DJCS-Workplace Safety Reform Agent Review

From: [redacted]
Sent: Sunday, 20 September 2020 10:36 PM
To: DJCS-Workplace Safety Reform Agent Review
Subject: Victorian Workers' Compensation System – Independent Review

Follow Up Flag: Follow up
Flag Status: Flagged

To whom it may concern,

Iam writing with regards to the Victorian Workers Compensation System Review.

Firstly, I wanted to query the intention of the enquiry into the "agent model in managing complex Workers Compensation claims" review and would like to know why this enquiry was not advertised or promoted via Worksafe or its insurers, in order to ensure that injured workers and their families were aware?

If the genuine intention is to find out whether the model is suitable, adequate and effective, then why were injured workers not contacted directly, advised about the enquiry, informed they had an opportunity to contribute to the survey and also make a submission about their experience and treatment within this very broken, corrupt system?!

I feel that it would be the only way to obtain an accurate representation of this system and it's failings, with the exception of a Royal Commission and I genuinely hope that this is not just for show.

I have completed the survey and have provided the same below.
I apologise in advance for my response to question 10 being a little disjointed. The below issues are only a fragment of the issues, pain, suffering, bullying, harassment And threats that I have endured from my insurer and Worksafe, since my initial injury in 2017.

I would also like to enquire as to whether or not there is an opportunity to address the enquiry directly, in person or via video link?
I want People to know what has been done to me and how I have been treated, simply because I had an accident!

I look forward to hearing from you at your earliest convenience.

[redacted]

1. Being careful not to identify yourself or your organisation, reflect on your own experiences. What are the key issues relating to the management of complex workers' compensation claims in Victoria? You may also wish to tell us what works well and what doesn't work well.

The main issue relating to the management of complex worker's compensation claims, is insurer involvement. Specifically the clear and deliberate patterns of unconscionable conduct perpetrated by insurers, as outlined by multiple Ombudsman reports, including;

- Inexperienced claims management staff.
- Claims management staff that are focused solely on financial incentives and not the health and well being of injured workers.
- Excessive and deliberate changeovers of case management staff, resulting in significant, multiple, unresolved issues that affect the physical and mental health of injured workers.
- Claims management and insurance staff misleading injured workers, providing them with incomplete or incorrect information and omitting information, for financial gain.

- Decisions being made contrary to medical evidence, seemingly for financial gain (I.e refusal of treatment, good & services, aids, medications, reimbursements, home help etc.), without complete or accurate explanations or recourse.
- Claims management making decisions contrary to binding Medical Panel opinions or refusal to comply with Medical Panel opinions.
- Unreasonable refusals to attend conciliations and unreasonable decisions maintained at conciliation, without proper, affordable methods of recourse.
- Conciliation as opposed to a binding arbitration, with appeals being required to proceed via the magistrates court, as opposed to say VCAT or similar. Making this unaffordable, unattainable or mentally and physically unmanageable.
- Woefully inadequate internal review processes, including refusing to provide compliant references, in an attempt delay or prevent further investigation by worksafe.
- Claims management staff falsifying or providing misleading information to IME's, attempting to obtain/illicit a specific outcome or response.
- Claims managers falsifying and cherry picking information to provide to 3rd parties, in order to commission reports that are favourable to them.
- Intentionally calculating PIAWE incorrectly to reduce financial liability to injured workers (including intentionally adding remuneration amounts and commissions as allowances, so they are removed from the PIAWE entirely).
- No provision of information or documentation provided by insurers, to show calculation and inclusions of PIAWE.
- Fabricating reasons for communication arrangements, to evade and reduce claims management duties.
- Claims management and senior insurance bullying, threatening and harassing injured workers.
- Intentionally delaying decisions and responses, to avoid financial liability.
- Ridiculous complaints procedure that is both extremely long and uneventful, as no one seems to have to ability to resolve issues.
- inappropriate Insurer and Worksafe affiliation, meaning deceptive and unconscionable decisions made by insurers are not adequately investigated by Worksafe or intentionally delayed because their goals and financial interests are aligned.
- Refusal of insurance staff to provide responses or explanations to enquiries or decisions, as it's not in their best interests to do so and Worksafe reiterating the refusal.
- Allowing employers to improperly and vindictively, influence outcomes and decision-making.
- Provision of IME reports direct to claims management staff and the ability of claims management staff to request supplementary reports from IMEs, to attempt to influence or change their opinion.
- Lengthy delays with requests for medical and like services, which in my case resulted in a now permanent injury.
- Use of in person private investigation services on injured workers with primary or secondary mental health issues, where it is reasonably foreseeable that to do so would exacerbate or cement mental health conditions such as PTSD, anxiety, depression and alike.
- The use of private investigators that break the law in order to obtain information to report on, including; use of drone cameras, looking inside homes, fabricating phone or in person surveys, refusing to leave once identified, initiating vehicle chases, attempting to induce vehicle accidents etc.
- Claims management staff refusing to pass on breaches of legislation perpetrated by employers, as it would potentially affect their financial liability.
- Claims management staff providing instant/immediate refusals to requests, reimbursements, assistance etc. where they had either not read requests or were required under legislation to provide an approval or reimbursement.
- Delaying ATI requests and responses, to force a conciliations and in turn intentionally drag out a timeframe, so that evidence that may have been relied upon in court, would be deleted or overwritten by their internal systems.
- Claims managers providing information or advice in writing and then refusing assistance when information or advice was followed because it was falsified/incorrect, in an attempt to cease entitlements.
- Refusal to provide complete file documentation from ATI request and refusing to provide a reason, when information being sought is not agains the act and is in the public interest.
- Fabricating/falsifying reasons for IME appointments, where appointments would be inappropriate and where purpose of appointment can be proven to be false/fabricated.

- Inappropriate use of IME's, for example: 1. Sending injured workers to multiple IME appointments, where 1-4 IME's in alternate specialties, have already made corroborated determinations/findings. 2. Booking an IME appointment and receiving an outcome unfavourable to the insurer, prompting another IME appointment and repeating this process. 3. Changing/alternating IME's where insurer has not received a favourable outcome. 4. Selecting IME's in locations that are a significant distance from injured workers when there are available IME's within the injured workers locality. 5. Booking IME appointments where they are aware that doing so would be detrimental to the injured worker.
- Harassing and falsifying documentation to provide to treating health providers, to illicit a response or provision of documentation they aren't entitled to.
- Bullying, harassment and stalking online by claims management and private investigation staff, befriending, following and engaging with on fb, Instagram, LinkedIn and twitter.
- No personal involvement or input into the claims management of my injury, instead discussed amongst in excess of 20 staff, who have never met or spoken to me and appear to only make decisions with favourable financial outcomes to them, with very little regard for my injury, safety, health or wellbeing.
- Claims management staff behaving in a manner designed to intentionally bait or illicit an aggressive/emotional response, so they can cease contact or implement contact arrangements.

2. How can claims management help an injured worker return to work?

I don't believe there is ANY benefit to insurer managed claims management.

The current system is an ethical nightmare and a complete conflict of interest. How you can have a mandated insurance scheme to ensure workers health, safety and support in the event of an illness or injury and then have it run by a for profit insurer, who is answerable only to shareholders, who is not held responsible/accountable for their unconscionable and deceptive conduct, whom there is no recourse against, who cannot be held financially, or criminally liable for their conduct, who benefits both personally (staff incentives) and as a business through discontinuing claims and who's interests are aligned with its governing body, ensuring unfair and non-transparent outcomes.

It has been proven through multiple channels that this regularly happens to legitimate claims, resulting in further physical injury, psychological injury, suicidal ideation and in severe cases, suicide. For what? So claims manager Joe Blow gets a bonus at 52 weeks, for his efforts doctor shopping and threatening injured workers, with the aim of inducing a forfeiture of their treatment, assistance or entitlements.

If it had not been for the unconscionable conduct, intentional delays with treatments, threats, bullying and harassment from the claims management staff charged with managing my injury, I don't believe it would have become permanent and my mental health may have improved enough to participate in some type of activity.

3. Does the Victorian workers' compensation system provide tailored support and treatment for injured workers based on individual circumstances and medical advice?

No

4. If you said 'no', what are the issues and what improvements would you suggest?

- Insurer based claims management staff need to be removed from the claims management process ENTIRELY and this should be completed by an IMPARTIAL 3rd party, not affiliated with Worksafe or the insurer.
- There should be ongoing consultation with injured workers throughout the duration of the injury, to ensure that everything that can be done is being done, to help the injured worker recover and return to work and life.
- Insurers need to be able to be held financially and criminally accountable for their conduct, both as individuals and the business as a whole.
- Financial incentives to insurers, payable for terminating claims need to be ABOLISHED COMPLETELY.
- Insurers need to be penalised/fined where they are found to have breached legislation, not complied with Medical Panel Opinions, unfairly or unjustly terminated/finalised a claim, intentionally delayed treatment or service approvals or where a termination has been overturned etc**.**
- **There needs to be assistance and services available to the family and partners of injured workers, to help them to cope and deal with the physical and mental limitations, additional stress and financial implications of the injury and to prevent relationship breakdowns and mental health issue.**

- **Injured workers need to be treated as PEOPLE, not numbers, claims or a $ amount, this will be assisted by removing incentives on claims.**
- **A limit on the number of IME appointments over a specific period needs to be introduced I.e. 2 IME's within a 6/12 month period UNLESS seeking advice relating to a requested surgery/treatment. These appointments are extremely stressful considering they are not independent, are selected and arranged by insurers, are paid for by Worksafe and injured workers can only obtain a copy from an insurer or GP upon request and AFTER insurers may have obtained a substitute report.**
- **Completed IME reports should be provided to the injured worker and insurer AT THE SAME TIME and within a specific timeframe, especially considering the information contained within is our own personal health information. By withholding it, it allows for deception and interference. If they were truely independent, this would not be an issue.**
- **There should be a PUBLIC REGISTER of IME's including the area of practice and an injured worker should be able to chose the IME (which if independent, shouldn't be an issue) OR the IME should be selected by location/distance from injured worker, to prevent doctor shopping.**
- **In person Private investigation services need to be BANNED for those suffering from mental illness, PTSD, Anxiety or alike. This conduct causes severe anxiety, depression, paranoia, suicidal ideation and causes people to live in fear. I'm now scared to be out of my home alone, drive alone, talk to strangers, friends, talk to people online, date or have any romantic interactions. Friends and family also feel uncomfortable visiting me, going out with me or assisting me with appointments etc. because of this conduct. It has taken away my life and completely isolated me, which some of you may now have a TINY understanding of given the Covid restrictions.**
- **Completely overhaul the complaints resolution procedure and either provide government funding for the appeals process to the Magistrates Court OR allow conciliation appeals to be heard at VCAT or in a VCAT type situation with the assistance of Workcover Assist.**
- **Remove financial incentives and KPI's from claims managers and employers, for finalising claims and returning to work. Look at incentivising injured workers by introducing some sort of timed RTW scheme, based on type and severity of injury. I.e. 20% impairment, returns to work for 6, 12, 24 months etc. gets X dollar amount on set milestones.**

5. In your experience, do people receive appropriate information and support to ensure they understand entitlement decisions, including their entitlements and any rights to have a decision affecting them reconsidered?
No

6. If you said 'no' what do you think should change?

Whilst injured works MAY on occasion be provided with a generic response, that outlines what they can do to appeal a decision, the complaints process is virtually pointless because there is no benefit to the insurer, conciliator, Worksafe and in some instances medical and rehabilitation professionals, in resolving it and in fact there is often financial implications for resolving complaints/disputes, so it is in everyone's best interest (except the injured worker) to not engage.
Injured workers would benefit from an independent 3rd party, that could assist, advise and enforce legislation and oversea Worksafe and insurers. With no government affiliations or incestuous appointments like icare!

Agent making decision
This Review will determine how and by whom complex claims should be managed. WorkSafe delegates most of its claims management to claims agents.
The Victorian Ombudsman's 2019 report identified evidence of unreasonable decision making by agents on complex claims, and evidence that financial rewards encouraged agents to terminate claims.

7. How can the system ensure agents make good decisions?
There are only four ways to ensure this;

1. **Make insurers liable and financially responsible for their decisions and delays. Allow injured workers to commence civil litigation and seek compensation resulting from illegal, inappropriate or unconscionable conduct of insurers.**

2. **Remove ALL financial incentives provided to claims managers.**
3. **Introduce an impartial third party, so oversee Worksafe and insurers, similar to the ombudsman but with the ability to enforce legislation, medical panel outcomes, legislated timeframes etc. not just an unbind omg it unenforceable opinion of what should happen.**
4. **Change the complaints and appeals procedure, so that agents are no longer able to refuse to attend or maintain unreasonable positions at conciliation.**

Oversight of agents

WorkSafe has oversight of the agents' functions. The Victorian Ombudsman's 2019 report found that WorkSafe was not making best use of its oversight mechanisms to address unreasonable agent decision making, or to identify and respond to systemic issues.

8. What can be done to improve WorkSafe's oversight of agents' management of complex workers' compensation claims?

You cannot have a mandated insurance scheme to ensure workers health, safety and support in the event of an illness or injury and then have it run by a for profit insurer, who's interests are aligned with its governing body, ensuring unfair and non-transparent outcomes.
The only way to resolve this is seperate Worksafe from insurers, so they do not mutually benefit from inappropriate, unfair and deceptive actions/conduct.
Claims management needs to be removed from insurers entirely or be open to litigation for mismanagement of claims and the ombudsman OR ideally an unbiased 3rd party needs to be able to give a directive to Worksafe to enforce legislation and appropriate conduct.

Your story

9. What best describes you?

Recipient of workers' compensation

10. Do you have a story about your experience of workers' compensation that you are prepared to share?

Please do not include identifying details about yourself. All responses will be de-identified and may be used or quoted in the report of the Review.

Yes.

YES! By listing these issues, I will I turn be identifying myself.
* Insurance policy commenced several months after my injury, resulting in significant delayed treatment.
*I had to pay all my treatments for months, with no money and bills piling up because my employer didn't and no one would tell me and insurer, claim number or reimburse me.
*my claim form wasn't submitted to the insurer.
* A complaint was made to Worksafe and an affidavit provided, along with in excess of 500 documents to prove claims listed in affidavit. Worksafe refused to accept all documentation and evidence stating "If the take the evidence, they would have to include every item in the summary prepared for the DPP. Several items were found to be proven, with the remainder not proven due to insufficient evidence, however I personally obtained this informant through an ATI request and ABN/ACN lookup but Worksafe refuses to resubmit the summary to the DPP because she was too lazy.
* As I tried to return to work, my injury claim was (by admission of insurer) not monitored/managed and I did not have a case manager in excess of 6 months from acceptance of claim, despite repeatedly contacting the insurer because I couldn't cope or manage and desperately needed assistance BECAUSE I WAS SHOWERING OUTSIDE EITH A CAMP SHOWER, UNABLE TO CLIMB THE STAIRS TO BATHE!.
* I repeatedly contacted the insurer about assistance moving home, as I was unable to get upstairs daily and this was exacerbating my injury, pain, stress and ability to cope emotionally with what was happening. I was ignored by the insurer until approximately a week prior to moving.
*I was advised by the insurer that an ADL assessment was required and I asked if I needed to obtain moving and cleaning quotations for consideration, I was advised no. A 10 minute ADL assessment was then completed in a home that was fully packed and almost clean and the assessors report was not provided until approximately 2 months

after the assessment took place, it was not completed by the person that attended and moving assistance and cleaning denied after the fact because I did not provide quotes, which I was told not to do.
Home help was also denied because they said my partner at the time could do everything. Home help was then approved a year later with a different ADL assessment by another company (this one was recorded).
*I was unable to complete my usual duties at work and was then made redundant amongst other things, a matter that was then resolved through fair work.
*Upon being made redundant, I realised my PIAWE was incorrect, was still following up reimbursement of leave and moving costs and submitted a request for conciliation. A conciliation was due to take place and I was contacted by Workcover assist and advised that the insurer **[agent, name redacted]** refused to attend, so all I could do is request a genuine dispute (I later found out that this was not true and the Workcover assist staff member didn't actually advise that I had other options or that I could have matters placed on hold pending additional items that would have ensured moving reimbursement, PIAWE recalculation and several other items.
*By this point I had had 18+ case managers in 1 year 2 months. Over 20 now in less than 2 years.
*I repeatedly requested assistance with deteriorating mental health, pain and inability to cope and was ignored for months, so I commenced and paid for treatment myself with a healthcare plan.
*I was then sent to a rehabilitation provider **[rehabilitation provider, name redacted]** and when I attended the first appointment, it was at a location with 2 flights of stairs that I could not get up (not appropriate location for a rehabilitation provider) and as a result, my first rehabilitation appointment with **[rehabilitation provider, name redacted]** then took place in a public cafe, at a cafe table, in front of people, until the cafe closed. I was told they would find a new office an in the interim to go to their [redacted] office next appointment and they would then give me the details of their new office. These appointments were ONLY to find a job and the staff didn't want to lose the appointment, so advised things like "you just need to fill in the diary with 10 jobs a fortnight, email it and come and hand it in, then the insurer will leave you alone and we'll keep the appointment". I was instructed by the staff to lie about my injury and not disclose it to any prospective employers, despite the fact that I could not walk and my injury, pain and mental state would affect ANY role I applied for. I attended [redacted] repeatedly before advising by text that I wasn't going to and couldn't continue to drive 40 minutes, to physically hand in something that I have already emailed, the text I received back was that he'll meet me in a cafe (which is against privacy and their company policy, despite it taking place previously. I declined and to keep the appointment he arranged a location in [redacted] however, their services ceased because I was entering a pain management program and I advised that I was terminating their services and would not use them again.
[Rehabilitation provider, name redacted] then completed a JSS report for **[agent, name redacted]**, that was falsified by staff and contained incorrect DOB, employment info and alleged I made statements that I did not make as well as stating I had seen and agreed with the report, which I did not, I put in writing and requested they change (which they refused).
*I was then bullied, harassed and threatened by the insurer. My emails and calls were ignored and the insurer refused to respond to queries.
*I got Worksafe involved and they made **[agent, name redacted]** agree to a recalculation of PIAWE once I obtained the payslips that my employer initially refused to provide. I provided payslips and a recalculation was completed but **[agent, name redacted]** refused to include all payslips, wouldn't advise why, wouldn't provide details of what they included,
wouldn't provide calculations or how they came to the amount and told me if I didn't like it, to proceed to the magistrates because after all, I did have the certificate of genuine dispute from the conciliation they had refused to attend!
Worksafe initially refused to assist any further, stating that a recalculation was done and no one could be bothered looking into it any further.
*PIAWE was then decreased and I got a letter saying that it was because allowances had been removed. I contacted the insurer via email to advise that I never had allowances and there must be a mistake, he replied saying it had nothing to do with allowances and that it was the end of an entitlement period. I knew that was incorrect because it was already at 80% so I continued to contact **[agent, name redacted]** to query it. At the same time I decided I'd do an ATI request to try and figure out what was going on with these people because they wouldn't help.
*my doctors had put in requests for Calmare therapy and a Ketamine infusion and the insurer refused to respond for more than 2 months. After I followed up and decided to do another conciliation I was told it was approved and they'd send the approval letter. Despite repeated requests, they would not send the approval letter for me to book the treatment and instead sent me a letter for an IME appointment with the reason being "to reassess a vocational assessment that had been done for me". No vocational assessment had ever been done for me, so I questioned if this was to do with the treatment approvals and again asked for them. I was told it wasn't. I then asked for a copy of the vocational assessment and was told they didn't have a copy because there was never one completed. Still didn't get the approval letter and was threatened that payment would be suspended if I didn't attend. Following this

appointment and receipt of report, 2 others were requested for the same reason "to reassess a vocational assessment that had been done for me".
It took 2 months and the confirmation letter was only provided after the last IME, as they were attempting to terminate the claim before giving the approval letter.
*I contacted **[agent, name redacted]** because the crutch feet rubber had broken and I needed new ones, given that previous reimbursements took months (including reimbursements where they had to register the providers), I wanted them to tell me which provider to go to. They dragged this out for 4 weeks telling me to send an email to tell them where I want to go and they'll tell me if it's registered, whilst telling me I'm only allowed to send one email a week. I needed crutches to WALK and I finally got an email saying they'd reimburse any aid up to $200. I looked back to find the place I hired the wheelchair from at the beginning and purchased crutches and a new shower chair (because I broke the old one) from there thinking it's probably registered. I submitted the invoice and on the 28th day they contacted rehab hire, paid them directly for the crutches and told them to take their time refunding to me but didn't pay the shower chair. I confirmed this with the provider and made them email me!
*the ATI request timeframe had passed and they still hadn't provided anything and then when they finally did, they sent several emails containing files, that were essentially the same 300 documents scanned in a different order, in an attempt to make it look like 1200 documents. I was already aware from Worksafe that there were 2200 documents, so I knew there was a lot missing AND there was no surveillance attached, despite me catching one PI and having another try to run me off the freeway, on the way to an appointment. I queried this and the missing documentation and some time after got an email from the ATI team saying it was "human error" and they'll post the surveillance and videos to my P.O. BOX, which they did via express post satchel. I then requested another conciliation to obtain the remainder and **[agent, name redacted]** was instructed to provide them but then refused to send them to my P.O. Box and said it had to be my courier to my house because it was private (despite previous documents being sent to my P.O. Box by express post (only address they've ever had). Couriers won't bring inside, so I asked for the courier details and said I'd organise to collect from the depot, insurer refused. Workcover assist says they couldn't help because it wasn't part of the complaint and they refused to get involved with where it was sent so it was suspended to be sorted out. **[agent, name redacted]** maintained their position and I had to get Worksafe involved again. [redacted] could see they were bullying me and had no reason for their behaviour and they were instructed to send to my P.O. Box.
*I injured my knee and tore meniscus because I tripped due to ankle pain. To date the insurer hasn't accepted the injury and ignored my communications about this, treatment approvals and physio for months until a conciliation request was made. They then delayed several more months before booking an IME and then Covid happened (meaning it was delayed). It's now been a year with no acceptance, no treatment, no Physio, nothing.

*In November 2019 **[agent, name redacted]** commissioned **[rehabilitation provider, name redacted]** to complete a Transferable Skills Analysis report on me, despite the fact that they had not seen me for more than a year, I had terminated their services and they had falsified 1 report that they refused to correct and stated I agreed with. This report stated amongst other things that; I'd completed VCE, was enrolled in a licence course and diploma course (both of which had been terminated long before, employment history and titles were incorrect and not even DOB was correct. This report made false statements about my abilities, pain tolerances and was written in such a way to make it appear as though they were actively working with me. They suggested jobs and then this was provided to **[agent, name redacted]**. **[agent, name redacted]** then secretly sent to my GP over the Christmas period and then called my doctor in excess of 10 times and insisted on him writing a report based on the falsified **[rehabilitation provider, name redacted]** report, which he declined. I then queried and contacted **[rehabilitation provider, name redacted]** and they advised they wrote the report based on information provided from **[agent, name redacted]** but the ATI request shows they were only provided with ONE IME REPORT from a doctor that said I HAVE NO CAPACITY. The then admitted in a length email chain that they wrote it from the information they were provided with, which is impossible when you read the IME report and inclusions in **[rehabilitation provider, name redacted]** report. They refused to correct the report, refused to withdraw the report, refused to tick that I did not agree, as did **[agent, name redacted]** and Worksafe. This report is being sent to IME's to induce a termination.

*from November 2019 o was restricted to 1 email a week resulting from excess communication relating to ATI and PIAWE. This was exceeded with the 4 weeks of back and forth over crutches and a postal communication arrangement was then put into place and they refused to accept any emails but then ignored ALL postal communications. [redacted] of Worksafe got involved, I told him history, gave him all the proof and as I said he resolved the ATI postal issue and then started looking into PIAWE. He instantly saw they had entered my commissions as allowances in order to remove them and did his own calculation to submit to**[agent, name redacted]** for a recalculation because the amount was visibly incorrect in addition to the commissions being entered as allowances. Insurer refused to give him their calculations and then started removing my certificates of capacity, so that I wasn't paid.

They then wouldn't enter when given by Worksafe and told [redacted] I was trying to circumvent their ban (that was put in place for ATI and PIAWE contact, which they were found to be wrong and acting inappropriately with).
I have proof in recordings and voicemails from the Worksafe advisory team confirming that certificates of capacity were entered and removed and they're not sure why. Following this, **[agent name redacted]** advised they sent me registered post envelopes via registered post but then refused to give tracking (which in July 2020 they finally said didn't exist, because they never sent) and they still Worksafe that they wouldn't accept because I wasn't using the envelopes that they didn't actually send.
[redacted] then sent me express post envelopes to use and told me he believed there was something "fishy going on".
*the communication arrangement was meant to be reassessed in April but never was. The insurer advised [redacted] firmly that I threatened to kill them online but then despite repeated requests, they wouldn't give me copies of the alleged death threats and then used that to keep the communication arrangement in place.
*[redacted] firmly submitted his recalculation of PIAWE to **[agent, name redacted]**, they refused to give their calculations, the then reimbursed my commissions WITHOUT TELLING ME, CONTACTING ME TO ADVISE, GIVING CALCULATIONS, RESPONDING TO WORKSAFE, NOTHING. [redacted] was then removed from my matter after months of no contact and I was advised it was simply "A business decision".
*[redacted] was then appointed and contacted saying essentially that all my issues have been resolved now (when not one had) and I went through them all again. He took weeks to get back and just reiterated what I wrote to him and asked for all the proof again and then disappeared. Weeks later it was taken over by "[redacted]" no surname and she looked into it and then closed the complain after summarising my prior conciliation outcomes, that were irrelevant to the matters raised.
I had involved the ombudsman repeatedly when Worksafe said they could no longer assist or had finalised the matters and then as soon as the ombudsman contacted worksafe, they lied and said they were still working on matters (this dragged them out over 9 months (still not resolved).
It took seven months to get a response to EVERY express post I sent with tracking (4 by express post, which were received and ignored with only COC's entered) (because they don't read the mail.

There are about 20 outstanding issues, I was told by Worksafe that I'm not eligible to go through the new WIRCS (despite looking this up and finding that every issue raised meets the criteria) and also advised by [redacted] at Worksafe that WIRCS don't have time for any more cases.

I have been threatened, stalked, harassed, bullied and lied to.
I've had insurers intentionally delay payments, remove certificates of capacity, accuse me of sending death threats online, not reimburse medications, delay treatment approvals, intentionally pay providers instead of reimbursing me and advise Worksafe that it's intentional because I am "difficult". I've had anyone that was helping me be removed/moved on. I've had private eyes on my property and using drone cameras. I've had my vehicle tire damaged whilst I was in with a treating doctor and much much more.

I have proof of ALL of these issues and more in writing.

I've been passed through Worksafe and have spoken with in excess of 6 people.
I've been passed through the insurer with more than 20 case managers over the duration of the claim.
NOW despite **[agent, name redacted]** knowing I'm immunocompromised, they apparently booked IME appointments and then sent notifications to my doctor NOT ME... so I don't even have an appointment letter or instructions or anything and we're still in lockdown with this virus.

I'm at the point where I'm in so much pain, my injuries have gotten worse, I now have injuries with hands, knees, back etc. and I just wish I wouldn't wake up anymore.

If you are prepared to speak with the Review team about your experience with complex workers' compensation claims please email agentreview@justice.vic.gov.au

11. Have you submitted (or do you intend to submit) a formal response to the discussion paper via email, in addition to your contribution here?
Yes

My submission

12. Your submission may be published on this website. You can choose to have it remain confidential. Required

I give permission for my submission to be published.

[redacted]