the employer to keep information regarding:

1. the rate of remuneration paid to the employee;[18] and
2. the gross and net amounts paid to the employee;[19] and
3. any deductions made from the gross amount paid to the employee;[20] and
4. any details about incentive based payments, bonuses, loading, penalty rate or separately identifiable amount;[21] and
5. overtime hours;[22] and
6. any leave that the employee takes or accrues.[23]

If the employer was required to provide the insurer with this information it is more likely to produce accurate PIAWE decisions than any information provided on the PIAWE form.

Ray notified the employer that he had suffered a work related injury. The initial notification was provided to the insurer. The employer was required to complete a PIAWE form by the insurer. The employer provided a base figure without any details as to overtime payments. The employer did not provide any supporting documentation such as a payroll report or payslips. The figure provided by the employer was not an accurate representation of the correct PIAWE. Ray's son contacted the insurer to raise concerns about the PIAWE and was told that his father (for whom English is a second language) would need to complete the form before the

[18] *Fair Work Regulations 2009* (Cth) reg 3.33 (1) (a).
[19] *Fair Work Regulations 2009* (Cth) reg 3.33 (1) (b).
[20] *Fair Work Regulations 2009* (Cth) reg 3.33 (1) (c).
[21] *Fair Work Regulations 2009* (Cth) reg 3.33 (3).
[22] *Fair Work Regulations 2009* (Cth) reg 3.34.
[23] *Fair Work Regulations 2009* (Cth) reg 3.36.

insurer would investigate the matter further. The insurer refused to ask the employer for supporting documentation to confirm that the calculation provided was actually correct.

The CFMEU attempted to calculate Ray's PIAWE based on the payslips provided by Ray. The CFMEU discovered that Ray consistently worked 5-7 hours overtime each week. This was not disclosed by the employer to the insurer and the insurer did not request copies of payroll records to confirm the declared figures. The CFMEU is currently assisting Ray with a review of his PIAWE decision.

7. Legal Representation in the Work Capacity Process

7.1 Background

There is a legislated power imbalance inherent in the work capacity system. Legal representation for an injured worker is all but prohibited during the work capacity review process, while the legislation does little if anything to prohibit an insurer from engaging legal assistance when making and reviewing a work capacity decision. Schedule 8, Part 19I clause 8 of the 1987 Act[24] (the former Section 44(6) of the 1987 Act) explicitly states:

> *A legal practitioner is not entitled to be paid or recover any amount for a legal service provided to a worker or an insurer in connection with a review of a work capacity decision for which an application is made under section 44 of the 1987 Act before the commencement of section 44BF of that Act (as inserted by the 2015 amending Act).*[25]

A legal practitioner is prohibited from charging an injured worker for assistance with a work capacity decision and WIRO is not permitted to grant ILARS for assistance with work capacity decisions, while insurers are receiving comprehensive legal advice from their in house lawyers. While the clause applies to both workers and insurers, insurers

[24] See former s 44(6) of the 1987 Act for restriction on legal costs for worker and Clause 9 Schedule 8 of the *Workers Compensation Regulation 2010* for restrictions on legal costs for insurers.
[25] Section 44BF is yet to be enacted.

are clearly accessing legal services to make work capacity decisions, make submissions to the Merit Review Service and make submissions to WIRO for procedural review.

This is not unexpected behaviour from the insurers though. During its Statutory review of the Workers Compensation Legislation Amendment Act 2012, the Centre for International Economics found that prior to the 2012 amendments there was an upward trend in insurer legal costs which is believed to be due to the reduction in the claim management capacity of System agents, resulting in an increasing reliance on legal providers.

An oft overlooked aspect of the work capacity system is that a decision regarding PIAWE is a work capacity decision for the purposes of s 43 of the 1987 Act. As outlined, decisions regarding PIAWE require legal assistance for injured workers to navigate and understand the complexity that has been created in this system. PIAWE is difficult for insurers, unions and the Authority. It needs the intervention of people who have an ability to construe complex concepts and legislation to try and apply the laws appropriately.

It is universally accepted by the legal profession, injured workers, and unions, that legal representation is necessary to properly navigate the work capacity process. The system is inherently complex. The principles involved in making a work capacity decision are not entirely logical or rational making it difficult for all parties in the process.

7.2 Current Review by SIRA

Legal representation in the work capacity process is necessary and long overdue. In its final report in the *Review of the Exercise of the Functions of the WorkCover Authority*, the Law and Justice Committee recommended:

> *That the NSW Government consider amending section 44(6) of the Workers Compensation Act 1987 to allow legal practitioners acting for a worker to be paid or recover fair and reasonable fees for the work undertaken in connection with a*

review of a work capacity decision of an insurer, subject to an analysis of its financial impact.[26]

On 12 August 2015 the government introduced the *Workers Compensation Amendment Act 2015* (assented to on 21 August 2015). The Amending Act contained a specific reference to legal costs. Section 44BF of the Amending Act states:

44BF Legal costs

1) *A legal practitioner is not entitled to be paid or recover any amount for a legal service provided to a worker or an insurer in connection with a review if:*
    a) *the review is of a prescribed class, or*
    b) *the regulations do not fix any maximum costs for providing the legal service to the worker or insurer in connection with the review.*
2) *Despite section 341 of the 1998 Act, the regulations may provide that, in prescribed circumstances, a party to a review under this Subdivision (other than an internal review) is to bear the other party's costs in connection with the review.*

On 29 October 2015 the government announced that as part of the benefits reform process SIRA would consult with stakeholders about the development of a regulation that could provide for payment of legal costs for work capacity decision reviews. On 29 October 2015, SIRA released the *"Regulation of legal costs for work capacity decision reviews – Discussion paper."* The paper requested stakeholders make written submissions about the issues raised in the paper, and contained a number of focus questions, some more worrying than others. One such question being *"In what circumstances should one party be required to bear the other party's legal costs?"* The mere suggestion that the injured worker may be asked to meet the legal costs of the insurer is offensive in the context of multiple inquiries referring to a workers legal costs with no mention of insurer legal costs.

[26] Legislative Council Standing Committee on Law and Justice, Parliament of NSW, *Review into the exercise of the functions of the WorkCover* Authority (2014) Recommendation 10.

The injured worker should not be required to bear the other party's costs. The injured worker is the most vulnerable party in the system and is at the behest of the insurance company. Every element of the work capacity process is designed to punish the injured worker for factors beyond their control. A requirement that they be forced to pay the insurers costs in the event that the review is not successful would deter injured workers from accessing the review process.

On 26 November 2015 submissions closed. On December 2015 SIRA issued a Submissions Summary which did little more than express the same views that had been expressed in other venues, particularly in the Parkes Project. The Summary provided nothing of substance nor a time frame for further consultation if necessary, or a time frame for the construction of the regulation. Ten months later and there is still no legal costs regulation with no indication that any such regulation is imminent. A significant component of the 2015 benefits reform has not been carried through to fruition and injured workers are still suffering at the hands of the work capacity process with little to no representation.

7.3 The Cost of Work Capacity Reviews

Since the introduction of work capacity process the CFMEU has been working hard to assist our members throughout the review process attempting to fill the gap normally reserved for legal representation. Through its experience the CFMEU has come to appreciate the complexity of the system and the necessity for persons with legal training to be available to navigate the system.

The complexity and expense of the process can be demonstrated by breaking down the work performed by the CFMEU in particular, in assisting injured workers to navigate the work capacity system. The CFMEU has one industrial officer responsible for work capacity reviews. In the initial stages of the work capacity regime, the CFMEU was averaging 4-6 applications a week. This was primarily decisions for existing recipients transitioning to the new system.

Initially the process undertaken by the union attempted to simplify the responses given the limited resources and what was viewed as the inevitability of the outcome. Of these applications lodged only one was overturned in the early stages of review. This decision

showed incredible creativeness and sensibleness from the insurer when reassessing suitable employment options. The vast majority of applications relied on the WIRO procedural review to challenge the decision.

As time progressed, and the Merit Review Service was delaying providing merit review decisions, it quickly became clear that a more detailed and involved response was needed to try and seek justice in the early stages of the review process. This detailed and involved approach requires full attention to all the documentation relied upon by the insurer in making the decision. It involves the applicant, in this case the union, dedicating 10-12 hours per week reviewing the documents, finding flaws or inconsistencies and structuring arguments to address primarily the issue of suitable employment. As the responses became more detailed there appeared to be more success in having the decisions overturned in the initial stages thereby reducing the impact on the individual injured workers.

As time progresses the arguments become more complex and legal, begging for the intervention of the legal profession. There is no logical basis for removing the ability for the legal profession to assist workers in the process.

Attachment C contains a series of work capacity review examples which demonstrate how legal representation can be used to navigate the work capacity system and assist in reducing administrative costs to the system. The examples also illustrate the level of work required to assist an injured worker through the process. They stand as a testament as to why legal representation is necessary in all stages of the work capacity process.

7.4 Limiting access to legal costs

While s 44BF allows for the prescription of particular classes of review, there is no restriction on allowing that prescription to include all avenues of review. There is no logical justification for not allowing paid legal representation at all levels of review.

The table attached at Attachment D, shows that a great deal of time and effort is put into compiling an internal review application. The internal review application is the first time an injured worker is presented with all the evidence in his file and is often several inches thick. It is overwhelming for the injured workers.

The internal review stage requires the legal representative time and opportunity to analyse the documentation, compare the decision to the documentation and compare the decision to the relevant legislation and Guidelines.

Examples D, E, F, J, K and L attached demonstrate that a well-argued internal review application can save the system administration costs by providing the insurer an opportunity to see the arguments against the decision to determine whether it's in the insurers best interests to proceed or whether the decision is likely to fail at a further stage in the process.

The adversarial nature of the review system is the reason why legal costs should not be determined on the outcome of the review. There are many circumstances where the internal review has confirmed the original decision but the Merit Review Service has overturned the original decision.

If such a regulation was to be implemented it would effectively make the review process obsolete. The system would be similar to the system we have now, where we ultimately expect legal representatives to work for free. If success was a precondition of legal expenses then why would a legal representative take on a client where they may be unable to recoup the cost. There is no logical justification for this kind of restriction.

The CFMEU has been very active in the work capacity process since the introduction of the system in 2012, along with several other unions. Any legal costs regulation should reflect that these matters may be dealt with by persons outside the legal profession. In that regard, any regulation should not be confined to lawyers, as with the ILARS system. The proposed regulatory changes must acknowledge and reward agents for the time and effort spent assisting injured workers with their applications for review.

The structure for legal costs must be kept simple and legal representation should be available at all tiers of the review process, available regardless of the outcome of the review process and available to agents of injured workers in addition to legal practitioners.

8. Medical expenses

The changes to medical and treatment expenses provisions as a result of the 2012 amendments represents the harshest and most damaging aspects of the new workers compensation system. Previously it was acknowledged that some injured workers require ongoing medicals in order to work or function socially. It was universally accepted that reasonable and necessary medical expenses for a work related injury should be covered for the entirety of an injured workers life. The amendments appear to have ignored this concept and have caused a great deal of pain for the people who are at the mercy of the workers compensation system.

The medical expenses limit contradicts the rhetoric that the system is focused on return to work outcomes. A person unable to receive the necessary treatment will be less likely to be stifled by the arbitrary limit on medical expenses, thereby defeating the purpose of the legislative system.

The real issue with the limit on medical expenses is that it is absolute. There is no necessity for an injured worker's personal circumstances or even injury to be taken into account prior to terminating their access to medical expenses. This is not acceptable or appropriate. Physical injuries may require further surgery in the future. Section 59A of the 1987 Act leaves no scope for taking this factor into account prior to terminating medical expenses.

Rather than the system becoming less burdensome, more accessible and easier to understand, each new amendment to the system creates an additional layer of confusion and complex. There is no greater evidence than the amendments to the provision of medical expenses.

As a result of feedback from stakeholders, the findings of this Honourable Committee, the Amending Act extended the time limit for medical expenses but in doing so added an additional layer of complexity. Medical expenses are still tied to the provision of weekly benefits, however they are now also tied to an injured worker's whole person impairment. Section 59A of the 1986 Act now states:

1) *Compensation is not payable to an injured worker under this Division in respect of any treatment, service or assistance given or provided after the expiry of the*

compensation period in respect of the injured worker.

2) *The compensation period in respect of an injured worker is:*
    a) *if the injury has resulted in a degree of permanent impairment assessed as provided by section 65 to be 10% or less, or the degree of permanent impairment has not been assessed as provided by that section, the period of 2 years commencing on:*
        i) *the day on which the claim for compensation in respect of the injury was first made (if weekly payments of compensation are not or have not been paid or payable to the worker), or*
        ii) *the day on which weekly payments of compensation cease to be payable to the worker (if weekly payments of compensation are or have been paid or payable to the worker), or*
    b) *if the injury has resulted in a degree of permanent impairment assessed as provided by section 65 to be more than 10% but not more than 20%, the period of 5 years commencing on:*
        i) *the day on which the claim for compensation in respect of the injury was first made (if weekly payments of compensation are not or have not been paid or payable to the worker), or*
        ii) *the day on which weekly payments of compensation cease to be payable to the worker (if weekly payments of compensation are or have been paid or payable to the worker).*

The amendments to s 59A of the 1987 Act create an environment where there is potential for further conflict between the injured worker and the insurer. It is not difficult to imagine a situation whereby the injured worker is seeking to claim medical benefits beyond the 2 year limit only for the insurer to claim they do not meet the threshold requirement.

In those circumstances in order to be appropriately compensated the injured worker may be forced to undergo a WPI assessment to prove entitlement. Unfortunately this will impact their ability to choose the timing of their lump sum compensation claim.

Section 322A of the 1998 Act states:

(1) Only one assessment may be made of the degree of permanent impairment of an injured worker.

If the injured worker is forced to undergo an assessment for the purposes of claiming medical expenses that will constitute their one assessment. If the medical expense claimed is for surgery, that surgery will likely impact the percentage of impairment. However, by virtue of s 322A of the 1998 Act, the injured worker will not be entitled to a second assessment.

Charlie was born in 1949 and had worked as steel fixer since the age of 18 years. For the majority of his working life Charlie worked outdoors in daylight hours resulting in occupational sun exposure. No form of sun protection was provided under approximately 1985. After the introduction of hard hats on site, Charlie was no longer able to wear his sun hat when working outdoors. As a result Charlie suffered from a number of skin cancers and severe scarring, particularly to his face.

Charlie brought a claim for lump sum compensation under Section 66 for 14% whole person impairment. The insurer failed to accept the assessment provided by Charlie's doctor and made arrangements for Charlie to see a doctor of their choosing. Following the examination, the insurer failed to respond to the claim or make any offer of settlement and Charlie was forced to commence proceedings in the Workers Compensation Commission.

Following the commencement of proceedings the insurer released the report of its doctor who had assessed 10% whole person impairment. The insurer declined to make any offer of settlement. Charlie's claim was referred to an Approved Medical Specialist who provided a binding assessment below 11% whole person impairment. Charlie failed to recover any compensation for his skin cancers.

It is also likely Charlie will require ongoing skin check and removal of skin cancers for the rest of his life. Due to the assessment of impairment, the insurer would only be liable to meet the cost of the treatment for a period of two years only.

The CFMEU submits that the amendments to the medical expenses, in creating separate categories, has created unjust and unfair outcomes. The CFMEU submits that rather than attempting to create separate medical systems for different workers the system must provide medical expenses for life for all injured workers.

9. Industrial Deafness claims

Industrial deafness is a significant problem in the construction industry as workers often transfer from one noisy employer to another with very little, if any break in between. While there may be stricter rules for trying to prevent hearing loss, these measures are not able to completely eradicate the risk to individuals.

Hearing loss can affect a person's ability to perform their work and can increase the safety risks to individuals and the people around them due to an inability to hear instructions from supervisors or warnings as to safety.

Prior to the amendments, a person suffering from a minimum 6.1% binaural hearing loss was eligible to make a claim for compensation under s 66 of the 1987 Act. There was no limit on the number of claims a person could make under this section so long as they were able to show that their hearing had deteriorated.

As a result of the amendments in order to make a s 66 claim for industrial deafness, a person needs to suffer at least 20.5% binaural hearing loss. This is an extraordinarily high threshold to reach. Many individuals attempting to make an initial claim for industrial deafness will struggle to reach that threshold.

Many workers who have had previous claims for lump sum compensation are disadvantaged by the need to reach the threshold every time a claim is made. Injured workers with industrial deafness do not receive the same benefit as workers with other physical injuries who had claims prior to 19 June 2012 as they don't get the option to pursue one further claim. The reason for this is that every ID claim is deemed a new injury with a new date of injury and this it doesn't count as a deterioration of the original injury. This means thousands of workers have a deterioration in their hearing loss and no way to be compensated as they don't have a further 11% which is a difficult threshold to reach even without having had prior claims.

Branko was assessed at 12% WPI in 2015. He did not recall having a previous claim in 1999 which was located by the insurer. He was awarded 5.12% binaural hearing loss which when deducted from the current claim just puts him under the threshold and he loses his claim for lump sum compensation. Now Branko can decide not to continue with the claim and as he is still working his hearing loss is likely to deteriorate. We can get him assessed later and he will be able to make a further claim if his hearing loss has deteriorated to get him over the threshold once the previous claim is deducted. However if Branko had ceased to work in noisy employment then his chances of his hearing loss deteriorating would be gone as hearing loss is assumed to stop deteriorating once the noise exposure ceases.

The CFMEU submits that changes be made to the system to recognise that industrial deafness claims are just as debilitating as physical injuries. The CFMEU submits that the system must appreciate that a 20.5% binaural threshold is out of reach for the majority of workers who suffer industrial deafness. The threshold fails to recognise the impact that industrial deafness can have on an injured workers ability to gain and maintain employment and the social isolation that comes with reduced hearing.