

*Submission to the Victorian  
Government's*  
**Independent Review into  
the management of complex  
workers' compensation  
claims by WorkSafe agents.**

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Slater and Gordon Lawyers appreciates the opportunity to make a submission in response to the Victorian Workers Compensation System: Independent Review into the Agent Model and the Management of Complex Claims.

## KEY POINTS

1. Management of complex claims by Agents has been a failure, with the consequences as set out in the Ombudsman's 2016 and 2019 reports. The issues with Agent management of claims have been widespread and have existed for decades. Realistically, they are unlikely to materially differ if the extent of change is to amend procedures, requirements, incentives and oversight within the current model.
2. Quality case management in relation to complex claims should be assessed based on indicators which demonstrate positive, sustainable outcomes for workers. Such outcomes for workers are likely to lead to a reduced need for future time off work or medical and like services, so reducing the cost of claims to both the scheme and employers.
3. There are many factors which could indicate that a worker's claim is either complex or at risk of becoming so. These factors will often be a critical indicator to the wellbeing and recovery prospects of injured workers. As with other comparable schemes, these factors should be taken into account to determine complexity.
4. In order to achieve improvements across the board more accountability needs to be established and this is likely to be best achieved by moving to a model in which complex claims are dealt with by WorkSafe in-house.
5. Methods by which WorkSafe oversight of Agent decision-making in non-complex claims might be improved include:
  - + Embedding WorkSafe employees within each Agent to monitor performance and culture.
  - + Ensuring that all complaints against Agents are investigated by WorkSafe.
  - + Providing greater openness and reporting regarding the processes for and outcomes of WorkSafe oversight of agent decision making.
6. Slater and Gordon have incorporated a number of specific case studies into our submission and would welcome the opportunity to expand and illuminate our submissions with further case studies on request from the review team.

## COMPANY BACKGROUND

Slater and Gordon Limited is a publicly listed company.

We are a leading Australian Consumer Law and Plaintiff Injury Law firm employing 800 people in 40 locations across the country. Our mission is to give people easier access to world class legal services. We provide specialist legal and complementary services in a broad range of areas, including:

- + Personal Injury
- + Superannuation and Insurance
- + Class Actions
- + Commercial Litigation
- + Employment Law.

Since our establishment in 1935, we have built a powerful reputation as a law firm built on social justice values that fights to achieve the best outcomes for our clients, while reducing the stress they go through to obtain justice. From the many landmark legal cases we have won, to the introduction of innovations such as No Win - No Fee, we have been determined to ensure that more Australians are able to access affordable legal services, no matter where they are.

In Victoria, Slater and Gordon represent clients at 16 offices across the state and handle a variety of disputes arising under the WorkSafe scheme, ranging from statutory benefits disputes at the Accident Compensation Conciliation Service (ACCS), through to claims for common law damages and appeals.

Our founders, Bill Slater and Hugh Gordon, recognised that representing the interests of clients and workers required more than legal practice work. It involved a deep commitment to contributing directly to the development and deployment of effective public policy. Indeed, Bill Slater served a number of terms in the Victorian Parliament contributing directly to the legislative process. As Attorney General and Chief Secretary in 1946 Bill introduced a number of reforms to Workers Compensation in Victoria. In introducing the legislation he noted:

***"I am not concerned about the profits of insurers. I have a single concern, and that should appeal to honourable members. It is that justice should be done by the dependents on men killed in industry and those incapacitated by accident or disease."***

**Bill Slater MP, Parliamentary Hansard - April 3 1946 (page 1145) Workers Compensation Bill**

Consistent with our deep commitment to the principle of social justice, Slater and Gordon has also long recognised the significant psycho-social difficulties our clients face within the legal context. In 2009 Slater and Gordon identified a service gap and made the decision to employ a social work team to provide free social work services to our clients. In fact, we were the first - and are still the only - law firm in Australia to do so.

The work of both our legal practices and our social work teams has given Slater and Gordon unique insights into the impact both a workplace injury itself and the subsequent impacts of trying to obtain their correct legal entitlements has on our clients. These insights are at the heart of how we have addressed the issues raised in the Victorian Workers Compensation System: Independent Review into the Agent Model and the Management of Complex Claims.

## **OVERVIEW**

Slater and Gordon is of the view that there are significant problems with the Agent model which impact upon the proper and appropriate management of injured workers' claims, particularly those with complex claims. This results from various factors, but the profit motivation of the Agents and the ability to achieve financial incentives are likely to be significant among these.

Slater and Gordon's view is that fundamental change is required to the case management of WorkCover insurance claims, in particular for complex claims. This is likely to be best achieved by moving to a model in which complex claims are dealt with by WorkSafe in-house, with non-complex claims being managed by Agents, subject to a requirement for continuing improvement in the conduct of Agents. A model which provides appropriate management of complex claims will ultimately result in benefits for all stakeholders.

At the heart of this observation is a need to strengthen the accountability and transparency of decision making to achieve the required step change in performance on the administration of all claims and in particular, complex claims.

At present, little to no thought appears to be given to the long-term cost or benefit of any individual decision. Agents frequently make decisions which save financial cost in the short-term but which are likely to result in increased long-term cost in financial, wellbeing and societal terms. For example, when medical and like expenses of modest cost are delayed or rejected, Agents ignore the reality that simply proceeding to ACCS will cost the agent more than the treatment in question, or that if the worker is rehabilitated and returns to work earlier, the agent will save more in weekly payments than it has paid in medical and like expenses.

The current system also exhibits a lack of clear escalation points when decisions are delayed or other problems are encountered with case management. Further, the response of Agents and WorkSafe to complaints often appears inadequate and often does not result in a meaningful outcome for workers. All these issues are likely to be impacted by the attitude and culture of individual agents, as well as case manager training and Agent KPIs.

In order to achieve improvements across the board more accountability needs to be established and in Slater and Gordon's view this is likely to be best achieved by moving to a model in which complex claims are dealt with by WorkSafe in-house.

## **IDENTIFYING AND ASSESSING COMPLEX CLAIMS**

### ***What are the features of a claim for worker's compensation that make it complex, or at risk of being complex?***

Slater and Gordon note that for the purposes of the discussion paper complex claims are defined as claims that progress beyond 130 weeks.

Taking the term "complex" in a broad sense, there are many factors which could indicate that a worker's claim is either complex or at risk of becoming so. Slater and Gordon notes that in the transport accident context the Transport Accident Commission (TAC) performs an initial screen of claimants at the intake stage, then allocates claimants to a stream of case management depending on their needs. Importantly, the screening criteria considers factors beyond those which are accident-related and includes factors such as mental health, persistent pain, physical health, service environment, accident response and recovery expectations.

Slater and Gordon note that a number of factors will often be a critical part of a worker's situation and will impact on their wellbeing and recovery and should therefore be taken into account to determine 'complexity' in a workers compensation context. These include:

- + Major traumatic injuries, for example those which WorkSafe would consider to be clear candidates to meet the "serious injury" test for the purpose of common law proceedings
- + Workers who develop chronic pain issues
- + Workers who experience significant psychological difficulties, whether as a primary injury or as a secondary effect of physical injuries

- + Workers who suffer overlapping health conditions unrelated to work. These are usually dealt with poorly by Agents, who focus only on issues which are compensable
- + Workers who suffer later sequelae injuries and who effectively therefore receive a double-hit to their health at different times
- + Workers who experience overlapping social issues, whether or not related to their workplace injuries, for example financial or family problems

Slater and Gordon's view is that for the purpose of case management, claims should be identified as "complex" before a worker reaches the stage of receiving weekly payments post-130 weeks. Using post-130 week payments as the definition for "complex" claims means that the horse will often have bolted – it would be far preferable to identify complexity at an earlier stage and so enable proactive case management to maximise the prospect of better long-term health outcomes for the worker.

Some claims can be identified as complex or at risk of becoming complex at the outset based on injury severity, for example significant brain injuries, quadriplegia, paraplegia, limb amputations or other major traumatic injuries. These matters should be identified at the earliest possible opportunity and should be managed appropriately.

In other instances, the likelihood of a claim becoming complex will only become evident as events unfold during the course of the claim. Examples of circumstances in which a claim is likely to become complex include major surgery, such as a spinal fusion, or any claim in which the worker appears likely to remain out of work after 130 weeks.

While workers who remain in receipt of weekly payments beyond 130 weeks should be considered "complex", in our view it would be sensible for claims to move into a "complex" stream if the worker is not working at either 78 or 104 weeks, as the cohort who remain on weekly payments beyond 130 weeks will be almost entirely drawn from those who are not working at 78 or 104 weeks. Moving workers into a "complex" stream at this stage would enable better and more focussed treatment and vocational support in order to maximise their prospects of a return to work.

In this regard, there may be sense in differentiating between workers who have suffered physical injuries and those who have suffered a psychological injury, with the latter being moved into a "complex" stream at an earlier stage, given the increasing proportion of psychological injury claims amongst those workers who remain on weekly payments beyond 130 weeks.

A worker's employment being terminated by the employer may also be a red flag in terms of the worker's ability to remain in the workforce. Although, due to the likely volume of such claims, this should probably not be a trigger to move a worker into the "complex" stream of cases, it would be of assistance to many workers if improvements were made in the current system of vocational assessments (see comments on this, below).

## **CASE MANAGEMENT OF COMPLEX CLAIMS**

### ***Are current case management practices able to support and treat the individual needs of injured workers with complex claims?***

Based on Slater and Gordon's experience there is ample evidence indicating that current case management practices do not appropriately support and treat the individual needs of injured workers with complex claims.

Particular issues commonly encountered by workers, including those with complex claims, include:

- + **Frequent changes of case manager** - This results in workers being unable to form a positive relationship with their case manager, having to re-tell aspects of their story when a change occurs and disruption/gaps to service delivery.
- + **Case managers lacking understanding of complex injuries** - It is common for Slater and Gordon to hear from workers who feel that their issues are not understood by case managers or, at worst, that case managers have been insensitive and disingenuous to workers when speaking on the telephone or managing their claim.
- + **Agents cherry-picking evidence and not having regard to the balance of the evidence when making decisions on paying or terminating benefits** - In many cases, it appears that case managers select evidence to justify an outcome rather than to genuinely determine an outcome based on the evidence. The evidence of Independent Medical Examiners (IMEs) is routinely preferred to that of treating doctors, despite treaters clearly having more knowledge of the issues, the worker's background and condition. Whilst IMEs may have a useful role in "sense-checking" the opinion of treaters at times, it should not be the case that their evidence is preferred simply because it justifies the outcome which an Agent is seeking to achieve.

- + **Decisions being delayed for significant periods with no clear timelines or updates being given to workers** - It would be helpful for clear maximum timeframes to exist, especially in relation to requests for major surgery where significant adverse consequences may eventuate in the event of delay, for example spinal surgery. It would be helpful for data to be published on the number or percentage of occasions on which requests for surgery are not approved within a specified timescale.

These issues are can be illuminated further in the following case studies:

#### **Case Study 1: Delayed decision-making causing risk of worse outcome for worker**

Slater and Gordon recently represented a worker with a complex medical history who suffered a neck injury at work in 2017. A request for surgery on the cervical spine was sent to the Agent on 3 January 2020. A second request for surgery, marked "\*\*\*\*URGENT\*\*\*\*" was sent to the Agent by the surgeon on 18 May 2020.

The worker subsequently attended a second treating surgeon, who made a request for funding. The worker was then seen by Worksafe's clinical panel, who approved the request for surgery at the beginning of July 2020. The treating surgeon stated that he was stunned at the extent of the danger of adverse consequences which the worker had faced due to the delays by the Agent, in particular a significant risk of paralysis and loss of arm use.

#### **Case Study 2: Example of delay, use of irrelevant evidence, failure to obtain relevant evidence**

A worker's claim was accepted in 2016 for a disc bulge sustained after falling from three metres. The Agent had paid for a number of hospital admissions for severe lower back pain. During hospital attendance in 2019, treaters found significant damage to the worker's hips and diagnosed him with post-traumatic osteoarthritis secondary to his back condition. The worker had no history of hip pain prior to his injury.

The worker's treating surgeon submitted a request for right hip replacement in March 2020, which the Agent rejected on the basis the hip injury was not a compensable condition. The Agent's decision was based on an IME report from 2018 and a Medical Panel opinion in 2019, both of which pre-dated the diagnosis of the worker's hip condition. The agent did not seek further clarification from the treating surgeon, nor did it arrange an IME appointment to assess the hip condition.

On 31 July 2020, four months after the request for surgery, the Agent's decision was overturned by the Workers Compensation Independent Review Service (WCIRS) and the Agent was directed to accept liability for the hip condition and to take steps to approve the requested hip replacement.

### Case Study 3: Example of delay, failure to obtain relevant evidence

Slater and Gordon represents a worker for whom a request for shoulder surgery was made on an accepted claim by the treating surgeon on 27 February 2020.

The agent arranged an IME appointment with an occupational physician in May 2020 to assess the request. Slater and Gordon raised a concern with the agent that the IME was not an appropriate specialist to consider the request. A request for conciliation was lodged for a failure on the part of the agent to make a decision.

The agent then re-arranged the IME with an orthopaedic surgeon specialising in knee and hip injuries. Without providing the IME report, the agent approved surgery on 29 June 2020, four months after the request had been made.

### Case Study 4: Grossly insensitive management of complex claim; ignoring treater recommendations; poor complaints management

Slater and Gordon acts for a worker who experiences suicidal ideation and had expressed a concern about suicidal thoughts if he was forced to attend an IME. In December 2019, the Agent was notified in writing by the worker's treating psychologist that the worker was psychiatrically unfit to attend an IME arranged for that month, and that he was at "extremely high risk of suicide should he attend".

Despite this, the Agent required the worker to attend the pre-arranged IME one week later. On the day before the IME, the Agent wrote to the treater and confirmed the IME would proceed. The treater replied to say that this was against her recommendation. Again, the Agent took no action.

The worker then attended the IME, but attempted suicide immediately afterwards by running into traffic outside the doctor's rooms. Thankfully, he was unsuccessful, but his family (who were present) were understandably distraught.

When our lawyer contacted the case manager to discuss the incident, the case manager confirmed that the treater's correspondence had been received but that she had nevertheless not spoken to the treater. The case manager said that as the worker was an adult, he should be able to attend an IME. After a complaint was lodged and investigated by the Agent, the Agent declined to change the worker's case manager and stated that "while there is always room for customer service improvement, there is not found to be any action or conversation where the claim consultant has acted inappropriately".

The incident has been notified to Worksafe and the Ombudsman.

## FINANCIAL INCENTIVES AND AGENT DECISION MAKING

***What role do the current financial incentives for agents have in the agents' management of complex claims?***

***Describe:***

- (a) The ways in which the current financial incentives for agents could change to maximise outcomes for injured workers with complex claims.***
- (b) Any different or additional measurements which could be linked to financial incentives to promote quality decision making by agents;***

It is not possible for Slater and Gordon to comment in detail on the impact of financial incentives on the behaviour of agents when managing complex claims without having full details of those incentives and, in particular, the events which trigger them.

However, given the examples and commentary provided by the Ombudsman in her 2016 and 2019 reports, it is likely that financial incentives play a negative role in the management of complex claims by agents, likely caused at least in part by their motivation to create profits for shareholders. Unless financial incentives are triggered by KPIs related to positive outcomes which are properly measured, their presence is unlikely to result in positive consequences.

For example, if a KPI related to the number of workers remaining in receipt of weekly payments after 130 weeks, this might cause an Agent either to maximise terminations or to maximise rehabilitation and retraining activities for injured workers. Re-casting the same KPI to reflect the proportion of injured workers who have made a sustainable return to work after 130 weeks would ensure that attention is focussed on a positive outcome for the worker, which would also then result in positive financial outcomes for WorkSafe. For commentary in relation to the meaning of a "sustainable return to work, see below.

Slater and Gordon believe quality case management in relation to complex claims should be assessed based on indicators which demonstrate positive, sustainable outcomes for workers. Such outcomes for workers are likely to lead to a reduced need for future time off work or medical and like services, so reducing the cost of claims to both the scheme and employers. Better long-term outcomes for injured workers will also have broader benefits for the worker, their family, employer and at a societal level.

Examples of assessment measures which might have this effect include:

- + Worker satisfaction measured across a cohort of workers with complex claims. Indicators of good case management and positive outcomes could include whether the worker considers the insurer's intervention contributed to an improvement in their situation (NB: as an example the TAC asks claimants to score their own situation on a

"life back on track" scale, which assesses the degree to which claimants believe their situation has improved and returned to a reasonable level of function).

- + A reduction in the proportion of decisions which are contested at ACCS.
- + The proportion of treatment requests which are determined within 28 days and which are not later overturned by internal review, WCIRS, ACCS, the Medical Panel or the Magistrates' Court.
- + The proportion of Agent decisions considered by WCIRS or the Medical Panel which are determined in favour of the agent. Magistrates' Court outcomes should not be included in this description, given that the majority of those disputes are settled rather than actually determined in favour of one party.
- + The proportion of workers who have made a sustainable return to work at specified intervals post-injury (with "sustainable" being better defined than at present).
- + Surveys of other stakeholders in the WorkSafe scheme, for example treating doctors who regularly engage with WorkCover Insurance claims.

***Describe any non-financial mechanisms by which agents could be encouraged to promote quality decision-making.***

There are a number of logistical mechanisms which may promote better quality decision-making by agents and these include:

- + A requirement to consider the cost versus benefit of any given decision, taking into account the likely impact on return to work and future medical and like costs of any decision to reject or terminate entitlements.
- + A requirement to make decisions which are supported by the balance of evidence, not as presently occurs where decisions are made simply on an arguable basis.
- + Mandated timescales for decision-making.
- + A requirement to justify why IME evidence is required if treaters have provided evidence which justifies the treatment sought.

However, Slater and Gordon also believe it is important for Agents to better understand the ways in which their behaviour can negatively affect the health of workers. It is extremely

common for Slater and Gordon to encounter workers who believe that their mental health has been adversely affected by the actions of and communication with agents.

Slater and Gordon's experience of workers who consider their mental health has been adversely affected by interactions with Agents is too frequent and too consistent in nature to write-off as being isolated incidents. Any workers' compensation scheme should ensure, as a baseline expectation, that it does not worsen the situation of injured workers. These matters were the focus of Slater and Gordon's July 2019 submission to The Royal Commission into Victoria's Mental Health System (a copy of which is attached to this submission).

These situations can be avoided, or at the very least mitigated, if culture and training is improved so that case managers can better understand the issues faced by injured workers. These initiatives could focus on:

- + Ensuring case managers are provided with education on injury types and their physical and psychological consequences for workers.
- + Providing education to case managers on the psychosocial context in which injured workers find themselves, including pressures on finances, relationships and family.
- + Ensuring that the principles of good case management are enshrined in case managers' methods of operating. Real life examples of poor case management should also be highlighted to illustrate inappropriate behaviour.
- + Case managers should hear from injured workers about the effects of their injuries and, where relevant, the impacts which Agent behaviour have had.
- + Ensuring, as far as possible, that case managers represent a cross-section of community backgrounds, for example in terms of gender, culture and language.

Agents should ensure that the in-house culture is one of striving to ensure appropriate benefit delivery and to achieve best outcomes for injured workers, rather than being a culture of benefit minimisation.

## **OVERSIGHT OF AGENTS BY WORKSAFE**

### ***Is WorkSafe's process for overseeing agent's management of claims achieving prompt, effective and proactive outcomes for injured workers?***

There is little transparency in relation to WorkSafe's oversight of claims management. However, the outcome of the Ombudsman's 2016 and 2019 reports, as well as the high levels of overturned decisions via the WCIRS all indicate systemic problems with agent decision-making. If WorkSafe's oversight was sufficient then it is unlikely that such widespread and common problems would either exist or persist.

Complaints to WorkSafe regarding the behaviour of Agents are often referred back to the Agent itself rather than being dealt with by WorkSafe, which is circular and does not give confidence that systemic issues can be adequately identified and addressed.

A system of oversight which operates at the level of file reviews also severely limits the opportunities to identify systemic or cultural behaviours which contribute to broader issues of poor client experience and claims' outcomes. For example, workers often report being spoken to by case managers in a demeaning or accusatory manner. This inevitably causes a negative impression of the Agent in the mind of workers, which sets-up a negative backdrop for subsequent interactions. Conversely, where oversight occurs at a level which does not include these day-to-day interactions, WorkSafe is unlikely to become aware of the impact this type of issue is having on overall experience and performance.

While WorkSafe's evaluation of Agents includes measuring the number of valid complaints made against the Agent, the system for making and evaluating complaints gives no cause for confidence that complaints will be acted on. Slater and Gordon's experience is that the majority of matters which appear to give valid grounds for complaint against the Agents are never lodged as complaints, as this is seen to be a waste of time without a likelihood of meaningful outcome. It is likely, therefore, that the level of dissatisfaction with Agent behaviour is under-recorded.

WorkSafe should consider a routine audit of claims on which issues have been identified with decision-making. The most obvious example would be matters in which a decision has been overturned at WCIRS, when by definition WorkSafe will have concluded that an unsustainable decision has been made. Poor decision-making is unlikely to occur in a vacuum and is likely to be an indicator of other problems.

### Case Study 5: Poor decision-making, delayed and circular response to complaint

Slater and Gordon represents an immigrant worker with no previous experience of WorkCover Insurance who injured his back when saving the life of a member of the public. The worker's claim was rejected by the Agent solely on the basis that the claim was lodged late, despite the Agent's IME accepting that the worker had suffered injury. The Agent did not change its decision at ACCS and a genuine dispute certificate was issued.

After being instructed, Slater and Gordon contacted the Agent on 5 September 2019 requesting an internal review of the decision to reject the claim, on the basis that the matter was exceptional and that an internal review would avoid the time and cost of pursuing the matter in the Magistrates' Court.

Beyond an initial acknowledgement of the request, nothing was then heard from the Agent. Chasing emails were sent on 1 November 2019 and 28 November 2019, with no response at all. The matter was escalated to WorkSafe on 4 December 2019, but no response was received from WorkSafe. Slater and Gordon chased WorkSafe on 16 December 2019, after which WorkSafe simply recommended that the matter be raised with the case manager at the Agent.

Slater and Gordon then raised the complaint again with the Agent that day, threatening to escalate the matter to the relevant Minister. Only then, on 18 December 2019, was the claim accepted. No indication was given by the Agent or WorkSafe on lessons learned or consequences for the decision-making and delay in this matter.

### ***Do the new mechanisms implemented by WorkSafe in response to the Ombudsman's 2019 report address any limitations in WorkSafe's oversight of decision making?***

The WCIRS has been helpful in allowing a merits review of agent decisions without the parties suffering the delay and cost involved in pursuing proceedings in the Magistrates' Court.

WCIRS monthly reports indicate that it is overturning the majority of decisions it considers. While it is positive that WCIRS is saving workers having to proceed to court, the fact that the majority of decisions are being overturned confirms clear ongoing problems with decision-making by Agents.

WCIRS also requires workers to have obtained a genuine dispute certificate, which by definition requires the decision to have been conciliated. Even assuming that the worker makes a prompt request for conciliation, it is likely to take in the region of three months from decision to genuine dispute certificate to WCIRS outcome, throughout which time the worker remains disadvantaged by the Agent's decision, and likely suffering from financial and/or health consequences.

While WorkSafe envisages that WCIRS will result in a cycle of continuous improvement for Agent decision-making, this is a slow and uncertain method by which to resolve the issues

which exist with Agent case management. Even assuming some improvement via these means, workers with complex claims will continue to live with the consequences of poor Agent decision-making in the meantime.

Slater and Gordon's view is that fundamental change is required in the Agent model to effect real change in problems which have now existed for decades. What is required is not the possibility of slow, incremental change, but rather a step change in the way complex claims are managed.

***How could any limitations in WorkSafe's oversight of agent decision making be overcome?***

It is our recommendation that complex claims should be dealt with in-house by WorkSafe Victoria, while non-complex claims remain with the Agents.

Methods by which WorkSafe oversight of Agent decision-making in non-complex claims might be improved include:

- + Embedding WorkSafe employees within each Agent to monitor performance and culture
- + Ensuring that all complaints against Agents are investigated by WorkSafe
- + Providing greater openness and reporting regarding the processes for and outcomes of WorkSafe oversight of agent decision making.

## EVALUATION MEASURES

***To what extent do current measurements of outcomes for injured workers, including return to work rates and worker surveys, accurately measure whether the agent model achieves prompt, effective and proactive outcomes for injured workers?***

***Describe any additional or alternative methods of measuring outcomes for injured workers that should be considered?***

Slater and Gordon does not know what data is collected in worker surveys by WorkSafe, or what cohort of workers are surveyed for that purpose.

As a general statement, return to work rates and worker surveys will only provide accurate measure of the success of the agent model if the definition of key terms is appropriate and if surveys are optimal in both the questions asked and the cohort surveyed.

Slater and Gordon understands that WorkSafe's definition of a sustainable return to work is a return to work at any time prior to a survey being conducted and that the return has been sustained for at least three weeks. With respect, this is a very short-term measure and does not incentivise Agents or employers to ensure the long-term success of a return to work. A three-week return to work would also be likely to be less than the probation period for any new job, so is unlikely to enable a worker to be confident that they will remain in employment. Clearly, any reduction in return to work outcomes will have negative consequences for both the injured worker and the WorkSafe scheme.

A far more sensible measure of return to work success would require a longer period of sustained time, say six months. This is less likely to be a period which a worker could "struggle through" and is far more likely to indicate that the worker has genuine prospects of remaining in the workforce long-term.

In terms of surveys, it would be sensible for the people being surveyed to include:

- + A significant number of workers with complex claims, given the length of time for which such workers remain engaged with the WorkSafe scheme and the cost to the scheme of their claims. Little of a constructive nature is likely to be learned from a survey if the participants are mainly those with minor injuries and short-lived claims, who are likely to have entered and exited the scheme quickly and who are more likely to be satisfied with their experience.
- + Other stakeholders in the scheme, for example treating doctors who are known to treat a significant number of injured workers. It is common to hear of doctors being unwilling to treat injured workers because of the doctor's negative experience of

dealing with Agents, so having input from health practitioners (in a more meaningful way than perhaps simply via occasional discussions with representatives) would be likely to provide helpful insights for WorkSafe and the Agents.

Surveys should ask for input on matters including:

- + General experience of the Agent
- + Satisfaction with case managers
- + Satisfaction with the timescales for decision-making
- + Whether the Agent has had a positive, neutral or negative impact on the worker's psychological state
- + Whether the Agent has had a positive, neutral or negative impact on the worker's long-term health, including mental health.

To generate meaningful data from the surveys, there should be a required number or proportion of workers with complex claims. Results should differentiate between complex claims and all other claims. The outcomes of worker surveys should be publicly available.

## **THE CURRENT AGENT MODEL AND ALTERNATIVE MODELS**

### ***Does the current agent model achieve prompt, effective and proactive management for injured workers with complex claims?***

No.

Beyond referrals to vocational assessors, it is difficult to think of ways in which case management of complex claims could be said to be proactive. The common experience of workers as reported to Slater and Gordon is of delay in decision-making by Agents and a need on the part of the worker to chase the Agent for action.

Agents appear to be almost entirely reactive in their management of claims, except when an opportunity exists to reduce benefits. For example, IMEs are routinely asked questions relevant to the tests for benefit eligibility, but are rarely asked whether they can identify additional treatment options or other interventions which might improve a worker's condition and capacity. This is not assisted by the general experience that Agents often select IMEs who are no longer in active practice and who are known to be likely to provide opinions helpful to the Agent.

Workers with complex claims often have long-term treaters who understand the nuances of their injuries. When these treaters seek approval for procedures or treatments, their opinion

often appears to be given less weight than that of an IME. IMEs usually meet a worker only once, for a limited time and with limited materials. Their area of specialty is often not directly on point with the worker's injuries.

***Describe any alternatives to the current agent model that would be more effective in delivering positive health and recovery outcomes to injured workers.***

Management of complex claims by Agents has been a failure, with the consequences as set out in the Ombudsman's 2016 and 2019 reports. The issues with Agent management of claims have been widespread and have existed for decades. Realistically, they are unlikely to materially differ if the extent of change is to amend procedures, requirements, incentives and oversight within the current model.

Provided appropriate changes are made to Agent decision-making and culture, simpler claims could continue to be dealt with by Agents.

Slater and Gordon believes that the preferable option for the management of complex claims is for WorkSafe to manage these in-house. As explained at the beginning of this submission, the definition of "complex" claims should be relatively broad, encompassing claims in which workers have either suffered major injuries or in which there are complex issues which increase the risk of workers remaining on weekly payments beyond 130 weeks. A broader definition will enable proactive case management so as to improve health outcomes for workers with complex claims and so reduce the prospect of those workers remaining significantly engaged with the WorkCover scheme long-term.

Moving the management of complex claims in-house at WorkSafe is likely to have various benefits:

- + It will concentrate expertise in best practice.
- + It will enable WorkSafe to directly oversee the management of complex claims and ensure that they are dealt with in a manner which ensures optimal benefit delivery and support to injured workers, which in turn is likely to result in better financial outcomes for the scheme.
- + It should enable the recruitment, retention and training of quality case managers, which in turn should flow through to better case management, decision making and outcomes.

- + It will enable WorkSafe to more directly influence strategic innovation and change in relation to the management of complex claims.
- + It would remove profit or the achievement of financial incentives as a motivation for decision-making, and so enable WorkSafe to focus on managing complex claims for the purpose of achieving better outcomes for injured workers and therefore the WorkSafe scheme more broadly.

## **VICTORIAN OMBUDSMAN 2016 AND 2019 REPORTS**

***Have you observed any changes (i) agent decision making and (ii) the oversight of agents by WorkSafe since the 2016 Ombudsman report?***

***What are the root causes of the problems identified by the Ombudsman in her 2016 report?***

***Do you think the implementation of the recommendations 3-9 in the 2019 Ombudsman report will address those root causes?***

Slater and Gordon has not observed a material change in the quality of decision-making by Agents since the 2016 report.

Of note is the fact that all but one of the case examples involving Slater and Gordon clients quoted in this report relate to Agent issues in 2020, after the publication of both the 2016 and 2019 Ombudsman reports.

The Victorian workers compensation scheme is complex, bureaucratic and reactive rather than proactive. It is operated day-to-day by Agents whose corporate interest is ultimately profit. There appears to be a fundamental distrust by Agents of workers and a lack of focus on achieving better long-term outcomes for workers and the scheme.

Recommendations 3 to 9 are all welcome and are all targeted at shortcomings in both the management of claims by Agents and oversight by WorkSafe.

However, the recommendations all seek change within the confines of a system which has not proved fit for purpose, in particular in relation to the management of complex claims. That fact that changes as basic as requiring Agents to make sustainable decisions are still required after 35 years of operation of the scheme points to the need for fundamental reform.

Slater and Gordon believes such reform is unlikely to be achieved within the current framework and therefore supports a model in which complex claims are managed in-house by WorkSafe as an important step towards achieving long term reform and cultural change.

## **FURTHER CONSIDERATIONS**

### ***Are there any other matters the Review should consider in meeting the Terms of Reference?***

#### Redemption of weekly payments

Consideration should be given to changing the legislative provisions around redemption of weekly payments in order to make that a more attractive and accessible option for long-term incapacitated workers. Changes might include the minimum age limit (currently 55) and the formula by which payments are calculated, as the current formula results in such low figures that workers will rarely accept. Redeeming weekly payments would mean fewer interactions between workers with a long-tail claim, which is likely to have benefits for both workers and agents (reduced case management, IME and other costs).

#### Certificates of capacity

Similarly, at present Agents can provide permission for workers to obtain certificates of capacity valid for up to 90 days. In contrast, the TAC does not have an upper limit on the validity of certificates and will often accept certificates valid for up to a year for long-tail claimants. Increasing the 90-day limit would reduce bureaucracy for complex claims and reduce the burden on treating doctors.

#### Vocational assessors

Relevant to proactive claim management which seeks to improve outcomes for workers, it is common for:

- + Assessors to suggest vocational options which are either of a cookie-cutter nature (ie the same options are repeated routinely for different workers). This tends to indicate that vocational reports are created for the purpose of identifying *any* option (so as to enable management of weekly payment entitlements) rather than for the purpose of

genuinely identifying suitable options appropriate for the worker which might lead to sustainable employment.

- + Treaters too often report feeling pressured by vocational assessors to provide a certificate which gives the worker at least some level of work capacity. The impression is that this is to enable the worker to be returned to work, at least temporarily, to achieve a target.
- + Vocational assessment reports to detail only a high-level outline of the requirements of a job. When the detailed requirements of a job are analysed, it is frequently the case that these are contrary to the worker's medical restrictions.

Further, there are regular instances of vocational assessors attending treating doctor appointments, sometimes without notice, or verbally telling workers that their benefits will be affected if they do not consent to attendance at consultations. Reports from workers are consistent in these details, and the issue has been raised by several plaintiff law firms at WorkSafe's Legal Liaison Group. It is understood that in response WorkSafe has reiterated to Agents and vocational assessors their obligations, however, in practice this has simply highlighted another example of a way in which the direct management of the scheme becomes convoluted and the ability to assist and support the rehabilitation of injured workers becomes a secondary concern.

Greater clarity should also be provided in relation to the extent of vocational retraining options which will be funded for injured workers, as workers often face difficulty in obtaining approval for courses other than those which are short in duration and low in cost. As with many issues, this goes to the short-term nature of decision-making in many claims, with little consideration given to the likelihood of a worker finding more sustainable employment options (and so being less likely to require ongoing support weekly payments) if vocational support appropriate to the individual was to be provided.

#### Presumptive payments on complex cases

Similar to the WorkSafe Victoria's trial of presumptive weekly payments for emergency services workers who suffer a psychological injury, consideration should be given to medical and like expenses under a nominated threshold being approved on a presumptive basis. This would give greater certainty to treaters, enable prompter health interventions, and avoid the delay and Agent cost focus which currently impedes worker recovery.

### Notice period for weekly payments at 130 weeks

At present, due to Covid agents must provide 39 weeks' notice of an intention to terminate weekly payments at the 130-week mark. It would be helpful to workers from the perspective of financial certainty (and resulting psychological benefits) if the notice period was to be permanently extended to 26 weeks. This would enable workers to contest decisions at ACCS and obtain an outcome from the Medical Panel prior to weekly payments ceasing. This would ensure injured workers would not be exposed to a loss of income if the Medical Panel was to support the continuation of benefits. The loss of payments during the ACCS / Medical Panel process experienced by many workers at present is detrimental to their financial and psychological wellbeing.

### Self-insurers

While the focus of this submission is on the behaviour of Agents, it should be noted that self-insurers constitute approximately 8% of the Victorian WorkSafe scheme based on remuneration. Slater and Gordon's experience is that the issues which occur with WorkSafe Agents also often occur with self-insurers. Given the structure of the scheme means that complex claims managed by self-insurers may not be able to be brought in-house by WorkSafe, it is important to consider how self-insurer claim management can also be improved and optimised.



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# **Submission to The Royal Commission into Victoria's Mental Health System**

**Submitted on behalf of  
Slater and Gordon Lawyers**

**July 2019**

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Slater and Gordon Lawyers appreciates the opportunity to make a submission to the Royal Commission into Victoria's Mental Health System

## Key Points

In Slater and Gordon's experience:

1. Individuals who sustain psychiatric injuries face inherent stigma and discrimination when navigating Victoria's accident compensation systems and public liability laws.
2. The process of proving the existence of a diagnosable mental health condition can often aggravate the mental health of an accident compensation scheme claimant
3. Systemic inequalities arise when psychiatric injury claims are assessed and litigated, and inherent prejudice exists in the relevant legislation and common law.
4. Because psychiatric injuries rely on an element of self-reporting and subjectivity there is more suspicion and scrutiny towards this type of injury in the compensation context with legislative frameworks maintaining higher threshold requirements
5. The terms of reference for the Royal Commission may not be broad enough to adequately examine these issues and the Commission should consider the opportunity to specifically explore these issues in more detail in the future.

Slater and Gordon would welcome the opportunity to expand on our observations on request from the Royal Commission.

## Background

### Company Background

Slater and Gordon Limited is a publicly listed company.

We are a leading Australian Consumer Law and Plaintiff Injury Law firm employing 800 people in 40 locations across the country. Our mission is to give people easier access to world class legal services. We provide specialist legal and complementary services in a broad range of areas, including:

- + Personal Injury
- + Superannuation and Insurance
- + Class Actions
- + Commercial Litigation
- + Employment Law.

Since our establishment in 1935, we have built a powerful reputation as a law firm built on social justice values that fights to achieve the best outcomes for our clients, while reducing the stress they go through to obtain justice. From the many landmark legal cases we have won, to the introduction of innovations such as No Win - No Fee, we have been determined to ensure that more Australians are able to access affordable legal services, no matter where they are.

### Slater and Gordon's interest in the Royal Commission into Victoria's Mental Health System

As one of Australia's leading Personal Injury Law firms Slater and Gordon assists many Victorians to exercise their rights and obtain their correct legal entitlements following a life-changing event such as sustaining a workplace injury or transport accident.

Consistent with our deep commitment to social justice principles we've long recognised the significant psycho-social difficulties our clients face within the legal context, and over ten years ago identified a service gap and made the decision to employ a social work team to provide free social work services to our clients. In fact, we were the first - and are still the only - law firm in Australia to do so.

The work of both our legal practices and our social work team has given us unique insights into both the causes and effects of mental health injuries.

Our submission wishes to explore these issues in three broad areas:

- + Workplace Safety and Compensation,
- + Transport Accidents,
- + Public Liability.

## Issues

### Workplace Safety and Compensation

#### 1. A Rising concern

Psychological injuries are the second most common cause of worker's compensation claims in Australia. In Victoria alone, they account for 11% of WorkCover claims and this statistic appears to be growing.

Our observation is that psychological injuries unsurprisingly result in longer absences from work than physical injuries. In cases involving purely psychological work-related harm, especially those injuries that arise from bullying, we often see a large number of employees who fear of returning to work with their pre-injury employer.

In Victoria, to be entitled to workers' compensation, any injured person must be considered a worker and must have suffered an injury arising out of or in the course of their employment. However, whether it be pursuant to the "no-fault" or "fault-based" compensation avenues, the Victorian WorkCover scheme forces workers to endure more rigorous criteria in respect of psychological injury claims when compared to physical injury claims.

#### 2. Onerous Criteria for the Psychologically Injured

To begin with, a worker must establish that they have suffered a diagnosable psychiatric disorder. From experience, we see many psychologically injured workers who are told that while they may exhibit some ongoing symptoms, they do not satisfy the criteria of a diagnosable injury. For these workers, the case can often end here unless they are prepared to challenge the decision about the existence or non-existence of a diagnosable condition – a process that can often aggravate their mental health.

A worker must also establish not only that their injury occurred in the context of employment but that work was a 'significant contributing factor'. This immediately sets the bar much higher than for a physical injury. Noting that 'significant contributing factor' takes into account the following:

- + The duration of employment;
- + The nature of the work performed;
- + The particular tasks of the employment;
- + The potential development of the injury if that employment had not taken place;
- + The existence of any hereditary risks;
- + The lifestyle of the worker;
- + The activities of the worker outside the workplace.

To put this into context, this bar only applies to physical injury claims so far as it relates to 'aggravation' injuries, that is, when the worker already had a pre-existing condition of the same nature which was then aggravated by work.

To have their WorkCover claim accepted, an overwhelming number of workers who suffer from a mental health injury must also overcome the complete defence that WorkCover insurers often deploy against psychological injury claims – the ‘Reasonable Management Action Defence’. This defence essentially states that if the mental injury was wholly or predominantly caused by reasonable management action, taken in a reasonable manner, then the claim will be denied. Anticipation or an expectation by the worker of such action being taken or a decision by the employer, on reasonable grounds, to take or not take any management action, are sufficient to trigger the defence. The legislation provides a long list of what is considered management action (which is not exhaustive) including:

- + appraisal of the worker’s performance
- + counselling of the worker
- + suspension or stand-down of a worker’s employment
- + disciplinary action taken in respect of the worker’s employment
- + transfer of the worker’s employment
- + demotion, redeployment or retrenchment of the worker
- + dismissal of the worker
- + promotion of the worker
- + reclassification of the worker’s employment position
- + provision of leave of absence to the worker
- + provision to the worker of a benefit connected with the worker’s employment
- + training a worker in respect of the worker’s employment
- + investigation by the worker’s employer of any alleged misconduct
- + communication in connection with an action mentioned in any of the above paragraphs.

The management action must only be reasonable and is assessed without using hindsight to reflect upon the ultimate consequences for an employees mental health.

Our firm has seen this defence relied upon by insurers to reject a worker’s claim in cases that included or involved elements of bullying, interpersonal conflict or harassment. When this provision is relied upon by WorkCover insurers, workers have no other avenue but to litigate in the Magistrates’ Court in order to have an opportunity at overturning this decision. They are otherwise precluded from accessing their no-fault benefits of weekly payments for lost income and medical and like expenses.

### 3. No Fault Statutory Benefits – the additional stressors for the psychologically injured

If a worker succeeds in these circumstances in having their claim accepted, they face a further stressor when it comes to resolving issues relating to return to work obligations, capacity for work and therefore an entitlement to ongoing weekly payments. Generally speaking, for the first 130 weeks of the claim, the test to continue receiving weekly payments assesses the worker’s ability to undertake all aspects of pre-injury work. However, for psychological injuries there is an exception.

Commonly now known as the ‘Kerridge’ principle, if a worker is found to have a theoretical capacity to return to their pre-injury duties with an alternative employer where they would not be confronted by the ‘perpetrator/s’ causing stress or the work culture that caused the psychological harm, then the

entitlement to weekly payments would cease. That is, an inability to return to the worker's pre-injury place of employment does not amount to an incapacity for work itself.

The no fault lump sum benefit available for injured workers, known as an impairment benefit, is assessed according to the *Guide to the Evaluation of Psychiatric Impairment for Clinicians*. The clinician makes an assessment on the injury's impact on intelligence, thinking, perception, mood, judgment and behaviour. However, what sets apart psychiatric claims compared to physical injury claims is the percentage threshold necessary to be awarded compensation. For psychiatric injuries, a worker must have a whole person impairment of 30% or more to be eligible for compensation. To put this into perspective – workers with musculo-skeletal injuries (those involving muscles or bones) are only required to establish a whole person impairment of 5% or more and for other physical injuries (such as scarring or respiratory disease), a whole person impairment of 10% or more is required for compensation to be awarded. This 30% psychiatric impairment hurdle often means that significantly injured workers (with ongoing debilitating symptoms) who are unable to establish negligence against their employer, have limited prospects in obtaining lump sum compensation for their compensable injury because the no fault benefit threshold is so high.

In addition, a person who suffers a physical injury initially and then goes on to develop a significant psychological sequelae is disadvantaged when trying to access compensation pursuant to the impairment benefits claim so far as it relates to their psychiatric injury. The legislation is quite clear that any psychological injury secondary in nature, notwithstanding that it is compensable and could be debilitating, is disregarded. In assessing the degree of impairment, regard must not be had to any psychiatric or psychological injury, impairment or symptoms (no matter how devastating) arising as a consequence of, or secondary to, a physical injury.

It must be noted that impairment benefit claims did not even exist for those psychiatrically injured between 1992 and 1997. Whilst this position seems to have improved after 1997, it was not until 2010 that psychiatric conditions reaching 30% impairment began receiving appropriate levels of no fault compensation awards. Notwithstanding the very high threshold of 30% impairment that was required, for claims lodged prior to 2010 psychiatrically injured workers received significantly lower compensation for their impairment benefits claim. For example, a worker who had a 30% impairment rating due to a psychiatric injury and lodged their claim before 10 December 2009, would only receive \$13,650 if their injury occurred in the 2009/2010 financial year. A musculoskeletal injury that rated 30% with a claim lodgement date before December 2009 and with a date of injury in the 2009/2010 financial year would receive \$68,240. It was only after 10 December 2010 that psychiatric injury claims arising from an injury in the 2009/2010 financial year received \$68,240 following significant changes to the compensation tables. The fact that this discrepancy persisted well into modern times, highlights the general inequity and social attitudes towards psychiatric conditions as opposed to physical ones.

#### 4. Common Law Negligence Claims – Jumping the “Severe” line and establishing negligence.

The common law entitles you to claim damages if you can establish that:

- + You have suffered a “serious injury” within the meaning of the WorkCover legislation; and
- + Your injury has been caused by negligence on the part of your employer and / or another entity, for example an occupier of a premises.

However, a worker with a psychiatric injury can only be granted a 'Serious Injury Certificate' if their injury is a "permanent severe mental or permanent severe long-term behavioural disturbance or disorder." In contrast, physical injuries need to show a "serious long-term impairment or loss of a body function". In this context the word "severe" coupled with "permanent" as opposed to "serious" has traditionally had a higher burden of proof. The test takes into account the medical condition and symptoms, treatment and medication, and the impact on work, home life, hobbies, relationships etc.

In our experience, the symptoms and treatment of a physical illness tends to be earlier and more straight forward and consistent than with psychological illnesses which can create additional hurdles for a larger battle ground in respect of serious injury certificates sought for "severe" psychological injuries. It can often be more challenging to disentangle consequences of the psychiatric injury caused by employment from the consequences caused by other stressors in that individual's life. If there are any pre-existing stressors, depression or anxiety, this often adds an additional layer of complexity.

In addition to establishing "Serious Injury" as defined above, a worker will also need to demonstrate that there has been negligence on the part of the employer. For claims where the psychological injury is the main grievance and where it has arisen in the context of bullying, harassment or interpersonal conflict, establishing 'fault' or negligence is difficult given the 'he said/she said' nature of these claims. It is often the case that establishing that bullying has taken place is not sufficient. A worker must establish that the employer had knowledge of the situation and failed to take reasonable steps to remedy the issue.

As solicitors, we can face barristers refusing briefs for these common law claims due to the degree of difficulty and complexity unless the injured worker is prepared to pay their fees upfront, which is prohibitive for many. This makes the hurdles surrounding the no fault scheme even more pertinent.

Furthermore, claims that arise from conflict that cannot be categorised by the bullying definition such as interpersonal issues, stress due to overwork or stress due to the inherent nature of the work are extremely difficult due to the High Court precedent set in *Koehler*. The High Court adopted a conservative and stringent approach to these claims. The Court confirmed that an employee who has contractually agreed to undertake onerous duties cannot subsequently rely on the fact that they lodged complaints about the excessive workload or complained about an inability to cope to prove their psychiatric claim in negligence. Instead, there must be some evidence of psychiatric injury observable by, or known to, the employer like the employee's external distress or prolonged absences from work to satisfy that such psychiatric harm as suffered by the worker was reasonably foreseeable. Therefore, the argument that an employer ought to be held liable for psychiatric injury resulting from an employee's stress in the workplace or being overworked, whilst not impossible, has been significantly curtailed.

## 5. Increased Litigation

Some claimants not only have to litigate at the outset to have their no fault WorkCover claim and benefits accepted, but then are also forced to litigate their common law damages claim because historically they are more frequently challenged by the Victorian WorkCover Authority and self-insurers. We can expect to litigate claims involving psychological injury either at the Serious Injury phase or, if the worker manages to satisfy the "severe" test and obtain a Serious Injury Certificate, then at the damages trial phase. In addition, cross-examination of these workers tends to be far more

lengthy and critical. For instance it would not be unusual to see a Plaintiff vigorously questioned about a smiling photograph on Facebook and have their mental “suffering” questioned.

Often short term or long-term support is denied by insurers by cutting funding for psychological treatment. The costs of litigation mean that pursuing disputes in the Magistrates’ Court about treatment, especially when it relates to short term treatment plans, can often be uneconomical for workers.

Anecdotally, workers suffering from psychiatric and/or psychological injury have had to endure a more rigorous scrutiny of their family and personal background from the outset of their claim. We are often managing distressed workers on the other end of a phone call following psychiatric medical examinations arranged by the WorkCover insurer. The vulnerable workers often have their entire lives and the lives of their immediate family members questioned and probed. These examinations often occur without a support person and workers regularly provide feedback that they did not feel sufficiently able to tell their story. Workers may have limited opportunity to explain inconsistencies in their histories before the insurer makes adverse determinations with respect to their entitlements based on these assessments. It is not unusual for the reports of psychiatrists commissioned by the WorkCover insurer to offer a diagnosis, often linked to non-work-related factors, that is in stark contrast to the diagnosis offered by long term treating practitioners who have seen the worker on multiple occasions. Unfortunately, the reports of the worker’s treaters are rarely favoured over these medico-legal assessments when insurers make determinations on the workers’ entitlements to weekly benefits, medical and like expenses and even lump sum compensation.

## 6. Our Observations

The road to recovery and the opportunity to pursue their legal rights and entitlements for those who sustain injuries to their mental health, compared to physical injuries, is - in our opinion - unjustly challenging, long and protracted and in some cases unfortunately never proceed. Forthcoming and fair changes to the WorkCover scheme for those that suffer from psychological / psychiatric injuries – whether it be in respect of eligibility to enter the scheme, the impairment and injury thresholds or the awards of compensation amounts – have not only been slow but also at times inequitable.

## Transport Accidents

### 1. Introduction

Any driver, passenger, cyclist or pedestrian who has been injured in a road or public transport accident in Victoria or in a Victorian registered vehicle interstate can make a claim to the Transport Accident Commission (TAC). The TAC will pay for treatment and compensation benefits for people injured in transport accidents, in accordance with the *Transport Accident Act 1986*.

A serious motor vehicle accident is considered a traumatic event in the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders), the handbook used by health care professionals in Australia and much of the world as the authoritative guide to the diagnosis of mental disorders. This means that depending on the circumstances, following a motor vehicle accident, an individual is at risk of developing Post-Traumatic Stress Disorder (PTSD). PTSD is a serious mental illness that causes significant distress and impairment to functioning.

In addition to PTSD, people may experience disabling mood disorders, such as depression and anxiety, following a motor vehicle accident. Chronic pain following a physical injury from a motor vehicle accident is also a common experience. Chronic pain has a significant mental health component with regard to its treatment and management.

Studies<sup>1</sup> have shown that psychological distress (PTSD in particular) mediates the relationship between trauma exposure and poor health and leads to adverse health outcomes via multiple pathways - physical, behavioural and attentional. Other studies<sup>2</sup> indicate that individuals with psychological trauma symptoms report much higher pain severity and higher impairment of functioning in their family, occupational and other social roles, than those with only physical symptoms. In short, psychological injuries arising from a traumatic event such as a motor vehicle accident are not only extremely disabling in and of themselves, they can lead to increased pain and more significant restriction of activities of daily living.

In Slater and Gordon's experience, individuals who sustain psychiatric injuries face inherent stigma and discrimination when navigating the TAC system, due to systemic inequalities that arise when their claims are assessed and litigated, and inherent prejudice in the relevant legislation and common law.

### 2. Impairment Benefits

Lump sum compensation is paid to an individual by the TAC if their injury results in a permanent impairment of greater than 10% of the whole body, according to the AMA Guides to the Evaluation of Permanent Impairment<sup>3</sup>. This assessment does not take into consideration any pain and suffering or how the injury affects the person's earning capacity.

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<sup>1</sup> Schnurr P.P and Green B.L. (Eds) (2004) *Trauma and health Physical health consequences of exposure to extreme stress*. Washington D.C. American Psychological Association.

<sup>2</sup> Geisser, M.E., Roth, R.S., Bachman, J.E. & Eckert, T.A. (1996) The relationship between symptoms of PTSD and pain, affective disturbance and disability among patients with accident and non-accident related pain, *Pain*, 66, 207 - 2014

<sup>3</sup> American Medical Association, 1995, Guides to the Evaluation of Permanent Impairment, 4th edition.

In terms of psychological injuries, this assessment can only take into account psychiatric impairment that is not secondary to physical injury (ie: only impairment arising from the trauma of the happening of the accident itself can be assessed. This precludes individuals being compensated for the significant mood disorders, such as depression and anxiety, that commonly arise after a motor vehicle accident. A person can be significantly disabled from psychological injuries caused by their involvement in a motor vehicle accident and receive no compensation under the impairment benefits sections of the *Transport Accident Act 1986*.

Further, individuals who suffer psychiatric disorders as a result of a motor vehicle accident face difficulties and prejudice in having their impairment claims assessed. Because psychiatric injuries rely on self-reporting, it is arguable that there is more scrutiny and suspicion towards this type of injury in the compensation context. Psychiatric conditions can be fluctuating in nature, and a person may function and present far better on the day of assessment than they do in their everyday life. The disentangling of neurological impairment from psychiatric impairment can be very difficult if the patient has a head injury and a psychiatric injury as a result of a motor vehicle accident.

Many factors can impact a person's susceptibility to developing a psychiatric injury following a motor vehicle accident. These include childhood trauma, lower education, female gender, belonging to an ethnic minority and pre-existing psychiatric psychopathology<sup>4</sup>. Yet under the *Transport Accident Act 1986*, any pre-existing or unrelated psychiatric impairment must be excluded from the assessment. This is a difficult task for medico-legal assessors, and anecdotally we have found that a person's background, previous life experiences and mental health history – the very factors that can influence the likelihood and severity of developing a psychiatric disorder - can negate the perceived severity or indeed existence of psychiatric symptoms arising from the motor vehicle accident.

In general, the TAC waits 12 months before assessing a person's level of impairment, however, assessments may commence as soon as three months after the accident provided the injuries have substantially stabilised. It is generally accepted that psychiatric injuries take 12 – 18 months to substantially stabilise and the TAC is unlikely to assess a psychiatric injury sooner than 12 months post-accident. As such, individuals with psychiatric injuries not only face more difficulties in the accurate assessment of their injuries, but it will generally take much longer for their impairment claims to be assessed, as compared to physical injuries.

### 3. Common Law Claims

The TAC will pay compensation under the common law for pain and suffering, loss of enjoyment of life and lost earnings (past and future). However, before proceeding with a common law claim, a person needs to satisfy the TAC or a County Court Judge that they have suffered a '*serious injury*' within the meaning of the law. They must also establish that another party is at fault, or partly at fault, for the transport accident.

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<sup>4</sup> Christiane Steinert, Mareike Hofmann, Falk Leichsenring & Johannes Kruse (2015) The course of PTSD in naturalistic long-term studies: High variability of outcomes. A systematic review, *Nordic Journal of Psychiatry*, 69:7.

An injury will be considered 'serious' if the person's degree of permanent impairment is determined at 30% or more. Alternatively, a person may be entitled to common law compensation if the injury has led to:

- + Serious long-term impairment or loss of a body function;
- + Permanent serious disfigurement;
- + Severe long term mental or severe long term behavioural disturbance or disorder; or
- + Loss of a foetus.

#### 4. Inequality, Stigma and Discrimination

It is clear that, at common law, the test in relation to psychiatric injuries is more difficult to meet than that for a physical injury. To access compensation under common law, a person must show that they have suffered a 'severe' psychiatric injury, as opposed to 'serious' disfigurement or a 'serious' physical injury. Victorian Courts have held that the word 'severe' connotes a stronger meaning than the word 'serious' – *Mobilio v Balliotis (1997) VSC 56*.

In terms of a physical injury or disfigurement case, to meet the threshold the injury must be, in comparison with other cases, 'fairly described as "very considerable" and certainly more than "significant" or "marked"' (*Humphries v Poljak [1992] 2 VR 129, [40]; [1992] VicRp 58*). In the case of psychiatric injuries, the common law states that the words 'serious' and 'severe' are not to be equated and that the word 'severe' is of stronger force than the word 'serious' (*Mobilio v Balliotis [1998] 3 VR 833*).

The inequality in the test for physical injuries versus psychiatric injuries is not accidental. As outlined above, the Victorian compensation scheme for work-related accidents also requires the higher threshold of 'severe' for psychiatric injuries to be deemed 'serious' under the law. When introducing the *Accident Compensation (Common Law and Benefits) Bill 2000*, the government explained that it intended to preserve the different standards required for a serious physical injury and a severe mental injury:

*"The definition of serious injury maintains the previous distinction between the requirement of a serious impairment or loss of a body function or serious disfigurement and a severe mental or behavioural disturbance or disorder. The government recognises it is proper to maintain a higher threshold requirement for a mental or behavioural disturbance or disorder due to the degree of subjectivity involved in such a condition."*<sup>5</sup>

This perceived 'subjectivity' involved in a psychiatric condition exemplifies the stigma and discrimination faced by claimants with a psychiatric injury in the context of a TAC claim. In Slater and Gordon's experience, this misconception that psychiatric injuries are more subjective than physical injuries, and that therefore there is a higher likelihood or risk that people will exaggerate or fake symptoms, means that our clients with psychiatric injuries can face a far more prolonged, difficult and stressful passage through the TAC claims process.

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<sup>5</sup> Parliamentary Debates, Legislative Assembly, Accident Compensation (Common Law and Benefits) Bill 2000, 13 April 2000, Mr Cameron, 1004

We recognise that psychiatric injuries are complex, in terms of diagnosis, treatment and the impact on the individual. A psychiatric disorder may have severe consequences, even though the claimant has not undergone much treatment. Claimants in this position may experience a particularly difficult road through the TAC Common Law process to prove their case. Conversely, merely because an individual has attended many doctors and undergone much treatment, the law is clear that a psychiatric disorder is not 'severe' unless the symptoms and consequences of the disorder properly call for that level of treatment (*TAC v Katanas* [2017] HCA 32, [23]). However, complexity should not lead to inequality and Slater and Gordon advocates for a review of the thresholds and processes in assessing common law claims for psychiatric injury.

Change can be achieved. In 2013 the Liberal government made the test for psychiatric injuries even more restrictive, requiring an injured person to show that over a continuous 3-year period since the accident they had:

- + Suffered from a recognised mental illness or disorder, **and**
- + Suffered symptoms and disability that have not responded to known effective clinical treatments provided by a registered mental health professional, **and**
- + that the condition caused significant distress and severe impairment to a person's relationships **and** social **and** vocational functioning

This was a very difficult test to satisfy and it greatly reduced the rights of those with psychiatric injuries resulting from motor vehicle accidents. Slater and Gordon applauds the Andrews Government for repealing this legislative change retrospectively in 2016.

## 5. Our Observations

Slater and Gordon see this stigma and inequity against people with psychiatric injuries and mental illness played out anecdotally across the breadth of the cases we act in.

Due to the narrower gateways for psychiatric injuries, our clients with psychiatric injuries and mental illnesses endure a more onerous journey through the TAC compensation scheme. Their requests for mental health treatment are more seriously scrutinised and more readily denied than for claimants with clear physical injuries that are simple to diagnose via scans or investigations.

We find that their applications for Serious Injury Certificates take far longer to process, are more heavily scrutinised and again more readily denied. Psychiatric claims for common law compensation are more likely to be litigated, rather than settled informally. These claimants are required to undergo more independent medical examinations. The background, history and credit of a claimant with a psychiatric injury is more commonly analysed, dissected and used against them in the claims and litigation process. They are more likely to be the subject of surveillance, online and in person, should their case proceed to Court.

Slater and Gordon would like to see the removal of this increased scrutiny of people with psychiatric injuries arising from motor vehicle accidents as they navigate the TAC claims and legal systems.

## 6. The future

Slater and Gordon note, and have been pleased to see, some recent recognition by the TAC of the complexity of psychiatric injuries and a progressive response to dealing with such claims.

Following the extremely distressing Bourke Street and Flinders Street incidents where multiple people were killed and injured by motor vehicles, the TAC (together with other insurers such as WorkSafe and Victims of Crime) took a very proactive approach to mitigating poor mental health outcomes for victims. The TAC ensured these claims were accepted immediately and treatment, particularly psychiatric treatment, was readily acceded to. This was a hugely positive example of the capacity of the TAC to recognise and respond to a large pool of potentially significant psychiatric injuries arising out of road trauma.

In addition, TAC's new claims management framework focussing on early intervention and treatment, including for psychological injuries, as a means of assisting people to get their lives back on track after a motor vehicle accident is a step in the right direction and should be acknowledged and used as an example for other insurers.

We also look to the future, where neuroscience and neurotechnology has the capacity to fundamentally change how psychiatric injuries are assessed in tort law by providing an objective assessment of subjective experiences – making the invisible visible.<sup>6</sup> Psychiatric disorders and mental illnesses have biological bases which neurotechnology can potentially present visually with neuroimaging, much like an MRI or X-ray does for physical injuries.

We hope that these advances will help to de-stigmatise conditions such as depression, anxiety and PTSD, and contribute to these conditions being managed and judged based on the scientific evidence that can be obtained.

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<sup>6</sup> *Making the Invisible Visible: The Effects of Neuroscience on Mental Injury Claims* by Justin Brandon Ng, A thesis submitted in conformity with the requirements for the degree of Master of Laws Faculty of Law University of Toronto, 2018

## Public Liability

### 1. Introduction

Public Liability claims in Victoria covers a wide range of circumstances where a person incurs injury or death as a result of another person's negligence, or failure to take reasonable care. Public Liability claims are governed collectively by the common law and the *Wrongs Act 1958* ("Wrongs Act").

The *Wrongs Act* encapsulates some aspects of the common law and sets out the process and restrictions that apply to negligent (non-intentional) and intentional actions (e.g. assault, battery, sexual abuse). The *Wrongs Act* governs claims for damages for not only public liability claims, but also matters of medical negligence and dust exposure.

In order to bring a successful public liability claim in Victoria, the injured party must prove that another party is wholly or partly responsible for the injury or loss sustained. Negligence must be established on the part of another party (or person) to receive compensation. "No Fault" benefits are **not** available to injured parties.

In order to bring a claim in negligence, necessary components of an action in negligence must be proven:

- + Duty of Care is owed to the Plaintiff by the Defendant;
- + Defendant/s breached the duty owed to the Plaintiff and failed to act to a reasonable standard of care;
- + Breach of duty causes actual loss and damage to the plaintiff that the defendant should have reasonably foreseen.

In circumstances of negligence there are potentially three heads of damage (compensation) available for claimants:

- + Pain and suffering (for loss of enjoyment of life or loss of amenity)  
*-Must satisfy the injury threshold defined in the Wrongs Act to qualify*
- + Medical and related expenses (both past and future)
- + Loss of earnings or loss of earning capacity (both past and future)

### 2. Changes to the Public Liability landscape

In the early 2000s the Australian insurance industry purportedly experienced a 'crisis' due to a surge in public liability claims. As a result of rising premiums and claims, a panel was appointed to review the law of negligence and its interaction with the then *Trade Practices Act 1974*. What came of the review was the 2002 'Ipp report' which was the foundation of major tort law changes in most Australian jurisdictions.

Reforms were rolled out in Victoria in 2002 and 2003 which introduced relevant injury thresholds for physical and psychiatric injuries. The introduction of such threshold was perceived to offset the requirement to have a system of legitimate insurance in place, while reducing the number of claims, or claims being made for injuries which were considered minor, modest or non-permanent.

In 2014, the Victorian Competition & Efficiency Commission tabled the *Adjusting the Balance Report* which reviewed aspects of the *Wrongs Act* including the injury thresholds. This was in response to a view that the changes a decade earlier had gone too far.

Thereafter came the *Wrongs Act Amendment Act 2015* which made further changes to the injury thresholds that must be satisfied in order to qualify for non-pecuniary damages. This included a change for threshold levels in relation to spinal injuries. It also included an amendment to the threshold for a psychiatric injury to an impairment of 10 percent or more (rather than the former, ‘more than 10 per cent’).

### 3. A “significant injury” in the Wrongs Act

Injury thresholds are defined currently in the *Wrongs Act* as follows:

| Injury thresholds for non-economic loss |                                           |
|-----------------------------------------|-------------------------------------------|
| Spinal                                  | permanent and equal to or greater than 5% |
| Physical injuries *(other than spinal)  | permanent and >5%                         |
| Psychiatric injuries                    | equal to or >10%                          |

- + Compensation for pain and suffering is currently capped at approximately \$600,000 (indexed annually).
- + Changes introducing injury thresholds have significantly affected claims for damages in public liability cases and restricted the common law right to claim for non-pecuniary (pain and suffering) damages in public liability cases.
- + Whether or not a claimant has a “significant injury” is determined in accordance with the *American Medical Association Guides to the Assessment of Permanent Impairment* (4th edition) for physical and spinal injuries, or GEPIC for psychiatric injuries.

### 4. Psychological and psychiatric injuries

Our work and experience in these claims, provides us with an insight into challenges which are faced by claimants who have sustained a psychological or psychiatric injury.

Psychological or psychiatric injuries typically vary in nature in both cause and impact. They can (commonly) be combined with a physical injury and are therefore secondary, consequential or reactive in nature. Others psychiatric injuries are ‘primary’ in nature and are caused through a traumatic event.

Examples of claims which typically have a primary psychiatric injury include the following:

| Common causes of psychiatric injuries (primary), subject to a Public Liability claim |                     |
|--------------------------------------------------------------------------------------|---------------------|
| Nervous Shock claims/ witness to a traumatic event or aftermath                      | Sexual Abuse claims |
| Animal Attacks                                                                       | School bullying     |

The significantly high thresholds required to be met in order to claim for pain and suffering damages for psychiatric injuries disproportionately restricts not only access to fair compensation outcomes to claimants; but the operation of such high thresholds can result in claimants feeling invalidated by the process despite instances of legitimate claims in negligence. This can ultimately lead to claimants being denied compensation (or being left under-compensated) by the operation of the high impairment thresholds for psychiatric injuries.

In our experience, psychiatric injuries have historically been viewed as 'lesser' injuries and have not attracted large pain and suffering awards. It has been rare to see compensation for pain and suffering exceeding \$200,000.

#### 5. Primary versus Secondary injuries

Section 28LJ of the *Wrongs Act* states that *"in assessing a degree of impairment of a person... regard must not be had to any psychiatric or psychological injury, impairment or symptoms arising as a consequence of, or secondary to, a physical injury."*

Therefore, in order for a psychological injury to qualify as a significant injury it must be:

- + A diagnosable psychiatric disorder;
- + Not explained as a consequence of (or secondary to) a physical injury;
- + An injury which leads to impairment that is permanent; and
- + Causally linked to the circumstances of the injury.

#### 6. Assessing a psychiatric injury in the claims process

In order to determine if a claimant has a 'significant injury' they are required to undergo an assessment with an approved independent medical examiner. If the injury is determined to satisfy the requisite threshold, the claimant is issued with a certificate which states that they have sustained a 'significant injury' in accordance with the *Wrongs Act*.

Assessments are based on permanent injuries and as such assessments of injuries typically do not take place until at least 12 months after the date of the injury (or diagnosis).

When a claimant has a psychiatric injury caused in circumstances of alleged negligence they are required to attend an appointment with a duly qualified assessor. During this process, the claimant is asked several questions regarding their injury and the relevant consequences, including (but not limited to): the incident or the injury, what treatment has been undertaken, what the impact of the psychiatric injury has been on the claimant having regard to active symptomology and effects on marriage, children, relationships and other interests as well as general family information, background (such as schooling and employment).

The issuing of a Certificate does not form the end of the determination of a significant injury having been sustained by the claimant. The respondent to a claim has the option to refer the “medical question” in relation to the impairment arising from the injury to the Medical Panel, who can make a final and binding determination as to the impairment level to a claimant.

The Medical Panel process requires a subsequent discussion of usually traumatic circumstances, injury, and consequences in front of a Panel (two to three psychiatrists) whom are independent, and the claimant has not met previously.

Certainly, there are default provisions (or a process) aimed to ensure that there is timely resolution to determine a claimant’s impairment. However, in practice this does not always eventuate for claimants who have sustained a psychiatric injury. There are two key reasons underlying this position:

- + As the legal landscape currently stands there is no provision which prevents multiple defendants (ie: more than one party) referring the claimant to the Medical Panel to make subsequent and potentially different assessments regarding issues of impairment and significant injury.
- + In circumstances where an injury is considered not yet stable, the claimant is required to attend the Medical Panel again for further assessment at a later determined date.

This onerous process can facilitate a degree of re-traumatisation for claimants, when they are required to restate their story, their psychological condition, their treatment and articulate how the incident has profoundly impacted on them.

Psychiatric injuries, by comparison to physical injuries, including spinal injuries, are subject to unreasonably high thresholds which disproportionately restricts the rights of claimants who have suffered mental harm.

Further, in circumstance where the assessments must disregard any impairment that is from unrelated causes or pre-existing in nature, the threshold does not fairly align with the purpose of ensuring a consistent scheme of assessment for injuries that are psychiatric in nature.

Rather, it facilitates a system where psychiatric injuries are more harshly assessed ultimately leading to under-compensated claims or claims where compensation is denied in its entirety for pain and suffering.

## 7. Nervous Shock claims

In the event of death of a loved one in circumstance of negligence, family members may bring a nervous shock claim if they have a genuine psychiatric illness or injury as a result of the loss.

In the public liability space, this will at times involve assisting parents with making a claim for a psychiatric injury following the death of their child. This in and of itself highlights the manner in which the system can be improved so as to ensure it supports claimants suffering from a genuine psychiatric illness.

It is our position that such a loss should be deemed a “significant injury”.

There are a number of reasons that inform this position. Firstly, the death of a child in circumstances of alleged negligence has typically already involved significant investigation by various bodies, which could include Victoria Police, the Coroners Court, Government bodies or departments, and Worksafe, all before the commencement of any personal injury claim. This results in claimants “reliving” the circumstances involving the death of a child repeatedly.

The process as it currently stands, requires that after such a loss it must be proven that there is a genuine psychiatric injury, which is then at the respondent’s election reviewed by the Medical Panel before a determination is made as to whether a significant injury has been sustained. This can mean attendance at numerous medical assessments before it is determined that “pain and suffering” may be claimed following the loss of a child.

A grieving parent must face the ignominy of the process, to satisfy thresholds despite the nature of the circumstances which have irrevocably altered their lives forever.

By way of example:

- + A young family lost their son and brother in a tragic incident where he was killed in a factory setting following a malfunction in the machinery used.
- + The teenage brother of the deceased had suffered majorly following the traumatic and sudden loss of his younger brother and proceeded to investigate a nervous shock claim.
- + After undergoing a traumatising assessment and satisfying that he had a significant psychiatric injury, the brother was referred to the Medical Panel for a further assessment.
- + However, when undergoing the Medical Panel appointment he was uncommunicative and unforthcoming, finding it difficult to speak and came across as being dismissive of his condition due to nerves and feeling overwhelmed by the process of further discussing the traumatic loss of his brother.
- + He was found not to have a significant injury and therefore was unable to claim pain and suffering damages in relation to the loss of his brother.

In a similar vein, our clients attending psychiatric assessments have faced difficulty in balancing the requirement to express their suffering from a medical standpoint while balancing their personal cultural mourning traditions, customs and rituals, some of which limit the periods of mourning following the loss of a loved one. These can vary of course, based on location, sect and religious belief

system and can dramatically impact on the level of treatment or medication a claimant has had, which in large part forms the basis of an assessment.

It is fair to submit that a psychiatric injury in those circumstances could be more accurately looked at through a combined assessment by a treater and an appropriate narrative test assessment, which can encapsulate the multifaceted aspects of a psychiatric injury.

## 8. Time Limitations

The *Limitations of Actions Act 1958* sets time limits for which a claimant must have brought their claim. It is typically three (3) years from the date an injured person discovers, or should have discovered the following facts –

- + The fact that an injury has occurred;
- + The fact that the injury was caused by the fault of another;
- + The fact that the injury is sufficiently serious to justify bringing a claim.

A time limit of six (6) years applies if you are injured when under the age of 18 (or under a disability).

On 1 July 2015 the *Limitation of Actions Act 1958* was amended so as to abolish all time limits for persons to commence legal proceedings in circumstances where the physical, psychological or sexual abuse occurred when they were a minor.

This was a small step in the removal of some of the barriers the personal claims process presents to people suffering with a psychiatric injury. An abolishment of time limits for claimants who suffer a psychiatric injury whilst under the age of 18 would be appropriate to ensure access to justice for claimants who suffered mental harm in instances of negligence.

## 9. Our observations

Slater and Gordon's experience has shown that at times, after being advised of the legal requirements of proof in relation to their psychiatric injury to enable a claim for pain and suffering damages, claimants ultimately elect not to proceed with a potential claim. In our experience the prospect of enduring such a process is too painful and places unnecessary barriers for claimants who can ultimately be denied compensation due to the high psychiatric injury thresholds despite the legitimacy of their claim and subsequent suffering.

Our experience has shown that at times due to the increased scrutiny placed on claimants with a psychiatric injury, they have been denied or provided limited compensation, or have had their claims process frustrated and obstructed due to the high thresholds they must meet to bring a claim.