Submission No 38

INQUIRY INTO PROPOSED CHANGES TO LIABILITY AND ENTITLEMENTS FOR PSYCHOLOGICAL INJURY IN NEW SOUTH WALES

Organisation: New South Wales Nurses and Midwives' Association

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SUBMISSION BY THE
NSW NURSES AND MIDWIVES' ASSOCIATION

Inquiry into the proposed changes to liability and entitlements for psychological injury

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NSW NURSES AND MIDWIVES' ASSOCIATION
AUSTRALIAN NURSING AND MIDWIFERY FEDERATION NSW BRANCH

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This response is authorised by the Elected Officers of the New South Wales Nurses and Midwives' Association.

Contact details

NSW Nurses and Midwives' Association

Introduction

1. The New South Wales Nurses and Midwives' Association (NSWNMA) is the industrial and professional body for nurses and midwives in New South Wales, representing over 80,000 members across the full spectrum of health care services in NSW, including public and private hospitals, midwifery, corrective services, aged care, disability, and community settings.

2. NSWNMA strives to be innovative in our advocacy to promote a world-class, well-funded, integrated health system by being a professional advocate for the health system and our members. We are committed to improving the quality of all health and aged care services, whilst protecting and advancing the interests of nurses and midwives and their professions.

3. We work with our members to improve their ability to deliver safe and best practice care, fulfil their professional goals and achieve a healthy work/life balance.

4. Our strong and growing membership and integrated role as both a trade union and professional organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions, and see us uniquely placed to defend and advance our professions.

5. Through our work with members, we not only strengthen the contributions of nurses and midwives to improve Australia's health and aged care systems but also advocate fiercely for the rights of those harmed by systemic failures. We achieve this by advocating for safe workplaces, mental health equity, and fair treatment for all workers.

6. The NSWNMA thanks the NSW Legislative Council's Standing Committee on Law and Justice for the opportunity to provide feedback on the proposed changes to liability and entitlements for psychological injury in New South Wales.

Overview

7. The NSW Government's proposal to restrict access to workers' compensation for psychological injuries shows a fundamental misunderstanding of how these injuries occur. For nurses and midwives, psychological harm is rarely caused by a single event, it is the result of cumulative exposure to trauma, stress, and unsafe working conditions. Between 2013-2015 and 2019-2021, there was a 150.6 % increase in psychological injury claims in this workforce, the highest growth rate of any profession.[1] This is not due to the malingering of nurses and midwives but reflects systemic failures. The committee must place this reality front and centre in its consideration of these amendments to workers compensation legislation.

8. Nurses and midwives are routinely exposed to multiple psychosocial hazards in the course of their work, these risks are compounded and exacerbated by systemic understaffing. When there are not enough nurses or midwives on shift, patient needs go unmet, which can lead to frustration, agitation and escalating behaviour, creating a higher risk of occupational violence. There are often too few staff to safely manage aggressive patients, increasing the likelihood of nurses being assaulted. Excessive overtime and missed meal breaks contribute to fatigue and burnout, which in

turn fuel interpersonal tension, incivility and conflict among colleagues. **Understaffing also results in moral injury, as nurses are forced to witness and participate in care that falls below professional standards, not due to a lack of skill or commitment, but because the system has failed to provide the necessary resources.** This convergence of hazards creates a dangerous and unsustainable working environment, placing nurses at serious risk of psychological harm.

9. The health sector fails to manage psychosocial hazards – identification of psychosocial hazards is generally reactive rather than systematic, based on individual workers reporting issues (or worse, only noticed when someone is injured). Reporting systems are time-consuming and don't lend themselves to psychological hazards, and when issues are identified, there is a failure to implement adequate controls to manage the risk. Members who report psychosocial hazards often report extremely poor responses from managers not trained in management of psychosocial hazards or how to take a trauma-informed approach to injured workers. This lack of support is a psychosocial hazard in its own right and causes significant harm, often being the tipping point for workers making a claim.

10. The NSWNMA expresses serious concerns regarding the proposed amendments to the workers compensation legislation. These changes would significantly limit access to compensation for workers who suffer psychological injuries unless they are able to prove that their injury was caused by a defined "relevant event".

11. The NSWNMA is particularly concerned about the implications for nurses and midwives, who are frequently exposed to occupational violence, bullying, harassment, chronic understaffing and poor procedural justice, all of which create an unsafe and high-risk work environment. The draft Bill's provisions create numerous legal and procedural barriers that will make it extraordinarily difficult for healthcare workers to access support following psychological harm. These barriers will disproportionately impact female nurses and midwives.

12. The reforms proposed by the NSW Government prioritise cost containment over the protection of frontline workers, including nurses and midwives. If enacted, these changes will remove income and medical support from many nurses and midwives psychologically injured while caring for others and force other traumatised healthcare professionals to navigate additional administrative burden while they are in recovery, compounding their harm and delaying their return to work. In our view, the Government could considerably contain cost within the workers' compensation scheme without attacking injured workers by focusing on preventative measures and ensuring employers abide by their obligations to provide safe and suitable work.

13. Removing access to income support and medical treatment for nurses and midwives with psychological injuries and introducing further barriers to those seeking support will have devastating and far-reaching consequences. These measures risk compounding the harm experienced by workers already at breaking point, leaving them without the financial means or therapeutic resources to recover. As the average Australian nurse and midwife is a 42 and 45-year-old female, respectively the financial impact of these proposed changes would have a flow-on effect on single-parent families, as 78% of Australian single-parent families are headed by women.[2] [3] For many, the inability to access timely treatment or maintain a livelihood during periods of psychological ill health can lead to social isolation, worsening mental health and, in some cases, self-harm or suicide. **Nurses and midwives dedicate their working lives to caring for others; failing to care for them when their work injures them is not only unjust, but also dangerously negligent.**

Summary of Recommendations

14. Reject the proposed eligibility restrictions that would deny compensation to psychologically injured workers unless they can prove their injury arose from a narrowly defined "relevant event".

15. Remove the proposed 31% whole person impairment (WPI) threshold for psychological injuries.

16. Empower the Industrial Relations Commission (IRC) to oversee employer compliance with return-to-work obligations, especially in cases where suitable duties are refused.

17. Mandate an independent review of employer decisions regarding suitable duties (including decisions to cease providing suitable duties) to ensure fair treatment and faster return-to-work outcomes, with the onus placed on the employer to demonstrate that suitable duties cannot be provided.

18. Focus on addressing the systemic causes of psychological injury in healthcare, such as role overload, chronic understaffing and proper systems for managing risk associated with workplace aggression.

19. Reinforce SafeWork NSW's authority and capacity to regulate psychosocial risks in healthcare workplaces by establishing a dedicated well-resourced healthcare and social assistance sector team of inspectors within SafeWork NSW and by implementing the proposed changes to the Model Work Health and Safety Act in relation to notifiable incidents as a matter of priority to ensure regulatory oversight of the key sources of serious harm to our membership.

20. Take proactive steps to prevent workers' compensation legislative changes from having disproportionate deleterious impacts on female workers including failure to align with the aims of the federal "Respect at Work" law reforms which have given women greater protections for reporting experiences of sexual harassment in connection to the workplace.

21. Amend the workers' compensation laws to introduce a presumption in favour of nurses and midwives experiencing psychological injury.

22. Bestow financial incentives for employers to provide suitable work to injured workers. This could come in the form of a reduced premium.

23. Impose severe penalties on employers and individuals who refuse to provide work to injured workers where such work is available. A financial disincentive could also be imposed by way of an increased premium.

24. Give insurers the capacity, and then oblige them, to rigorously examine whether their clients can provide suitable work to an injured worker prior to termination or suitable work being withdrawn and prior to requiring that worker to seek work elsewhere.

25. That it be an offence for an employer to require a prospective employee to declare whether they had previously suffered a workers' compensation injury unless that injury would prevent him or her from performing the inherent requirements of the role.

26. Make it an offence for an employer to inform another prospective employer that a former employee has suffered a workers' compensation injury.

27. The Government implement programs designed to educate employers regarding their obligation to provide suitable work to injured employees.

28. Remove the requirement in section 49, *Workplace Injury Management and Workers Compensation Act 1998* (NSW) for workers to request suitable work from their employer before the employer has an obligation to provide that work. Requiring a request of this kind is illogical and inconsistent with the strong return-to-work focus in the legislation.

29. Require recalcitrant employers to reimburse insurers for weekly payments of compensation which would not have been paid had the employer complied with its return-to-work obligations.

30. Adopt the five-point plan proposed by Unions NSW, which focuses on enforceable prevention strategies, insurer accountability, access to justice, and sustainable funding models,

Workplace Psychological Injury of nurses and midwives

31. Nurses and midwives face a higher risk of psychological injury than many other workers due to the inherently demanding and emotionally charged nature of their roles. Their work frequently involves exposure to trauma, suffering and death, as well as the need to provide compassionate care under time pressures and resource constraints. They often work in environments characterised by high workloads, shift work, inadequate staffing and exposure to occupational violence, all of which contribute to elevated psychosocial risk. Additionally, the ethical and emotional burden of balancing patient needs with systemic limitations can result in moral distress. These conditions, compounded over time, place nurses and midwives at significantly greater risk of developing psychological injury compared to workers in less complex and lower-pressure settings.

32. Psychological injuries among nurses and midwives are not isolated incidents. They arise from persistent, systemic issues embedded within the structure and culture of healthcare. These injuries are most often caused by the cumulative effects of role overload, occupational violence, bullying and harassment, and moral distress. Insufficient action is being taken to address these risks and prevent injuries from occurring.

Role Overload

33. One of the most widespread and deeply rooted contributors to psychological injury in healthcare is role overload, which exists where the demands placed on workers consistently and significantly exceed the time, staffing and support available to meet them. In nursing and midwifery, this often manifests as chronic understaffing, where nurses and midwives are routinely expected to care for too many patients at once, manage complex clinical presentations, navigate administrative burdens and provide emotional support to patients and their families, all without adequate resources or rest. Inadequate skill mix, combined with limited supervision and inappropriate delegation, significantly contributes to role overload and fatigue.

34. Wage suppression in NSW has significantly contributed to chronic understaffing and poor retention of nurses and midwives, creating a cascading impact on the entire healthcare system. As experienced staff leave, new recruits are discouraged from entering or staying in the profession, and those who remain are forced to absorb increasing workloads. This intensifies role overload, reduces the capacity for safe and effective care, and heightens the risk of psychological injury.

Without fair wages and conditions, the workforce will continue to dwindle, further cementing systemic pressures that harm nurses, midwives and their patients.

35. When less experienced or underqualified staff are expected to perform tasks beyond their scope without proper support, the burden falls on nurses and midwives to oversee, correct and absorb the additional workloads. This not only compromises patient safety, but also pushes experienced staff beyond their limits, accelerating psychological injury. The intensity of these workloads leaves little time for breaks, reflection or recovery, which is then compounded by the effects of shiftwork and unsafe levels of overtime. This forces nurses and midwives to operate in a near-constant state of high alertness and fatigue.

36. The unrelenting pressure can lead to decision fatigue, where mental resources required for safe clinical reasoning is depleted. Over time, this contributes to emotional exhaustion, a key contributor to burnout. Role overload often results in moral injury, which is the internal conflict and psychological harm that arises when workers are unable to uphold their professional and ethical standards of care. Inability to meet patient needs not due to effort but due to system failures leads to feelings of guilt, shame and helplessness.

37. This does not occur in isolation. Excessive workload increases the likelihood of interpersonal conflict, staff tension and communication breakdowns. These factors degrade team functioning and psychological safety. Heavy workloads and inadequate staffing act not only as primary stressors but also as key predictors of workplace bullying, which compounds psychological harm. When nurses and midwives are stretched beyond capacity, frustrations increase, collegial support deteriorates and opportunities for constructive feedback and mentoring are diminished.

38. Over time, these stressors contribute to toxic cycles, raising rates of sick leave, burnout and attrition, which further intensify staffing shortages and workloads for those who are left behind. The cumulative impacts of this overwork not only erode psychological safety but also reflect a broader pattern of systemic neglect, where the failure to provide safe and sustainable working conditions directly contributes to burnout, moral distress and long-term psychological injuries.

39. Workers' compensation data vastly underestimates the rates of workplace psychological injury experienced by nurses and midwives (and other health professionals), with many injured workers too frightened to make a claim for fear of potential impacts on their registration and hence their careers. These concerns arise from a widespread misunderstanding about the operation of mandatory reporting of healthcare workers who are "impaired", with impairment defined as "*a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect the person's capacity to practice the profession".* Unfortunately, there are many within the sector who will report other workers as impaired if they seek mental health support or receive a mental health diagnosis.

40. Ahpra and the Nursing and Midwifery Board of Australia are responsible for the regulation of the nursing and midwifery professions nationally. In NSW the management of impaired practitioners is delegated under the *Health Practitioner Regulation National Law* (NSW) (the National Law) to the Nursing and Midwifery Council of NSW. The process for management of impaired practitioners is described in National Law, but this can result in conditions or restrictions being imposed on the professional registration affecting the practice of nurses and midwives at a much lower threshold than in other professions. In many cases, this means that they cannot work or find employment within the nursing or midwifery professions. Increasing the threshold at which workers who are

nurses or midwives can access workers' compensation would place on them a much more severe injustice due to the nature of the professions in which they work, which are often in high-risk environments where they are at risk of physical or psychological injury.

41. Nurses and midwives are likely to be unable to continue in their work at a much more restrictive threshold than many other professions due to various regulatory factors affecting their ability to work to the requisite professional standards. It is questionable whether the public good would be served by restricting access to workers' compensation insurance to protect the health and well-being of nurses and midwives who are the victims of work-related injury and much more sensitive to regulator-imposed restrictions on their ability to return to their workplace and support themselves and their families.

42. A recent iCare funded research project examining psychological injury workers' compensation data across the healthcare sector in NSW identifies the three key causes of psychological injury for nurses and midwives as harassment or bullying (38.4%), work pressure (23.1%) and occupational violence (18%). It also found that, after adjusting for all other factors, workers in healthcare and social assistance industries had 32% higher likelihood of a workers' compensation claim for psychological injury than workers in other industries.[4]

43. While the claims data has shown that these are the three key causes of psychological injury, it is known that the situation is more complex than this, as workplace psychological injury most frequently arises not from exposure to a single, isolated psychosocial hazard, but from the cumulative and prolonged exposure to multiple hazards over time. These may include excessive workloads, patient/client deaths and dying processes, lack of control, poor workplace relationships, inadequate support, job insecurity, workplace violence and exposure to bullying or harassment. While each hazard individually poses a risk, it is the interaction and accumulation of these factors, particularly when left unaddressed, that significantly increases the likelihood of psychological harm. This complex and compounding nature of psychosocial factors underscores the problem with having a limited list of "events" to determine eligibility for access to income and medical support.

44. Data from SafeWork Australia (2024) showed that health care workers had the highest number of serious claims for work-related mental health conditions than any other industry over the last five years.[5] The data also highlights a disturbing gendered dimension where women are significantly more likely to be exposed to harmful behaviours at work, including violence, bullying and harassment. This reinforces the urgent need for strong protections and trauma-informed approaches in predominantly female workforces.

45. Suicide risk has been found to be higher for nurses and midwives than those in other occupations in an evidence review by the Sax institute.[6] The National Coronial Information Service, which provides reports on intentional self-harm deaths of health professionals in Australia, designates nursing and midwifery as a known high-risk sector.[7] Research from the Nurse Midwife Support service shows that female nurses and midwives are 192% more likely to commit suicide than females in other occupations, and male nurses and midwives are 52% more likely to commit suicide than males in other professions.[8] The factors contributing to this statistic include the high job demands that lead to poor work–life balance and increased experiences of anxiety. The NSWNMA is aware of many member suicides. Most of these members had been receiving support from the NSWNMA in relation to concerns about psychosocial hazards including workloads,

exposure to violence, poor supervisor/manager support and experiences of poor procedural justice.

46. Given the significant and well-documented risk of psychological harm faced by nurses and midwives due to the nature of their work and the poorly managed risks, there is a compelling case for amending the workers' compensation legislation to include a presumption in favour of these workers when claiming for psychological injury. A presumption provision would recognise the cumulative impact of repeated exposure to trauma, occupational violence, high workloads and moral distress and would ensure timely access to support and treatment without unnecessary delays caused by contested liability. Such a reform would not only acknowledge the unique challenges of the nursing and midwifery professions but also improve recovery and return-to-work outcomes by reducing the administrative and psychological burden placed on injured workers.

Occupational Violence and Aggression

47. Nurses and midwives are among the most assaulted professionals in Australia. They face physical violence, verbal abuse and intimidation, particularly in high-risk areas like emergency departments, mental health units and aged care. These experiences often lead to significant physical harm as well as anxiety, post-traumatic stress disorder (PTSD) and a desire to leave the profession. However, violence is frequently normalised as "part of the job", resulting in under-reporting and minimal support.

48. The SafeWork Australia *Workplace and work-related violence and aggression in Australia report (2024)* provides the table below showing occupations with the most claims for exposure to workplace violence or being assaulted, with a female share of employment.[9]

Occupation	Number of serious claims	Female share of employment
Registered nurses	1,848	88%
Welfare support workers	1,701	74%
Aged and disabled carers	1,501	77%
Police	1,476	29%
Nursing support and personal care workers	1,386	79%

Figure 1. Occupations with most claims for exposure to workplace violence or being assaulted with female share of employment, NDS (2017-18 to 2021-22p) and ABS Census (2021).

Workplace Bullying, Harassment and Discrimination

49. Workplace bullying is a pervasive issue in healthcare settings, where high-stress environments and chronic understaffing often intensify interpersonal tensions. Among the various antecedents, role overload has been identified as a significant predictor of bullying. Role overload is linked to emotional exhaustion, reduced coping capacity and increased workplace aggression. [10] [11] [12]

50. In healthcare, where staff frequently report excessive workloads and time pressure, these conditions can heighten the risk of intraprofessional bullying behaviours emerging, highlighting role

overload as one critical factor to address in promoting safe and respectful relationships and preventing psychological injuries.

51. Common behaviours include verbal abuse, exclusion, reduced opportunity for professional progression and unreasonable expectations. Early-career nurses and midwives are particularly vulnerable, often experiencing "horizontal violence" from colleagues. These behaviours are not isolated but are symptoms of broader cultural dysfunction.

52. Culturally and linguistically (CALD) nurses and midwives face additional layers of risk. The NSWNMA's 2018 Cultural Safety Gap Survey found that a significant proportion of CALD members experienced racism in the workplace, from both patients and colleagues.[13] Many reported being treated as "less capable" due to their accent or background, while others were excluded from social and professional opportunities. Alarmingly, less than one--third had reported incidents of racism, and 21% did not feel confident to do so.

53. Sexual harassment and sexual assault are also common workplace hazards experienced by nurses. The instigators of such behaviours are often patients or aged-care facility residents, with nurses frequently expected to continue to provide care for people despite repeated indecent assaults.

54. These experiences have tangible impacts. Exposure to bullying, racism, sexual harassment and assault and exclusion erodes professional confidence, contributes to long-term psychological distress and undermines workforce retention. When any group of workers is not adequately supported, the health system suffers a loss of skill, morale and cohesion. Addressing these patterns requires more than individual strength, it demands system-wide cultural change centred around safety, equity and accountability. Rather than acknowledging and addressing the systemic causes of harm, the proposed amendments shift responsibility back onto injured workers.

Moral Distress and Vicarious Trauma

55. Moral distress occurs when nurses and midwives are unable to act in accordance with their ethical and professional values due to systemic constraints, such as unsafe staffing levels or inadequate resources. This can lead to enduring feelings of guilt, shame and helplessness. Vicarious trauma is also widespread, as nurses and midwives regularly witness or are involved in traumatic events, such as patient deaths, child abuse or aggressive resuscitations. Without access to structural support the emotional burden accumulates, leading to emotional numbing, complex PTSD and professional disengagement. There is a strong correlation between moral distress and burnout, particularly in high-pressure clinical settings.

Organisational Culture and Systemic Failures

56. Toxic workplace culture is a common denominator across all these contributors to psychological harm. When healthcare organisations fail to manage psychosocial hazards, nurses and midwives experience the compounding effects of exposure to multiple psychosocial hazards, greatly increasing the risk of harm. Contributing factors include a focus on patient needs to the exclusion of the WHS of workers, inadequate risk management, including failure to identify foreseeable risks or to implement effective controls, inadequate reporting mechanisms, lack of staff consultation on WHS matters including workload, a blame-focused response to adverse events and insufficient access to trauma-informed psychological support.

57. Nurses and midwives bear the emotional, psychological and moral cost of systemic organisational and industry-wide shortcomings without meaningful support. As the 2024 SafeWork Australia data illustrates, harmful workplace behaviours disproportionately affect women, compounding risk in a female-dominated profession.[3]

58. Preventing psychological injury must go beyond resilience training; it requires commitment to reforming the environment that enables these harms to persist. The proposed amendments fail to address these systemic drivers instead leaving injured workers to bear the costs.

Trauma-Informed Reporting

59. Trauma-informed reporting acknowledges the high prevalence of trauma in healthcare and seeks to minimise the risk of retraumatisation when healthcare workers report adverse or distressing events. For nurses and midwives, reporting is not a neutral or purely administrative task. It often involves recounting experiences of workplace violence, clinical deterioration, system failures, bullying or ethically distressing situations, all of which carry a significant emotional burden.

60. However, existing incident reporting systems are predominantly procedural, designed to serve compliance and risk-management purposes, and often fail to recognise or support the emotional and psychological impacts on nurses and midwives. These systems and their related processes frequently require repeated retelling of traumatic events, lack psychological safety, and offer little-to-no meaningful response or follow-up. As a result, nurses and midwives commonly report feeling unsupported, disbelieved or even blamed, which discourages accurate and timely reporting.

61. Of particular concern is the failure to act on WHS reports. Even when staff disclose significant incidents affecting their wellbeing or patient safety, these reports often result in no tangible change. This not only undermines trust in organisational processes but can deepen harm by reinforcing a culture of silence and inaction. The lack of responsive, trauma-informed systems contributes to moral injury, psychological distress and professional withdrawal.

62. Nurse and midwife managers are rarely provided with the training and resources needed to prevent or respond to psychological injuries experienced by their staff. Despite working in environments where illness, trauma and death are daily realities, there are no standardised or mandatory mechanisms for debriefing after critical incidents. This absence of structural support leaves healthcare workers to cope in isolation, compounding stress and increasing the risk of psychological harm.

63. The implications for the nursing and midwifery workforce are profound. Ongoing exposure to trauma, combined with unsupported reporting experiences, increases the risk of burnout, vicarious trauma and attrition. When trauma is not adequately addressed, it negatively impacts the safety and quality of patient care, with broader consequences for workforce retention and system sustainability.

64. The NSWNMA advocates that all health systems embed trauma-informed principles in reporting processes. These include creating psychologically safe environments, ensuring transparency and follow-up, enabling staff choice and control of how they report, and recognising the need for emotional as well as procedural support. Employers have a responsibility to receive these reports

and to act on them. Failure to do so not only increases the psychological burden on workers but also perpetuates unsafe environments and institutional harm.

The Impacts of the Proposed Legislation on Nurses and Midwives

65. As outlined in the previous section, healthcare is a high-risk industry where workers are exposed to the cumulative effects of multiple psychosocial hazards, resulting in high rates of psychological harm. Nurses and midwives are regularly exposed to distressing and often traumatic events, including patient deaths, aggression from patients and families and workforce pressure stemming from unsafe staffing levels and skill mix. Rather than supporting workers in distress, the proposed legislation would reduce access to compensation and impose procedural hurdles that are both unnecessary and harmful.

Meaning of psychological injury

66. The Bill introduces terms that are likely to see a further increase in insurers seeking legal and Independent Medical Examiner reports prior to claim approval as well as an increase in legal disputation leading to delays in provision of income support and medical treatment for injured workers. Such delays in treatment and lack of support, as well as the adversarial nature of such conduct, causes further harm to psychologically injured workers.

67. The Royal Australasian College of Physicians research regularly cited by Australian health and safety regulators advises that the longer that people are off work, the less likely they are to return to work, not only to their original position, but to any job. It shows that workers who are off work for 20 days have a 70% chance of returning to work, with this declining to a 50% chance of return to work for those off for 45 days, and only a 35% chance of returning to work for those off work for 70 days or longer. Introducing additional processes such as the need for a finding by a court or tribunal will see workers off work for extended periods, reducing the likelihood of durable return to work.

68. The proposed new section 8A as set out in the Bill introduces a new definition of psychological injury: *"an injury that is a mental or psychiatric disorder that causes significant behavioural, cognitive or psychological dysfunction".* The introduction of this definition will give NSW the most restrictive definition of psychological injury for the purposes of workers' compensation in Australia (in line with the changes introduced in Victoria in 2024). The introduction of the word "significant" in this context will lead to medical and legal disputation, delaying access to care for those who are eventually deemed to demonstrate "significant" dysfunction, and excluding many more whose dysfunction is not deemed significant enough, from any access to support.

Relevant Event

69. The draft Bill seeks to severely limit access to psychological injury compensation by restricting eligibility to a narrow list of "relevant events". These include:

- Being subjected to an act or threat of violence, or
- Being subjected to indictable criminal conduct, or

- Witnessing incidents resulting in death or serious injury, or the threat of death or serious injury, including the following – an act of violence, indictable criminal conduct, a motor accident, a natural disaster, a fire or another accident, or
- Experiencing vicarious trauma within the meaning of section 8H, or
- Being subjected to conduct that a tribunal, commission or court has found is sexual harassment, or being subject to conduct that a tribunal, commission or court has found is racial harassment, or
- Being subjected to conduct that a tribunal, commission or court has found is bullying, or
- Another event prescribed by the regulation.

70. This list of "relevant events" for the purpose of workers' compensation is the most restrictive in Australia and ignores the well-established evidence around the psychosocial factors in workplaces that are known to cause psychological harm. It also fails to recognise that most psychological injuries sustained by nurses and midwives result not from one singular traumatic event but from the cumulative exposure to multiple psychosocial hazards over time.

71. In an assessment undertaken by the NSWNMA of psychological injury workers' compensation claims we have assisted members with in the last 12 months, we have identified that only 44% would potentially meet the new criteria to be eligible for support, with 53% of those required to appear before a court, commission or tribunal prior to application.

72. The concept of limiting compensation for workplace psychological injury to a narrow list of "eligible events" is both arbitrary and deeply flawed. Psychological harm does not discriminate based on whether it fits into a predetermined category. Whether an injury stems from a sudden traumatic incident or the insidious build-up of unlisted psychosocial hazards, the distress and functional impairment experienced by the worker are equally real and debilitating. By excluding injuries that arise outside these narrow definitions, the system will effectively deny support to those most in need, undermining recovery. Nurses and midwives, who are already at heightened risk, deserve comprehensive access to income support and therapeutic services when their work harms their mental health, not only when their experience matches an arbitrary event on a list.

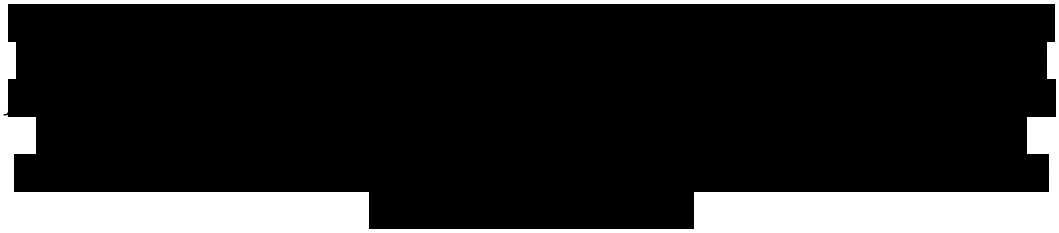
73. The proposed list of categories leaves many questions unanswered, for example:

    Being subjected to indictable criminal conduct – how would this be demonstrated by the injured worker? Would their word that they had been subjected to such conduct be adequate for the purposes of accessing compensation? Would it require a police report? Would police need to lay charges? Would the offender need to be prosecuted? Nurses are frequently subjected to indictable criminal conduct, including incidents such as sexual touching by patients. It is extremely rare for the police to lay charges in these circumstances. Including additional requirements to demonstrate that they have been subjected to indictable criminal conduct for nurses who have been sexually touched is not trauma-informed and will create barriers to accessing support when required, compounding the harm.

    Witnessing incidents resulting in death or serious injury, or the threat of death or serious injury, including the following an act of violence, indictable criminal conduct, a motor accident, a natural disaster, a fire or another accident – is the inclusion of the second part of this clause (from "act of violence" onwards) intended to place restrictions on the types of deaths or serious injuries that workers may witness that would be compensable or is this list included for illustrative purposes?

There are many situations that nurses face that may involve witnessing an incident resulting in death or serious injury, but may not be covered by the second section of the clause.

Nurses in a metropolitan Sydney emergency department witnessed a patient attempt to self-decapitate. As the patient ran around the ED, spraying blood from a severed artery, they needed to try to physically restrain the person and provide immediate medical care to prevent them from bleeding to death.



74. The NSW Code of Practice for Managing Psychosocial Hazards at Work (the Code of Practice) acknowledges the broad range of psychosocial hazards associated with psychological harm. This code was developed in conjunction with industry experts and academics and psychosocial hazards were only included where there was a substantial evidence base that linked them with psychological harm to workers. It includes:
    - Role overload (workload/understaffing)
    - Role underload
    - Role conflict/lack of role clarity
    - Low job control
    - Conflict/poor workplace relationships
    - Poor support from supervisors and managers
    - Poor coworker support
    - Violence
    - Bullying
    - Harassment including sexual harassment
    - Inadequate reward and recognition
    - Hazardous physical working environments
    - Remote or isolated work
    - Poor procedural fairness
    - Poor organisational change consultation

75. Under the proposed amendments, injuries caused by these common workplace psychosocial hazards would be excluded from support. This is particularly alarming in healthcare, where workers face many of these hazards in a sector already under strain, and where persistent understaffing, violence, moral injury and burnout are endemic.

Role Overload

Nurses caring for an adolescent mental health patient suffered injuries arising from role overload and exposure to trauma (that doesn't fit the proposed definition). The patient was admitted to their unit following an extensive (13 months) prior admission. The patient had developed several maladaptive attachment styles following severe trauma experienced as a child, and as a result, was only receptive to a limited number of nurses, especially when highly distressed. This left a small number of nurses involved in the majority of serious self-harm attempts by this patient leading to intense burnout.

A theatre nurse was psychologically injured following a prolonged period of short staffing. There were no attempts by the facility to reduce theatre lists in line with available staffing resources leading to excessive overtime including 18hr shifts and working on days off. Burnout was rampant and sick leave was increasing at a steep rate. The nurse had booked annual leave for her honeymoon 12 months prior but had her leave revoked 3 months before her wedding due to the staffing shortages. Additionally, Increased errors and unsafe workplace practices were occurring to manage the job demands, causing nurses significant anxiety. The nurse sustained a significant psychological injury as a result.

Hazardous Physical Environment

76. The Code of Practice includes a hazardous physical environment as a psychosocial hazard, and this is reflective of the experiences of NSWNMA members.

Covid 19 – Early in 2020, at the start of the pandemic, and with images from overseas of hospitals under collapse and temporary morgues being set up to deal with the mounting death toll, nurses were providing care to ill and dying patients. There was no vaccine, and frequently insufficient PPE. Some workers were immunocompromised or lived with loved ones who were and were terrified that their workplace exposures would kill their family members.

Blood borne virus exposure – a nurse had blood squirt in her eye while doing a dressing. The patient she was caring for had a history of injecting drug use. When she contacted her manager to find out what she should do, she found that the organisation she worked for had no internal procedures, and when she called the NSW Blood and Body fluid exposure hotline for advice, she found it had been shut down. As there were no processes for seeking consent for testing from the patient, she had to wait for many months to find out if she had contracted a bloodborne virus.

Cancer nurses work with hazardous drugs that are known to be carcinogenic, mutagenic and toxic to reproduction. When there is a lack of appropriate risk management in place, nurses can be psychologically injured. For example, a

pregnant nurse was exposed to a cytotoxic drug spill, without appropriate PPE. Nurses working with chemotherapy drugs (hazardous drugs) have a 100% increase in risk of miscarriage compared to nurses who do not work with chemotherapy drugs, as well as elevated rates of stillbirths and congenital birth defects. While it may be some time before the nurse knows if there has been harm to her unborn child or whether she will develop cancer herself, many nurses sustain psychological injuries arising from anxiety about the physical risks they have been exposed to.

Poor Support from Managers and Supervisors

A nurse was stalked and harassed by a male colleague for 9 months. She reported the incidents to human resources and her line manager 13 times during this period. No attempts were made to manage the risk to her safety, nor was any investigation commenced. On one occasion she was advised to confront the perpetrator and request that he stop stalking her, and another time was offered a hug. This poor handling of her report resulted in a psychological injury. Research shows that victims of sexual and gendered based harassment should not be required to partake in mediation or to confront the harasser in resolving the matter due to the power imbalance and the likelihood of causing further psychological injury to the victim.

A nurse was advised that a patient's father had made a serious death threat about her and her family. The threat included mention of her children (including ages and gender) and the suburb she lived in. No measures were put in place to ensure her safety at work. The nurse used her personal leave to stay away from the workplace for the rest of the patient's hospital admission. 2 years later the nurse discovered that the father was back on premises with another sick child. At this point the nurse had a psychological breakdown arising from her belief that her life was at risk from this person and that her employer would not take the necessary action to ensure her safety. This psychological injury was predominantly caused by her belief of poor safe workplace controls to ensure her physical and psychological safety.

Poor Procedural Justice

A nurse was assaulted by a visitor in a racially motivated attack. The nurse defended himself and used force to get out of a headlock. Consequently, the nurse was suspended from duties and was reported to the regulatory authorities without notice, despite a pending investigation and reports from witnesses indicating the use of reasonable force in a dangerous incident. It took his employer 10 months to deliver a decision to the nurse following the investigation process. The nurse suffered a serious psychological injury following the failure of his employer to investigate allegations using procedural fairness principles, including the failure to undertake the investigation in a fair and transparent manner, to offer a support person or to conclude the

investigation within a reasonable timeframe. This nurse had to be treated medically for his psychological injury.

Vicarious Trauma

77. The draft Bill provides a list of circumstances in which a worker will be considered to have experienced vicarious trauma that would be compensable. This list provides a further narrowing of access to workers' compensation. An incident will be considered vicarious trauma for the purpose of compensation in the following circumstances: "*where the worker becomes aware of any of the following acts or incidents that resulted in the injury to, or death of, a person (the victim) with whom the worker has a close work connection— (a) an act of violence, (b) indictable criminal conduct, (c) a motor accident, a natural disaster, a fire or another accident, (d) an act or incident prescribed by the regulations.*"

78. Recent examples from members that would not meet that definition:

A nurse discovered a patient who had died by suicide by hanging himself and as she cut him down, his body fell on her and she was pinned underneath him.

Nurses who have patients pass away because of a medical error, for example nurses caring for a woman living in residential aged care who died after an error in medication packaging by the pharmacist led to her death.

Mental health nurses work with patients who frequently intentionally self-harm, e.g. nurses were required to physically restrain a 16-year-old who was attempting to swallow pieces of glass multiple times per shift and for up to 35 minutes per occasion. Incidents like this have profound impacts on staff and are not uncommon. Further, mental health nurses work with people with traumatic histories of sexual assault, neglect, and physical abuse. Hearing these stories repeatedly dramatically increases the likelihood of developing psychological injuries through vicarious trauma.

During the Covid-19 pandemic, ICU nurses were using personal phones to facetime family members to allow them to say goodbye to their dying patients during the prolonged NSW Health no visitor policy. These experiences caused many nurses to experience psychological injuries, especially following cumulative exposure to distressed families who were denied physical visitation of their deteriorating loved ones. Concomitantly, these nurses were wearing full body PPE and N95/P2 masks for 12-hour shifts without adequate breaks and PPE shortages which led to exhaustion, burnout, anxiety and physical injuries. Many nurses were psychologically injured as a result.

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79. In a further narrowing, an event will be considered vicarious trauma only in circumstances where the worker has a "close work connection" with the victim. This disregards the complex nature of trauma exposure in the healthcare setting. For example: emergency staff who repeatedly attempt to resuscitate fatally injured patients, or nurses who must provide intimate care to victims of

violence, all may experience profound vicarious trauma even if they do not meet the Bill's rigid definition. The proposed language fails to account for the realities of healthcare work, where emotional labour and moral distress are daily experiences.

Requirement to First Attend a Tribunal, Commission or Court who has Confirmed they have been Subjected to Sexual harassment, Racial Harassment or Bullying for Compensation to be Payable

80. A key provision in the draft Bill imposes a new procedural barrier for workers who suffer from a psychological injury arising from bullying, harassment or racism. Under these proposed changes, affected workers must first obtain a formal finding from a tribunal, commission or court that the incident occurred before they can access any form of workers' compensation. The NSWNMA asserts that this is deeply concerning and problematic. This imposes a significant burden onto already traumatised individuals and introduces a delay that can severely impede recovery, as well as reducing the likelihood of a durable return to work. For many, this process will be retraumatising, intimidating and ultimately prohibitive. Rather than supporting injured workers, this change is likely to deter them from lodging claims.

81. The Bill obliges injured workers to commence and complete preliminary litigation before proceeding with psychological injury claims relating to sexual harassment, racial harassment or bullying. It is difficult to identify another area within the legal system where one cause of action depends upon the separate and distinct resolution of another cause of action in a different forum. In our view this is not only wrongheaded but is illustrative of intent to severely reduce the rights and entitlements of injured workers.

82. Litigation of all kinds is stressful, time-consuming and often traumatic for litigants. Forcing victims of sexual harassment, racial harassment and bullying to undergo such litigation as a precondition for claims is distressing, with the potential risk of increasing trauma. Victims of sexual harassment are often reluctant to pursue claims against perpetrators due to both the well-known difficulties associated with proving such claims, as well as the distressing factual circumstances. It is, in the NSWNMA's view, nothing short of a disgrace to force victims of sexual harassment to undergo the time, expense and trauma of litigation prior to proceedings with a workers' compensation claim.

83. The NSWNMA believes that a victim of sexual harassment will be unlikely to receive trauma-informed treatment within an industrial court or tribunal, with the probable expectation that victims be cross-examined, which research demonstrates can lead to experiences of shame, humiliation and guilt. It is a proposal which will potentially undermine the federal Respect at Work laws, reintroducing barriers to sexual harassment reporting with the potential to increase the perception that victims will not be believed or will be victim-blamed when reporting their experiences of sexual harassment in relation to the workplace. Adding another obstacle to workplace sexual harassment investigative processes will disproportionately affect the health and safety of all workers, but particularly in these largely female-dominated professions, to their detriment.

84. The NSWNMA frequently supports members experiencing extreme behaviours from others that may be referred to as sexual harassment by the worker and their employer. These behaviours are often criminal in nature and include sexual touching, stalking, sexual assault, sexually menacing comments, indecent texts and use of social media. The members who contact us have generally already reported to their employers who have failed to take any action, leaving members exposed to ongoing behaviours and compounding the harm due to the lack of support provided. In our

experience, members in this situation are often extremely mentally unwell (some have been hospitalised). They are certainly not able to appear before a tribunal hearing.

85. Currently, many employers fail to uphold trauma-informed principles when conducting investigations following sexual harassment reports. This often results in the victim being subjected to repeating the details of the incident(s) repeatedly to different managers, employee resources (ER) representatives or others. Additionally, there have been many occasions where female victims of sexual harassment have been assigned male representatives of ER or management to undertake the investigation of the alleged harassment without confirming if the victim is comfortable communicating the details of the harassment with a male. It is similarly disgraceful for victims of racial harassment and bullying to face the same requirements. It should be patently obvious that victims of bullying and harassment are some of the State's most vulnerable workers. Their claims for compensation associated with psychological injury should be met with compensation and care, not a series of distressing legal hurdles.

86. If a finding of a tribunal, commission or court is required for such claims to proceed, measures should be put in place to ensure that claimants are not subjected to the brutality of the adversarial system. Fully arbitrated hearings or the like, involving the collation of evidence and cross-examination of victims, should not be required. Instead, the Government should consider more informal options such as conciliation or paper-based reviews which do not subject claimants to trauma. However, the NSWNMA reiterates its opposition to any such barriers to justice.

Work Pressure

87. The Bill introduces the concept of a "work pressure disorder". Workers who are diagnosed with a "work pressure disorder" will not be eligible for compensation under the new reforms, but may receive a "special work pressure payment" for medical treatment for up to eight weeks from the date of the reported injury.

88. It is unconscionable for the Government to refuse compensation for psychological injuries arising from workload pressures, particularly when those pressures are the direct result of its own policy and funding decisions. Chronic understaffing, excessive overtime, and unmanageable patient loads are not accidental – they are systemic and ongoing failures to adequately resource our public hospitals. Nurses and midwives are routinely expected to fill the gaps, working in unsafe conditions that compromise both their wellbeing and patient care. For the government to then deny support to those who are psychologically harmed by these very conditions is not only unjust – it is a betrayal of the workforce that holds our health system together.

89. A short-term "work pressure disorder" payment fails to appropriately support injured workers. Further, due to critical workforce shortages, in many parts of NSW a worker may be unable to attend a first appointment with a mental health professional in those timeframes let alone to have concluded any meaningful treatment.

Changes to Whole Person Impairment Threshold

90. The Bill proposes raising the Whole Person Impairment (WPI) threshold for ongoing compensation from 15% to 31% for psychological injuries as a condition for accessing lump sum entitlements. The NSWNMA asserts that this threshold is both medically and ethically indefensible.

91. The current approach to quantifying compensation entitlements for psychological injuries under NSW legislation mirrors that of physical injuries, yet there are key distinctions in establishing a compensable psychological injury.

92. To qualify, a psychological injury must possess a specific diagnosis related to a psychological or psychiatric disorder. It is necessary to demonstrate that the condition exceeds mere "stress" but instead is a recognised psychiatric condition that can be diagnosed and treated. The DSM (Diagnostic and Statistical Manual of Mental Disorders, currently in its fifth edition), created by the American Psychiatric Association, although not mandated by legislation, is often relied upon for these diagnoses.

93. Psychiatric conditions are considered "*diseases of the mind*" and under the legislation establishing entitlement to compensation for a disease condition has a stricter test than that for a discrete physical condition in that, having identified a psychiatric condition that arose out of or in the course of employment, a worker would need to establish that employment was the "*main contributing factor*" to that condition.

94. Once these requirements are met, workers may encounter challenges from employers attempting to refute liability for the recognised psychological injury and any resulting incapacity, often by referencing section 11A of the *Workers Compensation Act 1987* (NSW):

    "No compensation is payable under this Act in respect of an injury that is a psychological injury if the injury was wholly or predominantly caused by reasonable action taken or proposed to be taken by or on behalf of the employer with respect to transfer, demotion, promotion, performance appraisal, discipline, retrenchment or dismissal of workers or provision of employment benefits to workers."

95. Section 11A of the *Workers Compensation Act 1987* (NSW) was introduced in 1992 and has since been the focus of extensive judicial discussion. The essential elements that have emerged are:
    - The employer bears the onus of proving its application.
    - The categories identified, transfer, demotion, etc, are distinct and need to be formal processes.
    - The employer needs to not only prove that the processes were formal processes but that the actions were *reasonable* and that the actions were the *whole or predominant cause* for a worker's psychological decompensation.
    - The actions by the employer are to be looked at objectively from the employer's viewpoint rather than from a worker's subjective view of the motivation behind steps taken by an employer.

96. In summary, s.11A of the *Workers Compensation Act 1987* (NSW) as presently framed places a burden on employers as far as proving all the elements above and very often an employer will prove their actions fall within the relevant classes identified in the section but fail to confirm those actions were "*reasonable"* and the "*whole or predominant"* cause. The latter definition is a critical protection for workers.

97. The Court of Appeal in *Heggie* emphasised that in determining if actions were "*reasonable"* the analysis is an objective one from the employer's perspective rather than a worker's subjective view as to why certain action was taken. In *Heggie*, employers have had more success in defending their actions but there are still significant protections available for workers within the current definition.

98. The South Australian legislation also incorporates the "*whole or predominant"* cause requirement. Adopting the proposal to replace the specific categories in NSW's section 11A with the broader term "administrative action" from South Australia is not considered a major concern, provided that the "whole or predominant" requirement in the current definition is maintained.

The Assessment of Whole Person Impairment

99. In 2002, the NSW government implemented new legislation related to the *Workers Compensation Act 1987* (NSW), introducing a system designed to assess lump sum compensation for permanent non-economic losses stemming from work-related injuries, commonly referred to as "pain and suffering" compensation. This new framework mandated that medical practitioners conduct objective assessments of lump sum compensation, following established Guides and Guidelines. The eligibility for compensation was contingent upon the injured worker's determined level of WPI.

100. Prior to this change, judges evaluated lump sum compensation claims for workplace injuries based on the Table of Maims (established in 1926) and, in more recent times (post-1987), the Table of Disabilities. With the introduction of the WPI method in 2002, workers could claim lump sum compensation for physical injuries with an impairment of less than 10% WPI, but psychiatric injuries required a minimum of 15% WPI to qualify for compensation. Subsequent legislative revisions in 2012 adjusted the threshold for physical injuries to 11% WPI.

101. A negligence claim for a psychiatric injury requires a worker to establish that an employer was aware or ought to have been aware that a worker was exposed to events or actions in the workplace that were likely to give rise to injury and failed to take steps to reduce or ameliorate the risk of suffering that injury. If negligence is established, a worker is entitled to recover damages from their employer for the economic loss caused by the injury.

102. The Government is proposing, for psychiatric injuries, to lift the threshold that establishes an entitlement to lump sums for "pain and suffering" and/or to bring a negligence claim from 15% WPI to 31% WPI.

103. This proposed modification would necessitate that workers demonstrate a level of impairment so severe that an estimated 95% of workers with psychiatric injuries would be denied lump sum compensation or, if assessed over 30% WPI, may be discouraged from pursuing a negligence claim due to the potential impact on their treatment and care funding.[14] Consequently, the proposed changes in NSW will prevent those with psychological injury from accessing lump sum compensation and negligence claims related to psychological injuries.

104. The assessment of WPI concerning psychological injuries in NSW employs the Psychological Injury Rating Scale (PIRS). To be classified with a WPI of over 30%, a worker would need to attain specific impairment levels according to the relevant PIRS categories set out in the below table:

Self-Care and Personal Hygiene	
Class 4 Severe Impairment	*Needs supervised residential care. If unsupervised, may accidently or purposely hurt self.*
Class 5 Totally Impaired	*Needs assistants with basic functions such as feeding and toileting*
Social and Recreational Activities	
Class 4 Severe Impairment	*Never leaves place of residence. Tolerates the company of a family member or close friend but will go to a different room or garden when others come to visit family or flatmate.*
Class 5 Totally Impaired	*Cannot tolerate living with anybody, extremely uncomfortable when visited by close family member.*
Travel	
Class 4 Severe Impairment	*Finds it extremely uncomfortable to leave own residence even with trusted person*
Class 5 Totally Impaired	*Cannot be left unsupervised, even at home. May require two or more persons to supervise when travelling*
Social Functioning	

Class 4 Severe Impairment	*Unable to perform or sustain long term relationships. Pre-existing relationships ended e.g. loss partner, close friends. Unable to care for dependents, e.g. own children, elderly parents.*
Class 5 Totally Impaired	*Unable to function within society. Living away from populated areas, actively avoid social contact.*
Concentration, Persistence and Pace	
Class 4 Severe Impairment	*Can only read a few lines before losing concentration. Difficulties following simple instructions. Conversation deficits obvious even during brief conversations. Unable to live alone or needs regular assistance with relatives and community services.*
Class 5 Totally Impaired	*Needs constant supervision and assistance within an institutional setting.*
Adaption/Employment	
Class 4 Severe Impairment	*Cannot work more than one or two days at a time, less than 20 hours per fortnight, pace is reduced, attendance is erratic.*
Class 5 Totally Impaired	*Cannot work at all.*

105. For a worker to be assessed at 31% WPI or worse the process under PIRS would require a score of 5 in 6 of the above categories.

106. In effect, a worker in this situation may become nearly catatonic and, as identified within the classes of impairment, would necessitate considerable supervision and medical care. Even if assessed with a greater than 30% WPI, a negligence claim would not be viable due to the resolution of such claims terminating the entitlement to medical treatment.

107. The establishment of a 30% WPI threshold effectively denies a worker's right to compensation for impairment or pain and suffering, as well as the ability to sue their employer for negligence that resulted in a permanent injury.

108. The argument from the Government that South Australia has a 30% WPI for psychological injuries fails to recognise that SA uses a different impairment scale to assess psychological injury to that used in NSW. A 30% WPI under the NSW impairment scale looks very different to a 30% WPI under the SA impairment scale. Of the other jurisdictions that use the PIRS scale used in NSW most have no impairment threshold for psychological injury claims. Tasmania has the second highest after NSW and this is 10%.

109. The proposed threshold of 30% WPI would effectively eliminate any entitlement to impairment compensation or the ability to pursue a negligence claim against the employer. The NSWNMA would be interested to see the percentage of workers making claims for impairment due to psychiatric injury that are assessed above 30% WPI.

110. Therefore, the Government's proposal to raise the threshold for receiving lump sum compensation or pursuing a negligence claim for psychological injuries to 30% WPI would likely result in very few, if any, claims for negligence related to workplace injuries involving psychological conditions.

111. Unlike physical injuries, psychological conditions are complex, often episodic, and rarely reach such a high level of impairment on standard medical/legal assessment tools. Mental health conditions do not lend themselves easily to quantification using physical impairment frameworks. As a result, almost all legitimate psychological injury claims would be excluded from lump sum compensation. Unions NSW confirmed that the proposed threshold will block “95 per cent of legitimate mental health claims”.

112. In practice, this would mean that only the most severely and permanently disabled individuals, those least likely to ever return to work, would qualify for compensation, leaving the vast majority of injured workers without recognition or meaningful support. This reform risks entrenching stigma and inequity by treating psychological injuries as less valid or deserving than physical injuries.

113. In addition to the lack of access to lump sum compensation, the WPI is used to determine ongoing access to income and medical support. This means workers suffering from serious psychological injuries will be cut off from financial support after approximately 2.5 years of income payments and 3.5 years of medical coverage, regardless of the severity of their condition, effectively abandoning them at their most vulnerable.

114. The NSWNMA sought expert advice from Dr Anthony Dinnen, an accredited WorkCover assessor and consultant psychiatrist, regarding the proposed amendments to the Bill. Dr Dinnen, in his correspondence with the NSWNMA (see Appendix A), noted:

> *I can say without any equivocation that the proposed increase will mean that no individual suffering work-related psychological injury will be eligible for compensation with that 30% threshold. The cases that I am asked to assess often are the most serious. They are individuals with chronic incapacitating psychiatric illness preventing them from working, restricting their quality of life to the extent that family life is disrupted, so that they are often housebound, unable to enjoy social and recreational activities, and requiring long-term psychiatric care. Such individuals seldom are assessed as having more than a 20% WPI according to the current PIRS scale. It is most unusual in my experience for an individual to rate between 20% and 25%. I repeat, I have almost never seen an individual rate at anywhere near 30% WPI.*

The Role of Suitable Duties, Tribunals/Industrial Relations Commission and Employer Accountability

The Failure of Employers to Facilitate a Return to Work

115. The main problems with the current workers' compensation scheme are the fault of employers, not workers. Whilst there are some employers show a great deal of compassion toward their injured employees, there are also many who view such workers as liabilities that need to be removed from their business. In our experience, this is even more prevalent in relation to workers suffering psychological injuries.

116. Over many years the NSWNMA has encountered a persistent reluctance from both NSW Health and private sector employers to provide injured workers with suitable work. Such attitudes result in injured workers being either dismissed, pressured to risk re-injury by returning to work too early or pressured to seek work elsewhere. Generally, this tends to occur:;

a. 6 months after an injury,
b. after a worker has been certified as permanently unfit for pre-injury duties,
c. after an insurer has made a decision to deny liability, or

d. after a worker has received compensation for a few years.

117. It is not uncommon for the NSWNMA to be contacted by a member at these times, advising that they believe their employer is taking steps to dismiss them. Generally employers begin to pressure their employees at these times in a range of ways. For example:

- Employers often advise their injured workers that unless they become fit for pre-injury duties, they may be terminated.
- Employers often withdraw any suitable work which is being provided and claim that no further work exists.
- Employers often advise workers that unless they become fit for pre-injury duties, they will have to seek work elsewhere.

118. The reason why such action tends to occur six months after an injury is because there is a common misconception among employers that they are able to terminate injured workers after that time. This misconception emanates from section 248 of the *Workers Compensation Act 1987* (NSW).

119. Whilst it is not generally an offence to dismiss an injured worker more than six months after becoming unfit for employment, this does not mean that employers have no obligation to provide suitable work after that time. Furthermore, there is widespread ignorance of the fact that the six-month period only relates to periods when a worker is totally unfit (see *Banning v Great Lakes Council* [2002] NSWIRComm 47).

120. Similarly, employers also frequently pressure injured workers after they have been certified as permanently unfit for pre-injury duties despite being fit for other work. This highlights another misconception among employers: that their obligation to provide work to an injured worker ceases when that worker is found to be permanently unfit for pre-injury duties. However, section 49 of the *Workplace Injury Management and Workers Compensation Act 1998* (NSW) imposes a positive obligation on employers to provide suitable work to injured workers. In our experience, many employers are either unaware of this provision, or willfully ignore it.

121. The result is that injured workers either have their employment terminated or are simply not provided with work. This then forces them to rely upon weekly workers' compensation payments whilst they search for work elsewhere. It is notoriously difficult, however, for an injured worker to find work with a new employer, particularly if they suffer from a psychological injury. Many employers require potential employees to declare whether they have ever suffered a workers' compensation injury. It is also not uncommon for prospective employers to be informed by a previous employer that a job applicant has suffered an injury. Employers are generally reluctant to employ injured workers for the following reasons:

- Injured workers are seen as a workers' compensation risk, that is, employers fear that a re-injury may occur at their workplace.
- Injured workers are seen as an occupational health and safety risk
- An injured worker's medical restrictions (both in terms of the number of hours which can be worked and the kind of work which can be performed) will not generally match the nature of any available positions. It is understandable that employers seeking to fill a vacancy will generally advertise for and appoint the most suitable candidate. For example, an employer seeking an employee to work 30 hours per week, is unlikely to engage an injured worker who is unable to work more than 26 hours per week. Equally, an employer is unlikely to consider engaging an injured worker who would be able to fulfil an advertised role only if they were provided with additional support and training.
- Injured workers are not seen as, and may not be, as productive or valued as employees who have not suffered an injury.

122. By refusing to provide their injured workers with suitable duties, employers can shift the cost burden of injured workers entirely to their insurers, who are then liable to pay weekly benefits which would either not otherwise be required or not be of the same quantum. The injured workers themselves then face an uncertain future living on a weekly workers' compensation benefit whilst they attempt to obtain work in a labour market where their value is seen as diminished.

123. In the NSWNMA's view, insurers are in the ideal position to prevent this cost shifting by employers. However, it is the NSWNMA's experience that insurers are unable to exert sufficient influence on employers to comply with their obligations to injured workers, other than by the use of premium adjustment. Our understanding is that insurers do not conduct a rigorous analysis of whether their clients are able to provide suitable work to injured workers. Insurers generally are left to accept at face value the employer's indication that no such work is available. Consequently, the insurer then sends the injured worker a letter identifying their obligation under section 38 of the *Workers Compensation Act 1987* (NSW) to seek suitable employment, that is,with another employer. By ignoring their obligation to provide injured workers with work, employers are able to trigger their insurer to invoke section 38 and impose an obligation on the worker to look for work elsewhere.

124. In the NSWNMA's view there is a double standard within our workers' compensation system. Whilst injured workers are constantly tested and examined by medical practitioners in order to justify their entitlement to workers' compensation benefits, there are no such checks and balances in place for employers. At no stage in the workers' compensation process is the employer's capacity to provide suitable work to their injured employee tested or examined. In our view, the responsibility for rehabilitating and caring for injured workers is a joint responsibility; whilst the worker has a responsibility to seek work and comply with their return-to-work plan, so too should the employer comply with their responsibility to provide work to that worker if possible prior to that worker being required to job seek.

125. The NSWNMA believes that the Government has a responsibility to intervene in the market to ensure injured workers are properly supported. An economist may view injured workers as a form of market failure. Currently, the extent to which injured workers are provided with suitable work is largely left to the market and this inevitably results in such workers being disadvantaged.

126. Unfortunately, the NSWNMA is frequently compelled to invoke dispute resolution procedures with employers who move to offload injured workers. Such disputes are not easily resolved because it is often difficult to prove that an employer has suitable work available.

127. It is particularly disappointing that such disputes are often with NSW Health, which holds itself as a model employer. The NSWNMA finds it remarkable that in a health system which needs nurses, public health organisations are frequently unwilling to provide an injured nurse with a few days of partial duties per week. Given that the relevant public health organisation is often the largest employer in the area and NSW Health is the largest employer in the state, it is astonishing that they continue to claim that suitable work cannot be accommodated.

128. Many employers are also unaware of, or ignore, their obligation pursuant to section 41A of the *Workplace Injury Management and Workers Compensation Act 1998* (NSW)to continue to treat a worker's injury as work related in circumstances where an insurer's decision to deny liability is to be disputed. Employers often rely on a disputed claim to justify treating a worker's injury as non-work related by withdrawing suitable work. This then further delays the rehabilitation process in relation to medical treatment and return to work. The NSWNMA's experience is that employers do this without making any attempt to determine whether the worker intends to dispute this decision. Often the withdrawal of suitable duties in these circumstances will be accompanied by a notification to the worker that termination of employment will occur unless they become fit for pre-injury duties within a specified time.

Psychological Injury and Suitable Duties

129. The failure of employers to abide by their obligations in relation to the provision of suitable duties to injured workers is a significant contributor to the exacerbation of such injuries. It is obvious that psychological injuries are different to physical injuries. Whilst the failure to provide suitable work to a worker suffering a physical injury is unlikely to exacerbate that injury, there is a very significant risk that such failures will either cause or exacerbate psychological injuries.

130. In light of this, the NSWNMA asserts that the Government should not attempt to reduce the number of psychological injury claims by disenfranchising injured workers through a series of legal and administrative hurdles to justice. Such an approach shifts responsibility away from the systems that cause harm and place it squarely on those who are already suffering. Instead, the Government should invest in robust, preventative strategies that address the root cause of psychological harm and reduce the frequency and severity of these injuries.

131. One of the most effective ways to prevent psychological harm and promote recovery would be to require that any case in which an employer has refused to provide suitable duties be automatically listed before a tribunal, such as the Industrial Relations Commission of New South Wales. That tribunal should be tasked with reviewing the circumstances of each case and facilitating timely, safe and meaningful return-to-work outcomes.

132. It is the NSWNMA's experience that many employers find it difficult to deal with employees who have suffered a psychological injury. These difficulties arise not only from the complexity of the injuries themselves but also from inadequate human resource practices and a widespread reluctance to engage with the interpersonal dimensions of psychological harm, especially when the injury stems from bullying, harassment or poor organisational cultures. Too often, employers default to excluding the injured worker rather than navigating the more difficult process of accommodation and reintegration. Refusal to provide suitable duties is frequently treated as the path of least resistance.

133. As a result, nurses and midwives with psychological injuries are often left without structure, purpose or connection for sometimes months. It is well understood and accepted that prolonged absences from the workplace significantly worsen psychological outcomes and reduce the likelihood of recovery. Quite apart from the damage to the worker and the associated social cost, the financial effect on the workers' compensation scheme itself is obvious.

134. If refusal to provide suitable duties to injured workers were subject to prompt review by an independent tribunal with appropriate powers, it would introduce a long-overdue mechanism for accountability. Such a process would help ensure employers uphold their obligations and reduce the incidence of psychological injury by supporting early and appropriate return-to-work. Importantly, it would also reaffirm the principle that workers who are injured by the workplace deserve support, not exclusion.

135. It is the NSWNMA's view that this is a far more constructive and just use of tribunal resources, particularly those of the IRC, than what is proposed under the current amendments to the Workers Compensation Bill. Under the scheme, injured workers face scrutiny at every turn, medical certificates must be provided accounting for every day of absence, medical appointments must be attended, work capacity must be assessed and medical evidence be obtained justifying claims. These requirements demand adherence by injured workers under threat of benefits being withdrawn. By comparison, there is a paucity of scrutiny on employers' decisions regarding the provision of suitable duties. Insurers exert no pressure on employers to provide duties and employers are generally left to self-assess as to whether they can provide work.

136. Whilst it is true that proceedings can be brought in the Personal Injury Commission, such proceedings are rare. We acknowledge that some progress was made in this area under the *Workers Compensation Legislation Amendment Act 2012*(NSW); whilst the vast bulk of this

amending legislation was detrimental to workers, there were some positive amendments relating to suitable duties. However, the problem is far from resolved.

137. The fact remains that there is no systematic scrutiny of employers' return-to-work decisions. In a system where the body parts and minds of humans have been attributed monetary worth and compensation is dependent on the impossible task of assessing percentages of impairment, the question of whether work can be provided to an existing employee by their employer is seemingly all too hard.

138. The NSWNMA urges the Government to use this opportunity not to penalise workers, but to hold employers to account. Mandating transparency and review of return-to-work decisions would not only reduce harm of and improve outcomes for injured workers, it would also ease the financial burden on the scheme. More importantly, it is a necessary and overdue act of fairness in a system that too often fails the workers it is designed to protect.

The Unions NSW Five-Point Plan

139. The NSWNMA urges the Committee to adopt the five-point plan put forward by Unions NSW, which would provide practical, enforceable, and evidence-based reforms:

    1) Empowering the IRC to deal with safety hazards reported by workers and making WHS Codes of Practice enforceable;

    2) Making it easier for injured workers to return to work by, for instance, enabling the IRC to resolve return-to-work disputes and prohibiting the termination of their employment;

    3) Incentivising employers to prioritise safety and return-to-work efforts by reintroducing premium loadings based on claims performance, which reward safety-conscious companies;

    4) Reducing waste and inefficiency within the scheme by expanding the State Insurance Regulatory Authority's powers to reduce insurer waste and addressing under-insurance by employers; and

    5) Diversifying the insurance pool and creating a more sustainable funding model by abolishing self-insurance and specialised insurer arrangements.

Conclusion: Protect Those Who Protect Us

140. The proposed reforms to psychological injury compensation in NSW represent a fundamental shift away from a system designed to protect injured workers towards one that silences and marginalises them. Narrower eligibility, higher impairment thresholds and complex legal hurdles will make support harder to access. These reforms ignore the everyday reality of nurses, midwives and workers. One-off violent events do not cause most psychological injuries in healthcare. They stem from chronic understaffing, moral distress, role overload, bullying, harassment and systemic failures.

141. This proposed legislation does not promote prevention. It does not hold employers accountable. Instead, it punishes workers for being harmed by the system that they work for and will contribute to further psychological injury. If passed, these laws would send a clear message: the Government is more interested in reducing claim numbers than supporting injured workers.

142. We must push for a fair, transparent, and accountable system. One that focuses on safe workplaces, not legal barriers. One that values the mental health of workers. One that achieves safer workplaces nurses and midwives and removes barriers to reporting experiences of sexual harassment. No injured nurses, midwives, or workers should be left behind or abandoned.

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Appendix

Appendix A