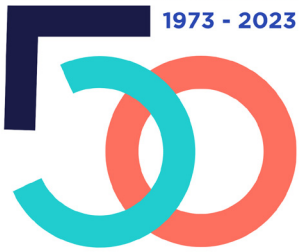
VICTORIAN ombudsman

WorkSafe 3: Investigation into Victorian self-insurers' claims management and WorkSafe oversight

June 2023



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The Victorian Ombudsman pays respect to First Nations custodians of Country throughout Victoria. This respect is extended to their Elders past, present and emerging. We acknowledge their sovereignty was never ceded.

Letter to the Legislative Council and the Legislative Assembly

To

The Honourable the President of the Legislative Council

and

The Honourable the Speaker of the Legislative Assembly

Pursuant to sections 25 and 25AA of the *Ombudsman Act 1973* (Vic), I present to Parliament *WorkSafe 3: Investigation into Victorian self-insurers' claims management and WorkSafe oversight.*

Deborah Glass OBE
Ombudsman

21 June 2023

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Foreword

"They helped me transition to a new position and get the treatment I needed."

"They took months to start my payment and have made many mistakes with my weekly payments causing a huge amount of stress in an already stressful period."

– Comments from injured workers

This is my third report into Victoria's workers compensation scheme. It concerns an area I did not look at in my two previous reports; what happens when companies are authorised by WorkSafe to handle their own claims, rather than using a WorkSafe-appointed agent.

My previous reports were highly critical of agent practices and WorkSafe's oversight of them, and have resulted in significant reforms, which I welcome. But many people expressed concerns that those reforms did not extend to companies acting as self-insurers. Did the same problems exist? Is it appropriate for those reforms to be extended? This investigation seeks to answer those questions.

There is an obvious power imbalance between injured workers and their employer, which can be exacerbated where the employer is also their insurer. On the other hand, when an employer offers tailored rehabilitative support, this relationship can also be an advantage.

Thirty-four companies – covering about 120,000 Victorian workers and including many of Victoria's largest employers – are currently approved to manage their own claims. The number and scale of companies acting as self-insurers imposed some challenges on the investigation; it was simply not practicable to fully explore the decision-making practices of each. We therefore focused on complaints, but acknowledge that self-insurers manage many claims and most are handled without complaint.

We found some self-insurers performing well and delivering the benefits the system intends. But the cases we examined in detail exposed large differences in both practice and capability. It was apparent that self-insurers' claims management processes did not always produce fair outcomes for workers, and that some echoed the undesirable practices used by WorkSafe agents that my two previous reports exposed.

Given the wide variance of practices across 34 companies, we focused on the role of WorkSafe, which is responsible for approving and monitoring self-insurers to enforce performance standards and promote good decision-making.

Ultimately, we found that more needs to be done – by WorkSafe, to ensure its oversight role is meaningful, and by government, to ensure greater consistency for workers.

We found multiple lost opportunities in WorkSafe's oversight, including a reluctance to become involved when self-insurers make unsustainable decisions and to use its approval power to support compliance.

WorkSafe has fewer levers for dealing with self-insurers than for agents. In particular, it has no power to direct a self-insurer to overturn a decision. However, WorkSafe seemed unwilling to use the levers it has. We were troubled by WorkSafe's tendency to use its discretion to approve the maximum six-year term for self-insurers with claims management performance issues. There is also little transparency regarding self-insurers, with WorkSafe publishing little information about their performance.

The picture we saw was not of a broken system, but a patchy and unequal one. Workers should not have a fundamentally different claims experience depending on who their employer is. All self-insurers are equally bound by legislation to ensure that compensation 'is paid to injured workers in the most socially and economically appropriate manner, as expeditiously as possible'.

I am pleased that WorkSafe acknowledges it needs to do more and is committing to greater vigilance in its regulatory oversight. Reviews and assessment should be purposeful and result in timely regulatory action; ensuring fair outcomes are achieved and decisions are made that are compatible with human rights.

I said in my first WorkSafe report, in 2016, that workers compensation has a fraught history; successive governments have wrestled with the complexity of creating a scheme that is both financially viable and fair. I acknowledge that the government continues to do so. The modest reforms proposed here should increase fairness – for example, by giving WorkSafe the power to direct self-insurers – without affecting financial viability.

The government and WorkSafe have responded admirably to my previous recommendations to ensure a fairer, more equitable system – for the sake of the next generation of injured workers and the community that bears the cost. It is in everyone's interests to promote sustainable and timely decision-making on what are not merely numbers, files or claims, but people's lives and livelihoods.

Until all workers in Victoria with the right to claim compensation have the same rights when they disagree with a decision, the system will not be truly fair.

We will continue to monitor both the successes and gaps in the system through the complaints made to us, and this report exposes the gaps around self-insurers. It has been a long journey to systemic fairness, and we are not there yet.

Deborah Glass

Ombudsman

Glossary

Arbitration	A process in which a binding decision is made in relation to a dispute. Arbitration is sought when a dispute has not been settled at conciliation.
Case Manager	Primary contact for both the employee and employer. The Case Manager's primary role is to manage a portfolio of claims by coordinating the treatment and recovery of injured workers.
Claimant	An injured worker who makes a workers compensation claim.
Conciliation	A dispute resolution process that brings the people involved in a disputed claim together to try to achieve an agreement. The people involved include the injured worker, the self-insurer and/or their agent.
IME	Independent Medical Examiner. An IME is a registered health practitioner approved by Worksafe to undertake a medical examination under the WIRC Act.
Injured worker	Worker injured in the course of their employment who is eligible for compensation under the WIRC Act.
Medical Panel	An expert panel tasked with providing legally binding answers to medical questions that assists in resolving disputes.
Non-compliance	Under WorkSafe's Self-audit Tool, a failure to meet a workers compensation legislative requirement.
Prompted satisfaction	A category of response in an injured worker survey: the response of an injured worker to a question about overall satisfaction asked after other questions about specific aspects of service.
Self-insurer	A company ('body corporate') approved by WorkSafe under legislation, to manage and fund the workers compensation claims of their employees instead of paying premiums to WorkSafe.
Substantiated complaint	Defined by WorkSafe as a complaint where it finds some evidence of a potential breach of the WIRC Act.
Unsustainable decision	A decision that does not have a reasonable prospect of withstanding a court challenge.

WCIRS	The Workers Compensation Independent Review Service. An independent review team within Worksafe that provides injured workers with a review of some Agent and WorkSafe decisions. Injured workers of self-insurers cannot currently request a review from this team.
WIC	Workplace Injury Commission. An independent government service that provides conciliation and arbitration services to resolve workers compensation disputes in Victoria.
WIC – genuine dispute	When a WIC Conciliation Officer is unable to bring the parties to agreement and considers there to be an arguable case on the part of the self-insurer or their agent. A genuine dispute certificate allows the matter to proceed to arbitration or court.
WIC – Direction	When a WIC Conciliation Officer deems that an self-insurer or their agent has no arguable case to deny liability to pay weekly compensation or medical and like expenses to a worker they may direct that limited payments are made.
WIRC Act	*Workplace Injury Rehabilitation and Compensation Act 2013* (Vic)
Workers compensation	A payment to employees injured at work or who become sick as a result of their work. It includes payments to employees to cover their wages while they are not fit for work, medical expenses and rehabilitation.
WorkSafe	The trading name for the Victorian Workcover Authority, a statutory authority of the Victorian government created under the *Accident Compensation Act 1985* (Vic).

Background

1. Victoria's statutory workers compensation scheme enables eligible injured workers to claim compensation and receive support to help them recover and, where possible, return to work.

2. The *Workplace Injury Rehabilitation and Compensation Act 2013* (Vic) ('WIRC Act') outlines a range of entitlements under the scheme, including weekly income payments for those unable to work, and payments to cover reasonable treatment costs.

3. One of the objectives of the WIRC Act is that compensation 'is paid to injured workers in the most socially and economically appropriate manner, as expeditiously as possible'.

4. The scheme is managed by the Victorian WorkCover Authority ('WorkSafe'), and operates on a 'no fault' basis, meaning employees are covered if they are injured at work, regardless of who is at fault.

5. The scheme is largely funded by compulsory annual insurance premiums paid by employers. In return, WorkSafe takes on liability for most workers compensation claims, outsourcing them to private agents to manage. Four WorkSafe agents in Victoria manage all the claims for about 95 per cent of the cost of the scheme.

6. The WIRC Act also allows for some eligible employers, mostly larger corporations, to run their own separate claims process instead of paying compulsory premiums to WorkSafe. These employers are known as 'self-insurers'.

7. There are 34 approved self-insurers at the time of writing, covering about 120,000 Victorian workers and including many of Victoria's largest employers (see full list in Appendix 2).

8. Most self-insurers handle claims in-house; but just as WorkSafe uses private agents to manage claims, some self-insurers also outsource claims management to private agents. Eight self-insurers have WorkSafe approval to outsource the management of some or all of their claims to agents.

9. WorkSafe is responsible for approving and monitoring self-insurers (and their agents) to enforce performance standards and promote good decision-making.

Our prior WorkSafe investigations

10. This is the Ombudsman's third investigation into the administration of Victoria's statutory workers compensation scheme. The first two were confined to WorkSafe and its agents, and did not look at self-insurers.

11. Our first report in 2016 looked at how WorkSafe's agents handled difficult and expensive compensation claims, and WorkSafe's oversight of them. The report concluded while the system was not broken, the handling of complex claims needed reform. WorkSafe accepted all 15 Ombudsman recommendations, with the support of the responsible Minister.

12. However, over the next few years we continued to receive complaints and heard anecdotal evidence not enough had changed.

13. Our second report in 2019 found some WorkSafe agents were continuing to make unreasonable decisions, leaving workers stuck in time-consuming, stressful and costly disputes. It was evident more systemic reform was needed.

14. We made three key recommendations. First, that the Victorian Government review whether the WorkSafe agent model remained appropriate for complex claims. In response, the Government commissioned *Improving the experience of injured workers: A review of WorkSafe Victoria's management of complex workers compensation claims* ('the Rozen report'), published in April 2021.

15. Second, the Ombudsman recommended the Government address a shortcoming in the dispute resolution system – that only a lengthy and costly court process could deliver a binding outcome where other efforts to resolve a dispute, such as conciliation, had failed.

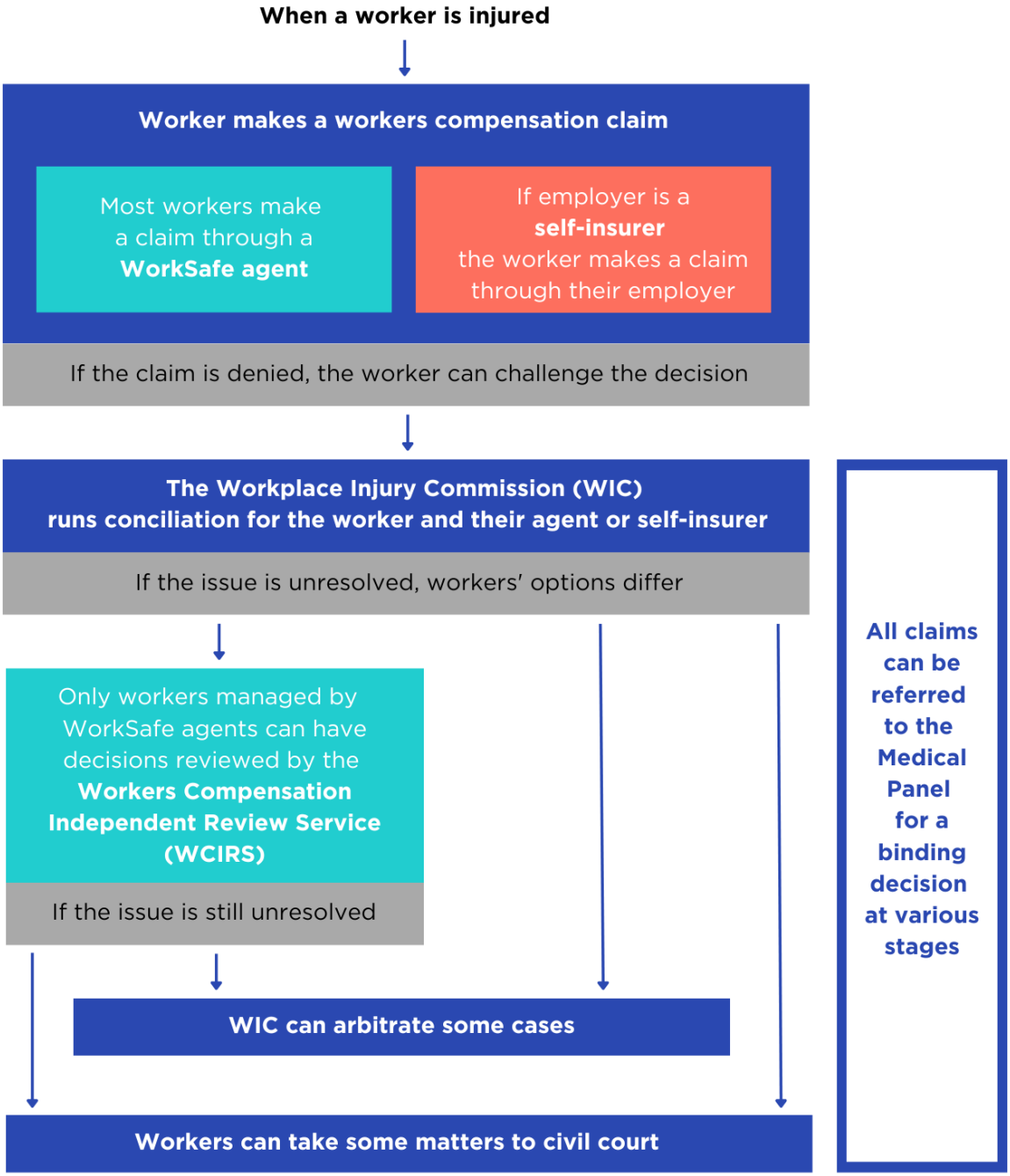
16. In response, the Government introduced legislation allowing arbitration as an option for injured workers after conciliation. All Victorian workers, including those working for self-insurers, can now seek binding determinations on disputes without having to go to court.

17. Third, the Ombudsman recommended WorkSafe establish a dedicated business unit to independently review disputed decisions following unsuccessful conciliation, and use its existing powers to direct its agents to overturn decisions unlikely to be upheld if challenged in court.

18. In response, the Workers Compensation Independent Review Service ('WCIRS') began in 2020. WorkSafe says in its first three years, WCIRS has had a significant impact, with fewer adverse decisions needing to be overturned, suggesting a measurable improvement in the quality of WorkSafe agent decision-making. It is hoped that more injured workers are getting timely and fair outcomes because of this change.

19. However, not all Victorian workers can take their concerns to WCIRS, with injured workers of self-insurers being excluded from using the service.

Figure 1: Victoria's workers compensation system



Source: Victorian Ombudsman

Why we investigated

20. Following the Ombudsman's two WorkSafe investigations, we continued to receive complaints from injured workers of self-insurers. Those complaints often echoed those made about WorkSafe agents. People complained about self-insurers making unreasonable claims decisions not supported by evidence.

21. Unions and other stakeholders have criticised the self-insurer scheme. Some criticisms are about the conduct of individual companies, including the use of technical grounds to deny claims, the misuse of medical evidence and a litigious approach to conciliation.

22. WorkSafe's annual surveys of injured workers from at least 2018 onward consistently show self-insurer workers are about 10 per cent less satisfied than those with claims managed by WorkSafe agents.

23. We received data from the Workplace Injury Commission ('WIC'). WIC is an independent authority established under the WIRC Act to help resolve workplace compensation disputes. WIC data for the 2020-21 and 2021-22 financial years showed notably lower rates of resolution at conciliation where a self-insurer was involved.

24. WIC told the investigation it had observed positive changes in WorkSafe agent decision-making after the Ombudsman's second WorkSafe report but this had not flowed through to some self-insurer decision-making. WIC stated some self-insurers were not meaningfully engaging in the conciliation process and were continuing to dispute matters unlikely to be upheld if challenged in court ('unsustainable decisions'). WIC suggested a lack of improvement by self-insurers in these areas may have been due, in part, to the limits of WorkSafe's role as regulator.

25. WIC noted injured workers of self-insurers were unable to seek a WCIRS review of a decision. This gap was highlighted by many when we called for public submissions to our investigation, and by the Rozen review. WCIRS cannot review decisions made by or on behalf of a self-insurer, because WorkSafe has no power to direct self-insurers to overturn decisions. This places workers of self-insurers at a disadvantage compared to most Victorian workers.

26. Another theme in complaints to the Ombudsman and submissions to the investigation was WorkSafe's oversight of self-insurers, and whether it can or does effectively address issues. Half of the 22 submissions that informed the Rozen review highlighted that self-insurers were engaging in the same practices WorkSafe agents had been prior to the Ombudsman's investigations. In response to these concerns, WorkSafe stated that it was implementing changes to align the review of self-insurer decision-making with that of WorkSafe agents. WorkSafe stated it was not taking any specific action to agitate for the power to overturn self-insurer decisions in response to the Rozen report.

27. Based on all of this – public complaints and submissions to the Ombudsman, the Rozen review and WorkSafe's response to its report, information from WIC and WorkSafe's surveys of injured workers – the Ombudsman decided to investigate.

Figure 2: Voices of injured workers

Workers' experiences with self-insurers varied significantly. These quotes from injured worker surveys describe both positive and negative encounters.

Great communication, fast reimbursements.

Lack of communication. When I needed things done, it would take months to get approval. They would always promise to respond, but never would, I was chasing them the whole time.

They were following up, calling me, asking if I needed any help. They checked my status, how I am, they follow up everything.

I have to always call them and ask for approval for ... No-one calls me to see how I am going.

They were always ringing me. I didn't have to call to confirm anything. They were very nice, both at my store, and at head office.

Didn't hear from them. No phone calls.

If needed anything they were there and they would look into anything I requested.

Poor communication, in other words their timeframes for contacting them were very limited, staff only work certain days, staff change, they only work certain days. Accessibility was very poor.

My Case Manager, he was very good, and understanding, and trying to get me back to work. He wasn't going to forget about me, I was very satisfied with him.

Too many Case Managers. You get one, then it changes a month later, and again. You have to tell your story all over again.

Handled my workers claim extremely professionally at all stages, and all dealings with staff were very professional.

The sheer rudeness and degrading belittling behaviour of their staff was beyond the pale.

Source: WorkSafe Self Insurer Injured Worker Survey Reports 2019 to 2021

The investigation

28. On 27 May 2022, the Ombudsman notified the relevant Minister, Chief Executive Officer of WorkSafe, Chair of WorkSafe's Board of Directors and the Chief Executive Officer of the Accident Compensation Conciliation Service (now WIC) of her intention to conduct an 'own motion' investigation, under 16A of the Ombudsman Act 1973 (Vic), into self-insurers' claims management and WorkSafe's oversight.

29. Between 27 and 30 May 2022, the Ombudsman also notified the Principal Officer of each of Victoria's 34 self-insurers.

30. On 14 July 2022 the Ombudsman publicly announced her decision to conduct the investigation and called for public submissions.

31. The objective of the investigation was to establish whether the claims management processes of self-insurers provide fair and equitable outcomes for their injured workers and whether the oversight processes of WorkSafe contribute to fair and equitable outcomes for injured workers of self-insurers.

32. Although self-insurers are required to manage claims in accordance with the WIRC Act and adopt the same claims management practices as WorkSafe agents, they have a discretion to take different approaches. The case studies and practice notes in this report highlight only a slice of the varying claims management approaches taken by self-insurers. They are included to encourage all self-insurers and WorkSafe to reflect on industry standards, and whether the current system is delivering fair outcomes and preserving workers' rights under the Act. Specific self-insurers are not identified in these samples to protect the privacy of the injured workers.

How we investigated

33. The investigation received 45 submissions, including from seven self-insurers, an agent who represented three self-insurers, injured workers and their advocates, lawyers, industry groups, unions and health care providers. Through submissions and other sources, about 240 claim files were identified for possible examination; and 87 of these were obtained from self-insurers and reviewed in detail. Information was also sought from WorkSafe and WIC, and we spoke to 20 injured workers and their advocates.

34. In all, the investigation obtained more than 850,000 documents, and reviewed material including:

    - selected self-insurer files and correspondence
    - data about the outcomes of disputed claims
    - examples provided by self-insurers at our request demonstrating best practice
    - WorkSafe documents, including processes, guidelines and assessments of self-insurer performance
    - WIC data, files, and feedback about the participation of self-insurers at conciliation.

35. Further details about what the investigation examined are included in Appendix 1.

Figure 3: Our investigation, by the numbers

Procedural fairness and privacy

36. The investigation is guided by the civil standard of proof, the balance of probabilities, in determining the facts of the investigation – taking into consideration the nature and seriousness of the matters examined, the quality of the evidence, and the gravity of the consequences that may result from any adverse opinion.

37. This report includes adverse comments about WorkSafe as the regulator of self-insurers. While the Ombudsman has not made adverse comments or conclusions about specific self-insurers, or their agents, it does include data, practice examples and comments from third parties, including injured workers, about claims management that may be perceived as adverse to self-insurers.

38. In accordance with section 25A(2) of the Ombudsman Act, the investigation has provided WorkSafe, each of the 34 self-insurers, and two agents who act for self-insurers, with a reasonable opportunity to respond to the material in the report. This report fairly sets out their responses.

39. Relevant excerpts of a draft of this report ('the draft report') were provided to the injured workers whose stories are detailed in de-identified case studies and to WIC, to confirm factual accuracy. Self-insurers were also provided with excerpts of the case studies to confirm factual accuracy. This report fairly reflects their responses.

40. In accordance with section 25A(3) of the Ombudsman Act, any other persons or bodies who are or may be identifiable from the information in this report are not the subject of any adverse comment or opinion. They are named or identified in the report as the Ombudsman is satisfied that:

    - it is necessary or desirable to do so in the public interest
    - identifying those persons will not cause unreasonable damage to those persons' reputation, safety or wellbeing.

41. To protect the privacy and welfare of injured workers, case studies in the report exclude identifying details such as employer names and dates. All case studies relate to claims made between 2016 and 2022.

42. In response to the draft report, some self-insurers provided detailed responses to specific points which are incorporated in the final report. The names of self-insurers are used in these instances as they do not identify individual workers.

43. It should not be inferred that claims management practices or decisions made on an individual case highlighted in this report reflect a self-insurer's or their agent's approach or performance in other cases. Some self-insurers manage many claims, and most are handled without complaint or necessary intervention from WorkSafe.

44. Nevertheless, it is important that injured workers' stories are heard, and their experiences valued and understood. From the 87 workers' stories examined in detail, the case studies we have included were chosen to reflect questionable or problematic claims management practices, and their adverse impacts. Some case studies were removed from the final report at the request of the injured workers who said they were still affected by the management of their claim, or were fearful of reprisals.

45. Any of us can be injured at work, and we are all entitled to expect best practice in response. All self-insurers and their agents can learn from the case studies and practice examples in this report. Adherence to best practice leads to appropriate compensation as intended by the WIRC Act.

About the self-insurer scheme

46. WorkSafe's website states the role of self-insurance in Victoria is to 'provide choice to eligible employers to manage and bear the costs and risks of their own claims'. WorkSafe advises self-insurance should:

    - provide direct incentives to improve injury prevention and rehabilitation performance
    - ensure that workers are treated fairly and equitably
    - contribute to continuous improvement in health and safety and return to work performance.

47. In the financial year ending June 2022, 1,713 claims were lodged with self-insurers. Unlike some of its interstate counterparts, WorkSafe does not publish claim numbers or statistics, however WorkSafe advised the investigation that self-insurers were managing 3,032 active claims at the end of December 2022.

48. WorkSafe is responsible for approving self-insurers under the WIRC Act. WorkSafe first determines if the company is eligible. This includes whether the company has the financial viability to meet its claims liabilities.

49. To be satisfied that a company is 'fit and proper' to be a self-insurer, WorkSafe must also consider:

    - the safety of working conditions at the company
    - the number of workplace injuries
    - the cost of associated claims
    - the resources, including employees, the company has to administer compensation claims.

50. WorkSafe's oversight framework is based on the WIRC Act and associated Ministerial Orders and WorkSafe Guidelines. WorkSafe regulates self-insurers using:

    - a 'tier' system
    - the Self-insurer Self-audit Program
    - a Regulatory Claims Audit Program
    - post-audit performance improvement plans
    - monitoring and reporting systems.

51. WorkSafe also conducts Quality Decision Making Audits ('Quality Decision Audits') of both WorkSafe agent and self-insurer decisions. A sample of claims decisions are reviewed every year to confirm alignment with good decision-making principles and the law. The audits focus on compliance with WorkSafe's Claims Manual and Quality Ethical Decision-Making Guidelines.

52. The Quality Decision Audits consider whether reasonable and appropriate evidence was sought and considered, whether the decision was correct in the circumstances, and whether it was 'sustainable'. Decisions are considered unsustainable if they do not have a reasonable prospect of withstanding a court challenge.

53. When there is a dispute about a claim, the matter can be conciliated through WIC. This is true regardless of whether a WorkSafe agent or a self-insurer is managing the claim.

54. WIC is an independent authority responsible to the Minister for WorkSafe and the TAC and reports through the Department of Treasury and Finance.

55. WIC's website states conciliation gives an injured worker 'the opportunity to come together with others involved in a workplace compensation dispute to find a way forward as quickly as possible'.

56. The goal of conciliation is to resolve disputes by involving all parties in an informal, non-adversarial process to reach a fair and mutually acceptable agreement. Ministerial Guidelines govern the conduct of self-insurers and employee representatives during the conciliation process.

57. In 2021-22, workers referred 9,182 disputes in total to WIC for conciliation, with resolution rates of 69 per cent for WorkSafe agents and 58 per cent for self-insurers (and their agents).

58. Where a matter cannot be resolved, Conciliation Officers have the power to:

    - dismiss the dispute
    - make recommendations
    - refer medical questions to a Medical Panel
    - issue a 'genuine dispute certificate'.

59. A genuine dispute certificate is needed before the parties can take the matter to arbitration or court. In limited circumstances, Conciliation Officers also have the power to give a Direction to a WorkSafe agent or a self-insurer to make payments to the worker.

60. Some disputes are referred to a Medical Panel for a determination on medical questions. Medical Panels can be used by WIC or a court to resolve a dispute where there are medical questions regarding a worker's injuries. These questions may relate to diagnosis, causation, work capacity or the appropriateness of treatment.

61. Each Medical Panel is independent and made up of expert specialist doctors. The Panel functions as a tribunal that provides final and legally binding answers to the medical questions referred to it.

62. In 2021-22, WIC referred 1,151 matters to Medical Panels. About 14 per cent (163) of these were for claims involving self-insurers.

63. If conciliation is unsuccessful and a genuine dispute certificate issued, injured workers now have two potential options.

64. Until recently their only choice was to go to court. Workers injured on or after 1 September 2022 now have an option for the matter to be arbitrated by WIC under the *Workplace Injury Rehabilitation and Compensation Amendment (Arbitration) Act 2021* (Vic).

65. This is a welcome system improvement, however, not all disputes are eligible for arbitration.

66. Arbitration can only provide a final decision on compensation disputes involving weekly payments, medical expenses, superannuation contributions and interest on an outstanding amount. In other cases, the worker's only option remains court.

67. As the regulator, WorkSafe has a role to support self-insurers to understand their obligations under the *Charter of Human Rights and Responsibilities Act 2006* (Vic) ('Charter of Rights Act').

68. This Act protects basic rights and freedoms of Victorians, such as the right to privacy and reputation. It promotes a culture where human rights are protected and considered in service delivery, policy, decisions, and legislation.

69. Under the Charter of Rights Act, it is generally unlawful for public authorities to:

    - act in a way that is incompatible with a human right; or
    - fail to give proper consideration to a relevant human right when making a decision.

70. Public statutory bodies, like WorkSafe, must act compatibly with, and give proper consideration to, relevant human rights when making decisions. Self-insurers, when licensed by WorkSafe to perform functions under the WIRC Act, are also required to consider these rights. The Charter of Rights Act recognises that human rights are not absolute and may be limited but any limitation must be reasonable and justified.

Self-insurers' claims management

71. In Victoria, self-insurer decision-making on claims must be guided by the WIRC Act and the WorkSafe Claims Manual, which sets out principles of good administrative decision-making. Although it is permitted for Victorian self-insurers to create their own claims management policies, in practice, all Victorian self-insurers have adopted the WorkSafe Claims Manual as their baseline for claims management.

72. These principles include that self-insurers must:

    - make decisions in accordance with the legislation and follow the procedures in the Claims Manual
    - consider all matters relevant to a decision
    - not take into account any irrelevant considerations
    - exercise discretion when appropriate
    - use the best available evidence
    - seek out information if it is relevant to the decision, or the information available is inadequate
    - give 'proper, genuine and realistic consideration' to the merits of a decision
    - list all matters considered when making a decision.

73. The Claims Manual also provides guidance to self-insurers on key claims management activities, including:

    - determining liability
    - following a sound decision-making process
    - arranging independent medical examinations and investigations
    - processing weekly payments
    - terminating weekly and medical payments.

74. WorkSafe's *External Guideline #16 – Claims management policies for self-insurers* says that 'self-insurers must ensure workers are not disadvantaged and will continue to receive at least the same level of entitlement as prescribed in the [Claims] Manual'.

75. Self-insurers also have the option of appointing an agent to manage claims on their behalf. Some companies do this, arguing it provides the best of both worlds for injured workers – the expertise of dedicated claim experts, the industrial knowledge of the employer and streamlined decision-making.

76. Where an agent is appointed, it is the self-insurer's responsibility to ensure that the agent abides by the legislation and the Claims Manual. As the case studies in this report illustrate, poor practice by self-insurer agents can occur when the self-insurer does not fulfill this responsibility.

77. Occupying the position of both employer and insurer creates a significant power imbalance between self-insurers and their workers. This potentially discourages some workers from reporting injuries or making claims.

78. Some self-insurers, like TLC Aged Care, advised they took their role as a self-insurer extremely seriously because of this perceived inequity. Department store operator Myer added that unions can and do play a role in addressing any imbalance. Investigators nevertheless heard accounts of workers who feared for their job if they pursued their compensation entitlements. In some instances, they said that fear was based on what they saw happen to colleagues. Others said they were told directly. Such fears and practices are not limited to self-insurers, but the vulnerabilities of the injured worker are amplified when dealing directly with their employer.

79. The investigation spoke to injured workers of self-insurers who said they were discouraged from or penalised for making a claim. Steel producer BlueScope suggested more claims would be captured by adopting a NSW-style system and placing the onus on self-insurers to proactively contact workers on reporting of an injury to advise of early access to provisional payments and medical treatment.

Resolving claims early

80. There are various ways claims can be resolved early. The investigation was told some methods discourage potential claims from being made.

81. Self-insurers, along with other employers in the WorkSafe scheme, can offer to cover an employee's medical expenses without the need for a claim. This may meet the worker's immediate needs and avoid a claims process. As some self-insurers acknowledged, not lodging a claim could leave the worker with limited recourse if their injury or condition did not resolve as anticipated and required ongoing treatment or time off work.

82. Evidence obtained showed that some self-insurers asked injured workers to use their own sick leave instead of putting in a claim. This shifts liability from the employer to the employee, undermining the intent of the workers compensation scheme.

83. The investigation also noted evidence showing some self-insurers offered financial settlements and used internal early intervention programs to resolve claims.

Financial settlements

84. With financial settlements for 'common law damages' often involving long and expensive legal proceedings, there are instances where a self-insurer and workers might prefer to reach an early agreement for a lump-sum payment. The Australian Lawyers Alliance said:

> Unlike WorkSafe agents, self-insurers take a proactive approach … and initiate early discussions with injured workers regarding common law damages. These discussions often result in the negotiation of a global settlement which can provide the worker with compensation for their pain and suffering, pecuniary loss and in some circumstances their future medical expenses …
>
> Importantly, it also represents to workers the taking of responsibility by an employer for the occurrence of an injury which serves as an acknowledgement of the harm caused. This early resolution has a positive outcome and benefits the injured worker.

85. Some submissions raised concerns about self-insurers' use of financial settlements. WIC stated that under the legislation there is only capacity to settle a common law claim for pain and suffering and losses that can be measured in monetary terms. This may not include all possible costs to the injured worker. Submissions consistently raised concern that settlements sometimes followed decisions to terminate entitlements that were not well supported by evidence. It was also suggested workers may be disadvantaged because lump-sum payments were usually conditional on the employer not being held liable for the claimed injury in future proceedings.

86. Self-insurers defended the use of financial settlements. Some claimed workers must be legally represented in certain circumstances. Myer, for example, said a settlement offer that permanently ceases a worker's entitlements under the WIRC Act would require legal representation so the worker can get advice to redress any power imbalance. The WIRC Act does not contain a provision that requires this.

87. Sometimes an injured worker seeks the settlement. Westpac bank told the investigation it was involved in:

> numerous cases where the employee is seeking financial settlement, based on independent legal advice and/or advice from their treating medical practitioner, especially where the case involved some psychological distress.

88. When workers are injured, financially vulnerable and possibly in fear of losing their job, a lump-sum payment can appear attractive. Accepting such a settlement could leave the worker without ongoing entitlements and may be to their longer-term detriment.

89. WIC outcomes data shows a large variance in how self-insurer disputes are finalised compared to those of other workers. Between January 2018 and June 2022, WIC issued a genuine dispute certificate due to court proceedings in 16 per cent of self-insurer cases, compared to 0.4 per cent of cases for other workers. This means many more self-insurer disputes were not actively conciliated. These disputes then either proceeded to court or in many cases were finalised prior to court by financial settlement.

Figure 4: Genuine dispute certificates issued by WIC because of court proceedings, self-insurers vs WorkSafe agents

Source: WIC outcomes 2018 to 2022

90. Often a settlement is conditional on the worker resigning. There may be valid reasons for such a condition, and the worker may have no capacity or desire to return to work. The injured worker may believe their relationship with their employer has broken down. However, pressuring a worker to resign in order to access compensation could amount to a breach of the WIRC Act if it is not legitimate, as the Act is intended to support workers to return to work.

91. Myer stated self-insurers tended to continue the employment of injured workers for extended periods often up to the time the matter was settled, which could be many years after the injury. It submitted the inclusion of a resignation condition was merely a reflection that, at settlement, the employment relationship ceased. This approach does not appear unique to self-insurers.

92. Paying a settlement may be preferred by a self-insurer if it costs less than paying a worker weekly compensation payments and associated expenses long term. This may not be beneficial to the injured worker, and they should have access to all options and understand the risks and benefits to make an informed decision. BlueScope agreed stating 'it is imperative injured workers be assisted to negotiate in a complex, legalised system'.

93. Anecdotally, it is suggested financial settlements are sometimes made in the absence of a claim. This was not directly examined by the investigation, and the frequency of such settlements is unknown. Given financial settlements are not independently scrutinised, and WorkSafe would have limited jurisdiction over settlements made prior to a claim (unless practices contravened the WIRC Act) this issue warrants further examination to ensure injured workers are protected. It is important settlements made outside of the formal claim process do not contravene the purpose or provisions of the WIRC Act.

94. Case study 1 provides an example of a worker being offered a settlement which if accepted would have disadvantaged the worker by tens of thousands of dollars.

Case study 1: Worker offered $2,000 despite being entitled to more than $75,000 – decision 'ripped to shreds' by WIC

A worker who stacked boxes advised their manager of a sore back.

The manager moved the worker to different duties temporarily. In this new role, the worker suffered another injury. The claim file noted the worker told the manager that:

> [they were] in a lot of pain as [their] back had spasmed as it usually does.

Soon after, the worker claimed weekly payments and medical treatment for the injury. The self-insurer's agent concluded the worker had aggravated a pre-existing injury while at work. The agent rejected the claim without seeking any further information, despite the worker making two requests for an internal review.

About a year after the first injury, the worker sought conciliation at WIC. The agent initially offered $2,000 compensation to settle, despite noting on the file that the worker needed to see a neurosurgeon and if they did not take the offer:

> [the self-insurer] will be up for weekly compensation … (approx. $25,000).

WorkSafe reviewed the decision to reject the claim as part of its Quality Decision Audits. WorkSafe raised concerns that the agent:

- made 'no serious attempt … to collect medical evidence'
- made 'no valid attempt to confirm the circumstances of the injury'
- rejected the claim 'without any supporting evidence'
- based the rejection on 12 grounds, most of which 'do not apply'.

WorkSafe said in its review the decision to reject the claim was not appropriate. However, WorkSafe did not have the power to direct the self-insurer to change the decision.

WIC, like WorkSafe, communicated concerns to the agent about its failure to obtain medical evidence and the lack of evidence to support its decision. WIC intended to issue the agent a Direction unless the agent withdrew the termination.

The agent's own file noted that its decision was 'ripped to shreds' by WIC.

After WorkSafe's review, the agent accepted the claim for weekly payments and medical expenses.

Four months later, the agent terminated the worker's entitlements, based on a report by an Independent Medical Examiner ('IME') who stated the injury was not work-related. Because the agent had already accepted the claimed injury, it could not terminate payments on that basis.

The worker again requested conciliation and four months later payments were again reinstated.

The entitlements were eventually terminated when the worker reached retirement age. Over the course of the claim, the worker received more than $75,000 in weekly payments and medical expenses – $73,000 more than the agent's initial offer.

95. Case study 2 provides an example of a self-insurer rejecting a claim to create an avenue for negotiations with the injured worker for a financial settlement. WorkSafe has criticised self-insurers for this practice.

Case study 2: Self-insurer's decision to reject claim in hope of financial settlement 'is not a practice that is acceptable to WorkSafe'

After nine years of intermittent employment with the same company, a worker claimed compensation for a mental injury. The claim cited increased workload pressure.

A circumstance investigation included evidence from other staff that the injured worker's role was extremely demanding, with a backlog of work putting them under a lot of pressure.

While in the role, the worker was subject to some performance management action. The Claims Manual states where a mental injury is the result of reasonable management action, the worker is not entitled to compensation.

The file notes showed the self-insurer thought the IME selected would support an argument that the condition was caused by reasonable management action. However, the IME's report indicated the worker was suffering a medical condition before any management action occurred.

Emails between the self-insurer and their lawyers explored the difficulty of rejecting the claim and that such a decision was unlikely to be sustainable:

> Regardless of any pre-existing psychiatric condition, it will be extremely difficult to avoid the finding of any work aggravation, exacerbation, deterioration, or acceleration at work based on the contemporaneous complaints made to medical practitioners all of which relate to … employment.

Despite this, the self-insurer decided to reject the claim after their lawyer wrote:

> Whilst it is unlikely the rejection will be sustainable before a Court, it will have the benefit of creating a dispute which will … create an avenue for some negotiations to occur …

WorkSafe said in its review the decision to reject the claim was not appropriate. However, WorkSafe did not have the power to direct the self-insurer to change the decision.

Two months after the claim was made, the self-insurer rejected it on the basis the injury was caused by management action. The worker challenged the decision at conciliation and WIC issued a genuine dispute certificate.

In the absence of access to WCIRS, where WorkSafe could direct that an unsustainable decision be overturned, the worker had to start court proceedings. The worker ultimately accepted a $185,000 settlement, plus medical and like expenses to a maximum of $10,000, with a condition they resign.

A few months after the settlement agreement, WorkSafe completed a Quality Decision Audit for this case. It noted:

> Legal advice clearly states that the rejection is unlikely to be sustained before a Court and yet [the self-insurer] rejected the claim hoping to have a negotiated settlement later. This is not a good practice.

WorkSafe's Quality Decision Audit report recommending improvements to the self-insurer's practice stated further:

- The history of deterioration in the worker's mental health was reported by the GP, and the independent examiner also believed the worker suffered a mental injury over a period of time. …
- The worker maintains that [they were] overwhelmed by the workload. There is also evidence of an accumulation of factors contributing to the worker's condition, and the management action may have been the straw that broke the camel's back.

…

- Rejecting a claim with the expectation of arriving at a negotiated settlement is not a practice that is acceptable to WorkSafe.

Case study 2: Self-insurer's decision to reject claim in hope of financial settlement 'is not a practice that is acceptable to WorkSafe' – continued

Based on the worker's medical condition and income at the time of the claim, if the claim had been accepted it is possible that the worker would have been entitled to weekly payments and medical expenses beyond the amount of the financial settlement.

The employer stated that while it did not accept the claim, it paid the worker's wage for 10 months after they stopped working.

As the claim was not accepted, the self-insurer also did not have to comply with the requirement to provide the worker with employment and assistance to return to work. The employer stated that they did attempt to get the worker to return to suitable duties under a return-to-work plan.

Employer-funded early intervention programs

96. Some self-insurers provide early intervention programs, designed to support staff during the injury management process and improve return to work outcomes. The investigation does not criticise these programs in principle, but we did identify instances where they featured in poor claims management.

97. Each early intervention program is different, but typically includes some form of employer-funded medical services for injury treatment. Some programs provide access to a network of general practitioners, while others have on-site medical and allied health practitioners for timely treatment of minor injuries. Some include support for psychological injuries.

98. Supermarket operator Woolworths launched an early intervention program, including access to clinical specialists and mediation for 'difficult conversations' to minimise claim impacts for both the employer and employees. Conglomerate Wesfarmers advised it had adopted a 'best practice mental health care model' that:

> puts the team members health and wellbeing at the forefront whilst claims management decisions are managed in the background …
>
> [While we recognise] claims for entitlement must be assessed and evaluated rigorously, they need to be balanced with the care owed to team members.

99. Supermarket operator Coles and airline Qantas told us they often prefer to deal directly with workers' treating practitioners to:

    - facilitate timely and ongoing clinical care and rehabilitation
    - better understand worker needs
    - develop suitable and sustainable return to work options.

100. Self-insurers who provided information about their programs – Qantas, gaming and entertainment group Crown, automobile club RACV, Westpac, Coles, BlueScope, Woolworths and their agent Employers Mutual Ltd ('EML') – all emphasised the benefits of early intervention for employees and employers alike. Some focused on the benefits of early access to specialist care including surgery, and many highlighted the importance of compassionate and supportive communication. RACV and Westpac highlighted the contribution of these programs to best practice return-to-work outcomes.

101. Payment of an injured worker's medical costs and referral to rehabilitation and support services by a self-insurer frequently occurs outside the claims management process because no claim has yet been, or is ever, lodged.

102. Case study 3 provides an example of workplace support and intervention working well.

Case study 3: Providing specialised in-house resources to assist return to work

A retail worker injured during a violent workplace robbery developed Post Traumatic Stress Disorder ('PTSD').

A trigger for the worker's PTSD was a particular smell closely associated with their workplace. This hindered their return to work.

The worker's injury also affected their behaviour and ability to emotionally self-regulate in stressful situations, leading to unavoidable conflict with some customers.

The self-insurer identified an alternate work location where the worker would not be exposed to the smell or challenging customer interactions, and close to the worker's home. This involved a complex cross-business transfer.

An in-house mental health specialist was closely involved, coordinating interactions between the worker, other health professionals, the company's safety teams and the new work location during a trial and even arranged for support workers to attend the new location when teething issues arose.

The worker returned to unrestricted duties in the new role.

This example shows the benefits of early intervention in the workplace, and how in-house specialist treatment can support the recovery of an injured worker.

103. Despite obvious advantages, there are ways in which this model can, by accident or design, produce an unfair outcome.

104. To obtain workers compensation, workers must notify their employer within 30 days of becoming aware of an injury, and must make a claim for weekly payments as soon as practicable. If an injured worker is channelled into an internal rehabilitation program their injury may not resolve as hoped. If they are later denied a claim for this injury based on lodging too late, this is unfair.

105. While some self-insurers accept claims beyond deadlines, the investigation saw several examples of workers' claims being rejected as 'out of time', despite the worker receiving treatment through an internal rehabilitation scheme. Self-insurers should consider all evidence indicating a possible workplace injury irrespective of whether a claim was lodged at that time, as it is reasonable to attempt early interventions without a formal claim.

Case study 4: Worker who sought early treatment later ruled 'out of time' for $400 medical expenses claim

A worker employed in a role involving manual labour for a self-insurer reported an upper limb injury after opening a heavy door.

The self-insurer, which had various subsidiaries, managed the injury via its early intervention program. About 10 months after the injury the worker, who had left the workplace, discovered payments for about $400 of medical expenses had not been made and lodged a formal claim.

The claim was rejected because the employer did not accept:

- the worker was injured as claimed, or at work
- the worker's employment was a significant contributing factor to a pre-existing injury
- the medical services claimed were for a compensable injury
- the worker had lodged a claim for weekly payments as soon as practicable
- the worker was an employee when they lodged their claim.

The worker sought a review, arguing at the time of injury, a manager had advised lodging a claim was unnecessary as the employer would cover medical expenses. The self-insurer provided evidence the worker had been advised they could lodge a claim.

Internal emails showed the worker did report the incident and seek treatment at the time. The self-insurer's internal reviewer noted while it could be argued the worker had not lodged the claim as soon as practicable, they should try to resolve the claim at conciliation.

A WorkSafe Quality Decision Audit identified that 'relevant and available information was not considered prior to making a decision' and 'the evidence does not support the decision'. WorkSafe noted the self-insurer 'maintained its rejection on a technicality'.

The self-insurer disagreed with WorkSafe's findings, stating the claim was not within time limits. It ultimately paid the medical expenses, stating this was to ensure the worker was 'not disadvantaged'.

Nevertheless, the self-insurer did not overturn their rejection of the claim.

This means that liability was not accepted and if the worker encounters longer-term issues, the employer will not be obliged to pay. The self-insurer stated 'it remains open to the worker to seek to appeal the decision via WIC'.

106. BlueScope advised the investigation early intervention or other programs should not be provided in lieu of a claim being lodged by the injured worker, and that workers must always retain the right to lodge a claim. Myer and Crown agreed and told the investigation their workers are specifically told they retain the right to submit a workers compensation claim after accessing early intervention programs.

107. Case study 5 provides an example of a worker signing away their rights to make a claim when accepting early intervention services. Self-insurers should be wary of asking workers to sign documents that may limit the employee's rights because as employers they are in an inherently conflicted position to provide advice. Employees should always be provided with accurate information so they can understand their options and give informed consent.

108. While WorkSafe provides WorkCover Assist, a free service to help injured workers with a claims dispute, this is only available when that dispute is referred to WIC for conciliation.

Case study 5: Worker's use of early intervention program clouds future injury claims

A casual worker in a role that involved heavy lifting felt back pain, stopped working immediately, and reported it to their manager and human resources department.

The self-insurer's incident report and related documents (including from the treating healthcare professional) stated the injury was work-related. The worker received first aid at work and paid medical treatment through an early intervention program.

The claim file indicated the worker was told by the self-insurer the early intervention program was the best option if the injury would resolve in three months. The worker was asked to sign a document acknowledging their right to claim workers compensation had been explained, that they had elected not to lodge a claim at that time, and that if they wished to claim later they could.

The worker followed the self-insurer's recommendation with records indicating they were concerned their casual hours would be reduced if they lodged a claim.

Two years later, the worker submitted a claim for a knee injury they said happened during rehabilitation for the back injury. A document in the claim file stated the knee injury could have built up over time because of an increase in work hours or an aggravation of the pre-existing back injury. About the same time, the worker submitted a claim for the original back injury.

The self-insurer's agent rejected the back injury claim on various grounds, including that the claim was late. The agent also rejected the knee injury claim on various grounds including that the injury was not from work or rehabilitation (based on a physiotherapist's notes). However, the agent could have obtained an IME's report or investigated to determine liability on either claim and have a better evidence-base for decision-making.

The worker sought conciliation and was issued a genuine dispute certificate by WIC for both decisions. The worker did not pursue the matter further.

109. In Victoria the early intervention model may in part offset the absence of 'provisional payments' for all but mental injuries. The NSW provisional payments system is broader, enabling self-insurers to make weekly payments and cover medical expenses while an injured worker's claim is assessed.

110. BlueScope advocated for provisional payments to be expanded in Victoria, and stated:

> ... it negates payment for treatment external to the workers compensation system and captures claims under the legislative framework. The additional cost to insurers would amount to less than 5 per cent of current claim costs and provide certainty for injured workers.

111. It also noted the provisional payment system 'reduces considerably the wait-time for injured workers to seek treatment'.

Rejecting and terminating claims

112. The investigation found examples of self-insurers rejecting or terminating claims without sufficient evidence to support the decisions.

113. In some instances, self-insurers did not take remedial action when WorkSafe notified them of these problems.

Rejecting claims

114. In 2019, WorkSafe's Quality Decision Audits found 25 per cent of the rejection decisions audited were not supported by evidence or otherwise unsustainable. It is not clear if these wrong decisions were driven by financial imperatives or were practice or capability issues.

115. In some of the cases, the grounds used to deny a claim did not apply to the worker's situation. In others, there was simply no evidence to support the decision. The cases where self-insurers maintained these decisions after WorkSafe or WIC told them the decision was contrary to law, demonstrate a need for WorkSafe to be empowered to direct self-insurers to overturn their decisions.

Terminating claims

116. Similarly, investigators saw examples of claims being terminated on unsustainable grounds and self-insurers refusing to overturn their decisions despite advice they were wrong. We also saw positive examples of self-insurers helping injured workers years after they had left the workplace.

Case study 6: Self-insurer helps former employee access medical treatment 20 years after initial claim

An employee of a self-insurer injured a joint at work. The claim was closed seven years later.

A decade later, the old injury required surgery and the employee, who had by then left the employer, lodged a new claim.

Due to the age of the claim, the self-insurer had destroyed the original claim file. Together with the worker, it reconstructed the file, obtaining documents from the self-insurer's lawyers and the injured worker's doctor.

These documents included a note from a specialist who had advised at the time of the original claim that the joint would deteriorate and eventually need surgery.

On that basis, the self-insurer re-opened the previous claim, approved and paid for the joint surgery.

The injured worker wrote a letter of appreciation to the self-insurer:

> Hello [self-insurer]
>
> You don't know me but I'm a former worker of [self-insurer] which at the time I had a workplace injury to my [joint]. When I left in [date], I thought I was over further surgery. 14 years later, I needed [surgery]. When I contacted WorkSafe, it always came to dead ends and I stressed about what to do next. Then here popped up [in-house claims manager] thank goodness I can't stress enough how helpful, always trying to doing right by me and looking out for my health. It's great to see people like [in-house claims manager] with a good kind heart when it comes to people with health problems especially someone who has left the business for over 14 years

Using evidence appropriately

117. Medical evidence and other reports are used both to determine the initial validity of a claim, and to inform ongoing assessments.

118. The Claims Manual requires that self-insurers must:

> … take all reasonable steps to seek, obtain and to fairly and properly consider all relevant information before making a decision based on the facts and the merits of the individual case.

119. However, the investigation found examples where self-insurers did not seek appropriate evidence or appear to give it the necessary weight when making decisions.

120. It can be challenging to determine the appropriate weight to give evidence, especially if experts disagree or the right specialist to make an assessment is unclear. All evidence should be examined objectively and not used selectively.

Seeking and assessing the right evidence

121. Some cases reviewed showed self-insurers did not seek sufficient evidence to make an informed decision. This included not seeking or selectively seeking medical reports, vocational assessments to inform job options, or circumstance investigations to determine facts or credibility. These requirements are clear in the Claims Manual, with section 104 of the Act also codifying employer obligations around the return-to-work process.

122. WorkSafe's Quality Decision Audits showed decisions can be unsustainable because of lack of evidence. In some cases, WorkSafe directly raised concerns with self-insurers that 'reasonable steps were not taken to seek and obtain relevant information'. In others, WorkSafe found that the available information was not properly considered.

123. In many cases self-insurers disagreed with WorkSafe's findings, such as these findings from WorkSafe audits conducted between 2019 and 2022:

    - The medical evidence does not fully support termination … the psychological secondary is not taken into account at all …
    - The decision to terminate weekly payments is based on inadequate evidence and the psychological condition is not assessed at all which makes the decision to terminate [medical expenses] unreasonable. Overall, the decision and evidence gathering is not aligned with WorkSafe's decision making framework …
    - There has been no attempt to assess whether the request is reasonable and necessary … the decision is not supported by evidence and is not appropriate …

124. Case study 7 illustrates how failing to properly obtain, comprehend or give appropriate weight to evidence can lead to poor decisions and detrimental outcomes for injured workers.

Case study 7: Injured worker's payments terminated without relevant supporting evidence

A worker suffered various injuries to their hand, arm, elbow, neck and back throughout their almost 20-year career with their employer.

Their work was described as 'heavy and repetitive'. The worker returned to work from one injury but was injured again the next year and stopped working.

The self-insurer's agent accepted the worker's claims.

The self-insurer paid weekly payments and medical expenses for one year but then terminated these. At the time, there were medical and other reports on the worker's file indicating the injuries required further investigation and that:

- the worker's injuries impacted their capacity for work
- the worker was not receiving adequate treatment
- the worker would benefit from a pain management program and psychological treatment.

After the worker disputed the termination at WIC, the decision was referred to a Medical Panel.

The Panel determined the worker was suffering from a pain condition caused by work, had a reduced work capacity and was critical of the medical treatment offered by the agent. The worker's weekly payments were reinstated (after one year without any payments).

Six months later the worker was assessed by a specialist IME. This 130-week entitlement review found the worker had no work capacity as long as their pain continued. Again, the treatment being offered by the agent was questioned.

Emails showed the agent considered this report to be 'disappointing' and that they 'would seriously reconsider using [the specialist] again as an IME'. The agent discussed obtaining a supplementary report from the IME but said even if the IME maintained their view, the agent would still terminate the worker's entitlements. They noted 'maintaining [the decision] … will be difficult, particularly with trying to get it through Conciliation'.

The agent terminated the worker's entitlements at 130 weeks on the basis the incapacity was not likely to continue indefinitely. This was not supported by the medical report.

WorkSafe audited this claim and found the worker was 'wrongfully disentitled' and the agent had 'used the incorrect IME specialities to assess a chronic pain condition' – contrary to the Claims Manual.

The agent disagreed with the finding but did seek additional medical reviews. These found the worker had only a very limited capacity for work.

Ultimately, the claim was settled with the self-insurer agreeing to pay the worker $400,000, on the condition that the worker resign.

125. The importance of obtaining key evidence to inform and support decisions, especially when terminating entitlements, cannot be overstated. BlueScope told the investigation that 'it would be fairer to say the case studies cited most likely reflect difference of opinion on the collected evidence'. This does not reflect what the investigation found.

126. The investigation examined cases where WorkSafe was critical because workers were not assessed properly: the right specialists were not engaged (eg pain specialists) or there was no expert vocational assessment to identify suitable job options.

127. The case studies demonstrate the need for WorkSafe to be empowered to direct a self-insurer where they have not met their obligations to the injured worker. Active follow-up by WorkSafe is also required where WorkSafe or WIC find that a self-insurer does not understand the law or their obligations to injured workers. The lessons from these case studies should be applied to other claims.

Assessing medical opinions

128. Claims decisions should be based on independent medical opinions. The quality of a medical assessment will be influenced by the quality of the referral seeking it.

129. Investigators were told of 'doctor shopping' – instances where self-insurers sought opinions from a variety of IMEs, or only from a preferred IME, seeking an opinion favouring a decision to reject or terminate a claim.

130. Further, it was alleged self-insurers sometimes contacted treating practitioners directly to try to influence the information provided.

131. Given the small number of claims examined in depth by the investigation, this report does not suggest such practices are commonplace. To avoid influencing decisions, or the perception of such, self-insurers should ensure that suitable specialists are engaged, all evidence is carefully considered and that when seeking reviews, claims managers do not deliberately or inadvertently attempt to lead the assessor in a certain direction.

Case study 8: Trying to 'get a favourable opinion', two-year wait to overturn decision with no basis in evidence

After 10 years in their role, a worker made a claim for a back injury. Their job involved repetitive lifting, stacking, and moving heavy boxes.

The self-insurer's agent rejected the claim on 11 grounds, including late lodgement, without any medical or other evidence. The worker said the delay in lodging the claim was due to the time it took to get a specialist surgeon's appointment.

Early the next year, WorkSafe's audit found errors by the self-insurer:

> Claim was rejected mainly based on the late lodgement of the claim without any medical evidence. Medical evidence or circumstance report supporting rejection was not found ...
>
> There is an email from [the agent's] solicitor requesting [the agent] to refer the worker to a particular medical practitioner to get a favourable opinion.

The agent disagreed with WorkSafe's finding, noting the worker had previous claims and would be aware of lodgement procedures.

WorkSafe responded:

> The [self-insurer] is required to obtain information to support if the worker has suffered an injury in the course of employment. The [self-insurer] has not made any attempts to obtain further information to support the circumstances of the injury or a diagnosis.

WorkSafe recommended the errors be addressed but neither the agent nor WorkSafe followed-up to confirm the outcome.

We reviewed the claim and found that the agent had not changed its decision or sought reports to properly diagnose the injury or circumstances as recommended.

Two years after the injury a Medical Panel overturned the rejection decision. It took the agent another four months to accept liability on behalf of the self-insurer for weekly payments and medical expenses.

Three months later, the agent sent the worker to an IME without providing the Medical Panel's binding medical opinion. When the IME stated the worker had a current capacity, the agent terminated the claim.

Factual and credibility disputes

132. Various submissions raised concerns about self-insurers focusing on the credibility of the claimant rather than the credibility of the claim, by not properly investigating disputes of fact through circumstance investigations.

133. Claims were also made that self-insurers or their agents sometimes raised factual disputes despite credible medical and other evidence that a workplace injury had occurred. In some cases, this was to reject a claim outright. In other situations, it was alleged this was to circumvent a referral to a Medical Panel.

134. In one case examined, the self-insurer stated the injured worker had 'credibility issues' as they had not advised of pre-existing injuries when employed. WIC raised concerns about the self-insurer's decision to reject the claim in this case, given the actions of the claimant and all the medical evidence (including two IME reports) supported that the injury occurred at work.

Medical Panel opinion

135. The Medical Panel is an expert panel of specialist doctors who come together to resolve medical questions if there is disagreement or uncertainty under workers compensation and personal injury legislation. Referrals to the Medical Panel can be made by WorkSafe and its agents, conciliation and arbitration officers from WIC, and self-insured employers. A Medical Panel cannot be used where there are unresolved factual issues.

136. Section 313(4) of the WIRC Act notes that:

> For the purposes of determining any question or matter, the opinion of a Medical Panel on a medical question referred to the Medical Panel –
>
> (a) is to be adopted and applied by any court, body or person; and
>
> (b) must be accepted as final and conclusive by any court, body or person –
>
> irrespective of who referred the medical question to the Medical Panel or when the medical question was referred.

137. Self-insurers most commonly interact with Medical Panels because of WIC referrals. WIC notes that a Medical Panel opinion is final and binding on all parties, and that WIC will issue an outcome certificate which reflects the Medical Panel's opinion. The opinion may only be challenged in the Supreme Court if a party believes there are errors of law.

138. In some cases, we saw self-insurers following the directions of the Medical Panel as they are supposed to. Case study 9 was submitted by the self-insurer to the investigation as a best practice example.

Case study 9: Self-insurer seeks extra opinion after surgery recommended, treatment delayed

An employee developed limb pain from a repetitive task. The self-insurer accepted the claim.

The injured worker had surgery and later returned to full-time modified duties.

Seven months later, at an IME review, the specialist recommended further surgery. However, two months later a supplementary report from the IME, did not recommend surgery. On that basis, liability for the surgery was refused.

Because the need for surgery was unclear, the parties agreed to conciliate and involve the Medical Panel. When the Panel recommended the surgery, the self-insurer promptly approved the treatment.

The self-insurer also supported the injured worker while recovering, including providing physiotherapy. The employee then returned to work full-time.

The injured worker's representative stated that the self-insurer's refusal to approve the surgery before the Panel delayed the treatment for about six months.

139. WIC claimed some self-insurers are reluctant to refer to Medical Panels, or create factual disputes as these prevent a referral. This approach to finalising referrals, or refusal to subsequently accept a legally binding opinion, causes delays for injured workers.

Case study 10: Factual disputes to prevent referral to Medical Panel

A worker injured an upper limb during a fall.

The self-insurer completed an investigation of the incident a year later in which it was stated the worker had 'tripped on a redundant concrete footing and landed on an outstretched arm …'.

The worker submitted a claim more than 18 months after the incident, which was rejected. The worker requested an internal review of this decision.

The same claims staff member who made the decision completed this review and confirmed their initial position. When the worker requested conciliation, the same claims staff member appeared for the self-insurer, and again argued their decision was correct.

The decision to reject the claim was based solely on the opinion of an IME, who said the upper limb condition was 'constitutional in nature' and unrelated to the fall. The IME further opined the surgery proposed by the worker's treating orthopaedic surgeon was not appropriate. The treating surgeon attributed the need for surgery to the work fall. This was precisely the sort of medical dispute that could be resolved by Medical Panel opinion.

The self-insurer involved lawyers early in the conciliation process and seemed to act in an adversarial manner to push the matter to court, without referral to the Medical Panel. The self-insurer insisted that 'factual issues' about the fall made the matter best suited for a court. The self-insurer's lawyers argued about the 'mechanism of injury':

> It goes without saying that if the worker was walking backwards, [they] could not have fallen backwards landing on an outstretched hand. It would be very unusual for [them] to land in this manner while moving backwards, if not physically impossible.

Conciliation took place four months after the claim was rejected. However, due to the alleged resistance of the self-insurer, referral to the Medical Panel took another year. The Panel concluded 'such a fall was indeed consistent with the [limb] injury' that the worker claimed.

More than three years after the injury, and after considerable disadvantage to the worker, the self-insurer finally accepted the claim.

Case study 11: Trying to avoid a referral to the Medical Panel

A worker requested surgery for an injured joint but the self-insurer refused.

The injured worker went to conciliation and WIC referred the dispute to the Medical Panel. The self-insurer's lawyers told WIC a referral was not appropriate because the individual was 'not an employee … and accordingly not a worker within the meaning of the [WIRC] Act'.

Eight months earlier, a court had already declared in a separate proceeding that the injured worker was an employee of the self-insurer. When challenged, the self-insurer persisted in telling WIC the court's earlier decision did not matter as that decision was not about workers compensation. They expected the injured worker to prove employee status again.

WIC told the self-insurer why it was appropriate to refer the issue about surgery to the Medical Panel, but the self-insurer claimed recent High Court decisions supported its position.

The self-insurer stated to WIC:

> To the extent that there is any question or dispute about employment status or the interpretation and application of the law […] [WIC] respectfully does not have the power to make a decision, nor to refer the matter to a Medical Panel in the circumstances.

To aid timely referral and resolution of the dispute, WIC consulted WorkSafe, which agreed there was no question about employee status and the referral could proceed to the Panel.

In response to the draft report, the self-insurer maintained its position and submitted WIC and WorkSafe had made legal errors. The self-insurer also questioned whether it had been afforded procedural fairness by WIC as it was unaware WorkSafe had been consulted.

Case study 12: Not valuing or understanding the Medical Panel opinion

A worker had a history of lower-limb injuries over several decades as transport worker.

The self-insurer accepted liability for various injuries and paid for surgery after the most recent incident, a fall. The worker's condition slowly improved, and despite complications and pain they returned to work full time.

Later, the self-insurer terminated the injured worker's weekly payments and medical services. The self-insurer had obtained two IME opinions that the injury was not work related. The injured worker challenged this at conciliation and the dispute was referred to the Medical Panel to determine if the injury was related to the recent fall.

The Panel expressly disagreed with both IMEs meaning the worker was entitled to backdated medical expenses, with the Panel's decision binding.

The self-insurer resisted reinstatement of the worker's entitlements, on the grounds it was providing the required treatment which would soon end. WIC explained the claim still needed to be reinstated. To their credit, the self-insurer did so.

Not long after, the self-insurer sought a new IME report about the need for any treatment or whether the injury was still related to employment.

The letter from the self-insurer to the new IME inappropriately referenced the two earlier IME opinions given only the subsequent binding Medical Panel opinion was relevant. The self-insurer asked:

> Do you subscribe to the opinions of [IME 1] and [IME 2] that any ongoing symptoms are unrelated to the [fall], or do you agree with the opinion of the Medical Panel – please explain?

The new IME stated 'I agree with the opinions of [IME 1] and [IME 2] and I do not agree with the opinion of the Medical Panel', so the self-insurer again terminated the worker's entitlement to medical expenses.

The worker challenged this decision. Despite evidence the worker had an ongoing entitlement, the self-insurer refused to reinstate.

In the end, the self-insurer agreed to settle the matter for $230,000 if the worker resigned and released the self-insurer from further liability.

Participating in conciliation

140. WIC was designed to provide injured workers and their employers with easy access to free, independent and impartial conciliation and arbitration services. Disputed decisions by WorkSafe agents or self-insurers must go through conciliation at WIC before they can be challenged in court.

141. Binding *Ministerial Guidelines in Respect of Conciliation* require self-insurers to engage in conciliation meaningfully and genuinely and take all reasonable steps to resolve disputes by:

    - providing all relevant information prior to a conciliation conference
    - attending the conference
    - meaningfully and genuinely discuss all relevant issues raised
    - only maintaining decisions which have a reasonable prospect of success, were they to proceed to arbitration or court.

142. Where a dispute cannot be resolved at conciliation, the Conciliation Officer may either certify there is a 'genuine dispute' (in which case the dispute may proceed to court) or, if they are satisfied that there is no arguable case for denying payment, give a Direction that weekly payments or medical expenses be paid to the injured worker.

Disputes not resolved

143. The aim of conciliation is to resolve a dispute: this usually means varying the original decision by agreement or recommendation.

144. Self-insurers are over-represented in the number of disputes taken to conciliation. Between January 2018 and June 2022 WIC received 47,663 disputes. Of those, 13 per cent were about the decisions of self-insurers. WorkSafe says that self-insurers account for approximately 6 per cent of new claims lodged annually.

145. Workers of self-insurers are also less likely to get a resolution at conciliation, with WIC data showing fewer self-insurer decisions are voluntarily changed compared to those by WorkSafe agents.

146. Between January 2018 to June 2022 WIC issued 17,334 genuine dispute certificates. Of those, 18 per cent were issued for self-insurer claims.

147. Between January 2018 to June 2022 WIC issued 46 Directions. Of those, 30 per cent were issued to self-insurers.

148. Self-insurers offered reasons other than resistance to conciliation to explain these differences. Crown stated fewer resolutions at conciliation could be because self-insurer decisions 'are more sound, better informed, and defensible'.

149. Construction supplier Hanson submitted that self-insurers were more likely than WorkSafe agents to make and maintain an adverse decision in a complex matter. Hanson's view is self-insurers (in contrast to WorkSafe agents) often use one person to manage a case for the life of the claim and this person has detailed knowledge which assists them and leads them to maintain the decision at conciliation, which they believe to be correct.

150. Good administrative decision-making should guide all phases of claims management. Detailed knowledge of a claim should be used, in accordance with the Ministerial Guidelines, to engage meaningfully in conciliation and to take all reasonable steps to resolve disputes. Decision-makers should not be resistant to changing their decisions when the merits of the case warrant.

151. Data reviewed by the investigation shows self-insurers make proportionally more decisions that are disputed, and are less likely to successfully conciliate those disputed decisions.

Adversarial approach

152. Submissions to the investigation spoke about an adversarial and combative approach by some self-insurers at conciliation. People complained of an overly litigious mindset and refusals to alter decisions which had little reasonable prospect of being upheld in court.

153. WIC told the investigation some self-insurers approached claims management and dispute resolution with a litigious mindset, regardless of the merits of the case or the information available. WIC expressed concern these self-insurers seemed to disregard the alternative dispute resolution objectives set out in the WIRC Act. Unsurprisingly, some self-insurers directly objected to these assertions.

154. Some self-insurers said WIC and litigation were necessary avenues for the small number of complex claims which required legal interpretation. They acknowledged concern about some of the problematic conduct by self-insurers reported at WIC, and distanced themselves from such conduct. Some expressed pride in their meaningful engagement and professionalism at conciliation, and called for further examination of conduct issues and for them to be addressed directly with the self-insurers involved.

155. Other self-insurers alluded to problems they experienced with conciliation. One claimed its representatives felt considerable pressure from Conciliation Officers to change its decisions.

156. Another suggested WIC may not have a good understanding of the challenges self-insurers faced at conciliation, so further education may be beneficial.

157. WIC observed self-insurers tend to have the original decision maker as their representative at conciliation. This is supported by Hanson's observation that the same person who has managed the case is more likely to maintain the adverse decision. This contrasts with the approach taken by WorkSafe agents, where a trained dispute resolution officer will attend, often with 'fresh eyes' and potentially more openness to alternative options.

158. WIC stated when decisions or attitudes obstructed an injured worker's access to a genuine early dispute resolution process this impacted the most vulnerable who were less willing or able to pursue their matter in court.

159. The power and resource imbalance between an injured worker and their employer is obvious, particularly when the employer is a multi-national corporation with access to legal resources. Self-insurers need to be conscious of these dynamics and ensure workers have access to fair and just processes.

160. Some parties observed that law firms representing self-insurers act in a noticeably more aggressive way than those same firms representing WorkSafe agents or WorkSafe directly. Further, WIC raised concerns that firms providing legal advice sometimes provided different advice depending on whether the claim was managed by a self-insurer or a WorkSafe agent, and questioned whether this was because self-insurer decisions had less oversight by WorkSafe.

Case study 13: Self-insurer's agent 'cheekily' tries to avoid conciliation in breach of Minister's rules

A worker was injured and lodged a claim four months later.

The self-insurer engaged an agent to manage the claim on their behalf. The agent told the injured worker their claim had been rejected.

The rejection notice sent was based only on the worker's claim form and verbal communication from a manager at the self-insurer.

The worker requested conciliation at WIC.

WIC was concerned the file did not seem to contain a thorough assessment of the claim and why it was rejected, nor was WIC provided with all the evidence, as required by the Claims Manual.

The injured worker then lodged a second injury claim.

In preparation for conciliation, the agent made many case notes. These clearly documented that the agent planned to ask for a genuine dispute certificate, without trying to conciliate the claims. They wrote about calling WIC to 'cheekily maybe ask for [genuine dispute certificate] without the need to [participate in a conciliation] conference'.

This would allow the self-insurer to take the matter to court. This approach was in breach of the Ministerial Guidelines because self-insurers and their agents are required to 'take all reasonable steps to settle disputes'.

Other actions that did not indicate a genuine willingness to resolve the dispute fairly were:

- refusing to provide WIC a copy of the circumstance investigation report, wrongly claiming it was 'exempt'
- discussing not providing evidence critical of the rejection decision in advance to other parties, and only bringing them in-person to conciliation for 'inspection'
- refusing to provide information unless the manager at the self-insurer consented.

When WIC raised concerns with the agent about rejecting the claim, the agent maintained it was a genuine dispute.

The injured worker complained about their treatment and said it was causing mental health issues. Their concerns included not being contacted about their second claim, not getting help to return to work, and not getting their claim/s reviewed by senior officer/s despite request/s. The Claims Manual says these all must be done.

WIC later provided WorkSafe feedback about the self-insurer's conduct in this case, telling them:

> '... prior to, during and after the conference [the self-insurer] was uncooperative and obstructive ... the decisions were not arguable, let alone sustainable ...'

This dispute remained unresolved.

161. The self-insurer's agent in this case told the investigation claims management issues persisted because the self-insurer had not delegated full decision-making authority to the agent. The agent no longer accepts assignments where its ability to act is limited, to avoid such conflicts.

Following conciliation Directions

162. In very limited circumstances, WIC has the power to direct a self-insurer to make limited weekly payments or limited payment for medical expenses. This can only occur if the conciliator is satisfied that:

    - the self-insurer has no arguable case to support the decision in dispute and justify not paying entitlements
    - the self-insurer refuses to alter their decision voluntarily.

163. WIC does not issue Directions frequently. They can be appealed to the Magistrates Court. The investigation encountered cases where appeals were unsuccessful, but no formal data is available on appeal outcomes. WIC is not advised if a Direction is overturned. This advice should be obtained and reported on as it would allow assessment of the quality of decision-making by WIC and by self-insurers.

164. Thirty per cent of all Directions issued between 1 January 2018 and 8 June 2022 were to self-insurers. Self-insurers must be open to changing decisions when new evidence is available, or the circumstances warrant a reassessment. This should occur even if it is at the eleventh hour of a conciliation or court case. This demonstrates integrity, accountability and the good administrative decision-making the law requires.

165. The investigation saw cases where self-insurers received advice a decision was unsustainable or received new evidence (including on the day of conciliation) that justified a different decision, yet decisions to reject or terminate were maintained. In some cases, self-insurers were slow to make payments even after WIC directed them to.

166. The failure to comply with a Direction is a breach of the WIRC Act punishable by a $55,000 fine. However, WorkSafe must be aware of the breach for there to be consequences for the self-insurer.

Options when conciliation fails

167. If conciliation fails, injured workers of self-insurers have limited options. One is to withdraw from the process.

168. Another is to seek arbitration. WIC's relatively new arbitration power allows it to make binding determinations on disputed cases after they have not been resolved by conciliation. This is intended to allow people to resolve claims without having to go to court. Arbitration can only be initiated for injuries that occurred after 1 September 2022. At the end of May 2023, no cases had yet been arbitrated.

169. The final option for workers of self-insurers is to take the matter to court. This option can be stressful and expensive, which is especially challenging for people who are injured and not earning income.

170. Victorian workers who do not work for self-insurers have an extra option available – review by WCIRS. But WCIRS cannot consider cases from self-insurers. Various submissions, including from WIC, raised concerns about this lack of access. WIC said:

> … injured workers employed by Self-insurers are further hampered by their inability to escalate decisions for review prior to taking their dispute to court. This clearly disadvantages a worker employed by a Self-insurer and distinguishes them from workers whose employers pay premiums to a WorkSafe Agent …

Workers Compensation Independent Review Service

171. In response to the Ombudsman's 2019 investigation, WorkSafe established WCIRS in April 2020 to review disputed decisions not resolved at conciliation. WCIRS review officers apply consistent sustainable decision-making criteria to their reviews of claim decisions. They then use WorkSafe's power in the WIRC Act to give directions to WorkSafe agents to overturn unfair decisions. This part of the Act only applies to WorkSafe agents. No equivalent legislative power exists for self-insurers. Injured workers of self-insurers are therefore currently excluded from access.

Why WCIRS works

172. WorkSafe now has compelling evidence to show the positive impact of WCIRS on decision-making by its agents. A single direction from WCIRS can improve the quality of decision-making for many other claims. WorkSafe agents learn from WCIRS directions and apply the principles to future decisions. This is vital to system improvement. The importance of this within the scheme cannot be understated in WorkSafe's view. If self-insurers were subject to WCIRS, their decision-making should similarly improve.

173. Over time, if claims managers change to align with WCIRS directions, fewer matters would need to proceed to WCIRS. Figure 5 shows a smaller proportion of WorkSafe agent decisions are being overturned by WCIRS or withdrawn by the WorkSafe agent as the system matures. This is because fewer of the disputed decisions referred to WCIRS need to be changed.

174. The results show in its first months of operation (2019-20), 12 of the 13 disputed decisions referred for review (92 per cent) were overturned by the Review Officer or withdrawn by WorkSafe agents. Many more disputed decisions were referred for review the following year (301) with the proportion overturned or withdrawn still relatively high at 50 per cent. In the 2021-22 financial year, only 38 per cent of decisions referred for review were overturned or withdrawn.

175. This process is an important oversight mechanism for WorkSafe that delivers meaningful and systemic improvement.

Figure 5: WCIRS review outcomes to January 2023

	Total	2019-20	2020-21	2021-22	2022-23
Total Finalised Reviews	**988**	**13**	**301**	**406**	**268**
Affirmed	**546**	1	143	234	168
Overturned	**356**	11	115	133	97
Withdrawn (by Agent)	**57**	1	35	20	1
Withdrawn (by Worker)	**29**	0	8	19	2

Note: 2019-20 and 2022-23 figures are for partial years (December 2019 to June 2020, and July 2022 to January 2023).

Source: WorkSafe, February 2023

176. Self-insurers account for a disproportionate number of disputes at conciliation and Directions issued by WIC. Given this, WCIRS may act as an equally strong (if not stronger) impetus for change in self-insurer practices than already seen among WorkSafe agents.

177. This would require close collaboration between self-insurers and momentum by WorkSafe to drive change and develop best practice.

178. It is also noted that only four WorkSafe agents in Victoria manage claims for about 95 per cent of the work force, making it relatively easy for these agents to apply learning from one wrong decision to many other claims. This may be much harder for the 34 self-insurers, some of whom deal with only a small number of claims.

What self-insurers say

179. While some self-insurers acknowledged the current inequity in access to WCIRS, few directly supported the need for change to close the gap; their responses to the draft report instead calling for more detail on how change could be implemented and operationalised.

180. In its response to the draft report, healthcare company Healius claimed that WCIRS reviews were limited in scope in that they only look at adverse decisions:

> There has not been any review of decisions made to accept liability which should have been rejected … quality of decision making goes both ways …
>
> It may well be … that the reduced number of disputes being raised with respect to [WorkSafe] Agents is an outcome of [WorkSafe] Agents accepting claims because this is the most practical solution in the circumstances.

181. Westpac did not support self-insurers being subject to WCIRS, stating the conduct of a few should not be considered reflective of all. Crown maintained only self-insurers who engaged in poor conduct should be subject to WCIRS.

182. BlueScope presented a mixed view. It agreed all injured workers should have the right to access WCIRS, though stated in their experience:

> WorkSafe are no better positioned to interpret complex matters than an insurer, and ultimately a matter may need to be determined in a legal forum.

183. In their responses to the draft report Westpac, Wesfarmers, Crown, Hanson and RACV called for more detail about how the power to direct by WorkSafe would be implemented and called for review mechanisms to apply.

184. Agent EML which currently acts for three self-insurers, welcomed the suggestion that WCIRS be extended to include self-insured employers to further ensure fair and equitable outcomes for all injured workers. Wesfarmers was also broadly supportive and advised it saw no reason for the employees under a self-insurance program to be subjected to different rights and processes. It suggested a trial of any new process should be considered to assess the effect on claims experiences and conduct.

185. These varied responses indicate the purpose and current functioning of WCIRS may not be well understood. It is not a punitive measure. Fixing the current inequity of WCIRS access would only have an impact on self-insurers who made unsustainable decisions. There would be no basis to overturn decisions of self-insurers undertaking claims management in line with best practice and the legislation.

WorkSafe oversight

186. One of WorkSafe's key functions is to oversee self-insurers to ensure they manage claims in accordance with laws designed to protect workers and support their return to work. WorkSafe is responsible for approving and monitoring self-insurers to enforce performance standards and promote good decision-making.

187. WorkSafe is also responsible for ensuring self-insurers comply with the Charter of Rights Act. Denying and terminating genuine claims is unfair. Not only could it result in the employees being financially disadvantaged, it could also lead to a loss of dignity and self-esteem and reputation within the workplace.

188. WorkSafe believes that the principles underlying the Claims Manual align with the Charter of Rights Act, however, we saw no evidence that WorkSafe comments on workers' human rights when reviewing claims decisions. Wesfarmers was the only self-insurer to make specific mention of human rights in its response, telling the investigation the company understands and embraces its obligations under the Charter of Rights Act and that corporate values of integrity, accountability and openness underpin their approach to management of its self-insurance portfolio.

189. WIC noted workers of self-insurers are particularly vulnerable and raised questions about WorkSafe's oversight:

> The shortcomings that these [earlier] reports consistently identified with WorkSafe's oversight of [its] agents are further compounded in the context of Self-insurers, due to the limits of WorkSafe's role as regulator.

190. While WorkSafe does not have the same power over self-insurers as it does over WorkSafe agents, it is not powerless. It took steps to improve system oversight following our 2016 and 2019 investigations.

191. WorkSafe made further changes in March 2023 to obtain more timely and comprehensive data about claims and decisions, so it is not intervening months later. WorkSafe is also analysing data to identify issues early so it can work with self-insurers, peak bodies, conciliators and agents to remedy poor practice and improve systems.

192. Despite these initiatives, WorkSafe appears to struggle to effectively regulate self-insurers in some areas, constrained in part by the limits of its legislative powers.

193. This report has already highlighted an instance where WorkSafe has failed to verify or scrutinise implementation of its Quality Decision Audit recommendation to the self-insurer. This may have allowed poor practices to continue. WorkSafe acknowledged that verification of Quality Decision Audit recommendations had not been undertaken consistently.

194. During our investigation, WorkSafe acknowledged that a change of approach was required. WorkSafe implemented a procedure to verify the outcome of all its Quality Decision Audits with self-insurers who have agreed with its recommendations. This new procedure ensures the agreed changes are actioned.

195. Another limitation is WorkSafe's inability under the WIRC Act to direct a self-insurer to overturn an unsustainable decision. In several of the case studies in this report, self-insurers said they agreed with WorkSafe's recommendations but then did not follow them. WorkSafe's position as regulator and subject matter expert did not convince those self-insurers to change their decisions.

196. For WorkSafe to compel a self-insurer to change a decision that is unsustainable, it needs this legal power. WorkSafe has not taken any steps to seek this power. It argued it is just now seeing the impact of the power to direct WorkSafe agents as they change their practices in response to WorkSafe's directions.

197. WorkSafe told the investigation it would welcome the power to direct self-insurers to overturn an unsustainable decision.

198. The power to review and overturn self-insurers' decisions is not unprecedented in Australia. In Queensland, for example, the Office of Industrial Relations conducts independent reviews which can confirm, vary or set aside a self-insurer's decision. These are based only on the application and claim file, and review officers cannot make enquiries or conduct investigations.

Approving self-insurers

Initial approval

199. An employer applying to be a self-insurer must first demonstrate to WorkSafe that it is 'eligible' under section 375 of the WIRC Act. This primarily means showing it is capable of meeting its potential claims liabilities.

200. Self-insurers must also demonstrate they are 'fit and proper'. In addition to the employer's financial viability, WorkSafe must look at a self-insurer's:

- safety record
- number of workplace injuries
- cost of associated claims
- capacity to manage claims.

201. When assessing the company's resources for managing claims, WorkSafe advises prospective self-insurers it expects:

> a strong claims management, occupational rehabilitation and return to work history, including compliance with the [WIRC Act], appropriate participation and implementation of agreements in conciliation processes, strong results in worker satisfaction surveys, and minimal substantiated complaints, which have been resolved in a timely manner if they occur.

202. In other jurisdictions, expectations of self-insurers are articulated in a more detailed way. For example, in South Australia approval as a self-insurer is conditional on the self-insurer abiding by a detailed Code of Conduct.

203. Finally, WorkSafe must also have regard to 'such other matters as the Authority thinks fit'. This provision means WorkSafe can consider any other relevant topic. WorkSafe has used this provision to request details of prosecutions under the WIRC Act and details of an employer's consultations with their employees and relevant unions about the proposal to become a self-insurer.

204. The names of organisations applying to be self-insurers are posted on WorkSafe's website, and anybody with relevant information can make a submission to WorkSafe as part of the initial approval process.

205. If approved, the new self-insurer is granted an initial approval period of three years.

206. After this, self-insurers may apply to WorkSafe for reapproval. The standard reapproval term is four years. The reapproval process is WorkSafe's key mechanism for managing self-insurers' performance and is designed to be informed by data from its various monitoring systems. Reapproval of self-insurers is discussed more later.

Outsourcing to agents

207. The WIRC Act allows a self-insurer to 'appoint a person approved by the Authority to act as the self-insurer's agent' to carry out the role.

208. In 2023, eight self-insurers have WorkSafe approval to outsource the management of some or all of their claims to agents.

209. In a submission, one of these agents, EML, identified its perception of the benefits of 'effectively managed self-insurance' as:

- providing immediate access to care and support
- ensuring continuity of care for workers
- bringing strong workplace knowledge, allowing them to tailor and establish suitable duties to assist with an early and sustainable return to work
- delivering direct feedback on opportunities to change operational processes to improve safety and prevent injuries.

210. EML provided its perspective on the advantages of self-insurers using 'specialist claims managers'. For example, it suggested specialist claims management brings a higher level of expertise and understanding of regulatory requirements.

211. EML also said it provided independent decision-making, though noted in the past not all self-insurers had delegated them full decision-making power. EML acknowledged this had led to conflicts in decision-making.

212. In response to the draft report EML noted that the current Ombudsman investigation had identified opportunities for improvement. It advised it had made significant improvements to its services to self-insurers following the Ombudsman's previous WorkSafe investigations. EML told the investigation it had:

> observed the positive impact of these changes on our decision making including achieving 100% compliance in the most recent WorkSafe Quality Decision audits undertaken in April and November 2022.

213. In contrast, BlueScope questioned whether self-insurer agents offered superior decision-making to self-insurers, noting the conduct of [WorkSafe] agents had led to a review of claims management practices initially by the Ombudsman and other oversight bodies or regulators. Hanson also recommended caution weighing the perceived benefits of appointing an agent. This report includes case studies highlighting problematic approaches involving both self-insurers and their agents.

214. Ordinarily, WorkSafe can direct its agent to overturn a decision. As noted, WorkSafe cannot do this when the agent is acting on behalf of a self-insurer. Perhaps not surprisingly, several submissions raised concerns that agents can behave differently when acting for self-insurers.

215. EML emphasised separate business units manage self-insurer claims and other workers compensation claims. While such separation may be appropriate for management purposes, it carries a risk that any positive changes may not flow equally across the whole system. If changes are made to one claim because the approach or decision was wrong, they should apply to all subsequent claims, no matter the type.

Monitoring self-insurer performance

216. WorkSafe monitors self-insurers through a combination of audits, feedback and complaints. This framework is designed to ensure self-insurers meet their statutory obligations. It adopts a targeted approach for oversight and intervention in line with the risk profile of individual self-insurers.

217. WorkSafe's oversight framework includes multiple monitoring mechanisms:

- Claims Management Audits
- the tier system
- Self-insurer Self-audit Program
- Performance Improvement Plans
- regulatory monitoring (including complaints, WIC lodgements, enforcement activity and the comprehensive review of performance in the lead up to reapproval).

218. WorkSafe also receives information about self-insurer performance through:

- Quality Decision Audits
- health checks
- injured worker surveys.

219. WorkSafe reports back to self-insurers on monitoring activity via quarterly reports (about complaints, WIC lodgements and enforcement activity) and a yearly Self-Insurer Performance Snapshot ('yearly report').

220. WorkSafe says yearly reports 'contain insights into a self-insurer's performance across key areas of being "fit and proper", including safety, services to injured workers, and financial and prudential capacity'. These reports are sent to self-insurers for the attention of the CEO or equivalent (such is their importance) and include 'areas of interest and/or areas of concern that require improvement'. WorkSafe does not follow up to ensure the self-insurer understood the issues highlighted or acted on required improvements.

Claims Management Audits

221. In the year before a self-insurer's approval term expires, WorkSafe conducts a Claims Management Audit. This checks performance against a set of claims management criteria, although none of these criteria evaluate decision-making quality.

222. The self-insurer's performance against the audited criteria is expressed as an overall 'compliance rate', out of a possible 100 per cent. This rating is used to place self-insurers into different 'tiers'.

The tier system

223. The tier system, introduced in 2018, is fundamental to WorkSafe's risk-based approach to oversight – focusing less on those self-insurers who are performing well. How much monitoring and reporting a self-insurer is subject to depends on their performance (see Figure 6).

Figure 6: WorkSafe's self-insurer tier rating system

Tier	Benchmarks
1	**95% compliance rate or higher**
2	**80% to 94% compliance rate**
3	**65% to 79% compliance rate**

Source: Victorian Ombudsman, based on WorkSafe's *Self-insurance oversight framework for claims management*

224. While Tier 1 is only for self-insurers rated 95 per cent and higher, Tier 2 covers a large range. A high-performing self-insurer with a compliance rating of 94 per cent can be categorised and monitored the same as one with only 80 per cent. Currently, no Victorian self-insurer is rated Tier 3.

225. Unlike NSW, self-insurers' tiers are not published in Victoria. Publication of performance and assessment information enhances transparency and accountability across the sector and may motivate self-insurers to improve their performance.

226. At present, Victorians have no way of knowing which self-insurers are performing well. The compliance ratings and tiers for WorkSafe-approved self-insurers at the time of this report's publication are shown in Appendix 3. Because tier assessments for self-insurers are not reviewed by WorkSafe each year the assessments for some self-insurers are several years old.

227. Of the 34 self-insurers operating in Victoria, 17 are rated Tier 1, and 16 are Tier 2. One, multinational resources company BHP, is not rated because it has not had auditable activity. In such cases, WorkSafe reattempts the audit every subsequent year until there are claims to audit.

228. Several self-insurers' compliance ratings do not match their assigned tier as there is a significant lag between WorkSafe calculating a rating and assigning a tier at reapproval. For example, food company Mondelez achieved only 71 per cent compliance in 2022 which ought to place them in Tier 3 but it remains in Tier 1. Mondelez is not due to be assigned a new tier until reapproval in November 2023.

229. Mondelez told the investigation this compliance result made for sobering reading. Mondelez advised it had reflected on the poor audit result and engaged experts to improve performance. The self-insurer's commitment to improving its performance is commendable. WorkSafe should consider what it can do to address flaws in the tier system itself.

230. The tier determines the number of audits the self-insurer must undergo during its approval term. A Tier 1 self-insurer will be audited three times during a six-year approval period, while a Tier 2 self-insurer would usually be audited four times during that period.

231. A self-insurer's tier also influences the circumstances in which improvement plans are required by WorkSafe. These plans are completed by self-insurers to address performance issues identified in audits. Tier 1 self-insurers are allowed a 10 per cent decline in compliance rating before an improvement plan is required, while a Tier 2 self-insurer is allowed only a 5 per cent decline.

232. It is in a self-insurer's best interest to be in a higher tier, and WorkSafe states the main purpose of the tier system is to encourage performance improvement. However, there are flaws with the system.

233. Tier placement is based solely on the Claims Management Audit in the year before a self-insurer's approval term expires, which does not evaluate decision-making quality. Other data and feedback available to WorkSafe about self-insurer performance does not affect tier ratings. This needs more consideration from WorkSafe.

234. Also, a self-insurer's tier does not change throughout its approval term. Irrespective of how its performance may change, the level of oversight remains consistent for up to six years.

235. In contrast, NSW regulator State Insurance Regulatory Authority ('SIRA') takes a more holistic approach, and reviews self-insurers' tiers at least annually. A self-insurer's conduct, claims management practices and financial viability are all used to determine their tier. SIRA contemplates shortening licence periods for poor performers. SIRA reserves Tier 1 for 'exemplar performance' only.

236. WorkSafe's approach is different. Sometimes WorkSafe uses its discretion to assign self-insurers to a higher tier, even when their compliance rating is below the minimum for that tier. WorkSafe's guideline to self-insurers about oversight explains:

> If a self-insurer's compliance rate is borderline below achieving a Tier 1 or Tier 2 level of compliance, WorkSafe may apply a margin of 3% and assign the self-insurer to the higher tier level, taking into consideration the:
>
> - action required to rectify their non-compliances
> - overall performance under the measures listed under regulatory monitoring in the framework.

237. It is unclear why this discretion is applied at all, and only to assign a self-insurer to a higher tier. This may create a 'near enough is good enough' approach to compliance, rather than self-insurers having a clear consequence if they do not meet the required benchmark.

Self-audit Program

238. Self-insurers are required to audit themselves through the Self-insurer Self-audit Program ('self-audit'). The self-audit contains two aspects. Part I relates to occupational health and safety and Part II relates to claims management, employer obligations and other requirements. This investigation has only considered Part II of the self-audit.

239. Like the Claims Management Audit, the frequency of self-audits required depends on the self-insurer's tier and approval term. Tier 1 self-insurers must complete a self-audit twice during any approval term; Tier 2 must self-audit three times.

240. Self-audits are undertaken by an external auditor nominated by the self-insurer who WorkSafe mandates must have 'suitable qualifications, knowledge and experience'. WorkSafe provides detailed instructions on the criteria and sampling methodology. The criteria used mirror the Claims Management Audits, so self-audits also do not examine the quality of a self-insurers' decision-making.

241. Self-audits lead to an overall compliance rate expressed as a percentage. These ratings do not influence the self-insurer's tier as the Claims Management Audits do. The average rating over the financial years 2018-19 to 2021-22 varied markedly for each self-insurer, with one as low as 67 per cent, while others averaged 100 per cent.

242. Where a self-insurer fails to meet certain requirements, it must prepare a remedial action plan to correct deficient practices. WorkSafe monitors remedial action plans required due to non-compliance at self-audit.

243. WorkSafe states it uses the self-audits to:

- monitor and promote continuous improvement in claims management and return to work practice
- include in the yearly report
- identify breaches of the WIRC Act, which WorkSafe may investigate.

244. WorkSafe advises auditors who conduct self-audits that remedial plans must be prepared and reported 'for criteria that did not meet requirements which are indicative of systemic deficiencies in practices'. Systemic deficiencies include:

- incorrect interpretations of legislative requirements
- incorrect application of WorkSafe's policies
- repeat findings that financially impact a worker's entitlement, like the miscalculation of average pre-injury earnings
- repeat findings which require a review of remedial actions.

Practice example 1: Self-insurer's self-audits showed the same errors repeated – WorkSafe reapproved for maximum six-year term

A self-insurer's first self-audit resulted in a compliance rating of 70 per cent, failing to meet requirements on almost a third of the criteria.

The self-insurer's claim acceptance letters did not provide workers with all required information. It also made critical errors calculating public holiday rates. This is important because a worker's weekly payments depend on the correct calculation of their average pre-injury earnings.

The self-insurer made a remedial action plan.

WorkSafe verified this plan noting an improvement in their communication to workers, with compliance on that reaching 100 per cent. However, the self-insurer had only increased its compliance with calculating pay from 36 per cent to 43 per cent.

The self-insurer completed another self-audit the next year. Their overall compliance rating dropped from 70 per cent to 67 per cent.

One of the reasons was ongoing pay calculation problems, with every calculation of average pre-injury earnings reviewed containing errors.

Despite this, WorkSafe exercised its discretion and granted the self-insurer a six-year term of approval. WorkSafe stated the ongoing errors in calculating pay by this self-insurer caused no disadvantage to injured workers. While this is fortunate, it is concerning that there was no consequence for the self-insurer persistently miscalculating pay.

245. Auditors are told that 'an effective remedial action will correct a deficient practice and prevent future recurrences'. As illustrated in Practice example 1, more needs to be done to verify if remedial plans are effective and this must influence WorkSafe's assessment of the competence of the self-insurer, including when determining reapproval and terms.

246. WorkSafe has mechanisms for addressing repeated non-conformance. It can revoke a self-insurer's approval or impose additional obligations. We discuss WorkSafe's use of these mechanisms in the section on managing poor performance by self-insurers. To be effective, these mechanisms need to be used, and be seen to be used.

247. As well as highlighting issues with individual self-insurers, self-audit results can be a useful comparison with WorkSafe's Claims Management Audits. The investigation compared self-audits from 2019 to 2022, against the most recent WorkSafe Claims Management Audit and found variances in the compliance ratings.

248. Although most self-insurers' self-audit ratings are broadly consistent with their Claims Management Audit ratings, where there was a substantial variation, the better result was achieved in the Claims Management Audit. This supports information provided to the investigation suggesting some self-insurers devote significant resources to performing well in Claims Management Audits. This may be because this determines their tier.

249. We also found a self-insurer's tier is not necessarily representative of how they will perform over the life of their approval period because compliance ratings can change significantly. The average self-audit compliance rating for Tier 1 self-insurers was around 94 per cent, which is below the Tier 1 benchmark.

250. One self-insurer had a 24 percentage point drop in Claims Management Audit compliance during its six-year approval term. However, it remained at Tier 1 even though this did not accurately reflect its current performance. This self-insurer's own self-audits showed a steady performance decline but there was no change to the oversight regime by WorkSafe based on the tier. Earlier intervention may have prevented the decline and had a necessary and positive impact on the injured workers whose claims were being managed.

251. WorkSafe should link the outcomes of self-audits to the tier determinations and ensure when issues are identified, prompt remedial action is taken.

Quality Decision Audits

252. WorkSafe audits a sample of self-insurer's claim decisions every year to confirm alignment with WorkSafe's sustainable decision-making framework. We refer to these as 'Quality Decision Audits' in this report. WorkSafe and self-insurers often call these 'Quality Decision-Making Audits' or 'QDMs'.

253. These reviews specifically aim to ensure decisions:

- are supported by reasonable, appropriate and sufficient evidence
- afford injured workers procedural fairness in assessing entitlements
- have not wrongfully disentitled injured workers
- are communicated accurately, clearly and in a timely manner.

254. WorkSafe assesses whether each decision meets the quality criteria for initial claims liability, medical expenses and entitlements to weekly compensation. The findings in past reviews can influence the focus of future reviews. For example, in 2019-20 WorkSafe audited 'initial eligibility' decisions and found almost 25 per cent did not meet the criteria. Having identified this as an area of concern, it audited more cases where this type of decision was in dispute the following year.

255. This is a good example of a targeted and responsive approach, because WorkSafe's focus appears to have had a significant impact on the practices of self-insurers. In 2020-21, 95 per cent of audited 'initial eligibility' decisions passed.

256. WorkSafe assesses decision-making compliance based on good administrative decision-making principles, which are set out in the WorkSafe Claims Manual. These principles are underpinned by the Quality Ethical Decision-making framework detailed in the manual.

257. This approach was developed and implemented in response to recommendations made in our second workers compensation investigation in 2019. This approach is also consistent with the tests applied by WCIRS in deciding if a decision is sustainable.

258. Before 2019, WorkSafe did not conduct Quality Decision Audits of self-insurers. From 2019 to 2022 WorkSafe completed 575 reviews of individual decisions of self-insurers, of which 57 failed one or more requirements.

259. Results varied a lot between self-insurers. Some performed very well, failing few, if any, audit criteria. The results of Quality Decision Audits are not made public by WorkSafe. Several self-insurers advised the investigation their most recent Quality Decision Audits showed 100 per cent compliance. The Ombudsman encourages each self-insurer to make their Quality Decision Audit results, and all other audit results, public.

260. Quality Decision Audit failures from 2019 to 2021 did not align with the self-insurers market share. For example, one self-insurer that employs less than 3 per cent of the self-insurer workforce in Victoria accounted for 16 per cent of the Quality Decision Audit fails. Others with similar market share had no audit failures.

261. Only in 2022 did WorkSafe start considering Quality Decision Audit results as part of its reapproval assessment. WorkSafe told the investigation this three-year lead time was required to 'establish procedures, benchmarks and to provide procedural fairness to self-insurers'.

262. Many of the issues WorkSafe identified in Quality Decision Audits appeared to be recurring and there is no evidence WorkSafe intervened or adequately followed-up after it notified self-insurers' of key audit fails. For example, the investigation found two of the largest self-insurers received feedback they had failed to take reasonable steps to obtain relevant and available information before making decisions. This is a significant issue that should have attracted close follow-up from WorkSafe.

263. When a self-insurer fails a Quality Decision Audit, WorkSafe makes recommendations to the self-insurer. However, this does not guarantee the decision will be revisited. This is because WorkSafe does not possess the power to direct self-insurers to overturn their decisions when its recommendations are ignored.

264. While Quality Decision Audits are useful for providing information about self-insurers decision-making practices, they are not an effective mechanism for changing self-insurers' decisions or improving practices. WorkSafe believe that Quality Decision Audits did result in some self-insurer decisions being changed and some overall improvements. Nevertheless, it described the use of Quality Decision Audits without legislative authority to require a self-insurer to change a decision as 'a lost opportunity'.

265. In several cases examined, self-insurers disagreed with WorkSafe's finding that a decision was unsustainable. WorkSafe provided the investigation its analysis of the Quality Decision Audits. This showed 55 cases where self-insurers expressly disagreed with WorkSafe.

266. Self-insurer rejections of WorkSafe's assessment were often based on:

- a misunderstanding of the Claims Manual or the right process
- a failure to consider whether the decision was sustainable.

267. In only three cases self-insurers advised WorkSafe of changed decisions.

268. In other cases, the self-insurer failed to provide any response to WorkSafe. WorkSafe also did not enquire about whether any wrong decisions were changed.

269. WorkSafe said it was committed to taking a more active role in verification of outcomes where the self-insurer agreed the decision was not sustainable. Where the self-insurer did not agree, WorkSafe believed it could not take further steps.

270. WorkSafe advised the investigation that:

> … neither the legislation nor the Ministerial Order allow [WorkSafe] to direct the self-insurer to accept a claim for compensation or to reinstate benefits to an injured worker if the decision does not meet WorkSafe's requirements.

271. As such, WorkSafe considers it is limited in the extent to which it can intervene in a claim outcome, even where, in their opinion as the system's regulator, they find a decision to be incorrect or unsustainable.

272. WorkSafe tries to make an impact on self-insurers' decisions by making recommendations – for example, recommending they seek further IME reports, seek further non-medical evidence or simply they change their decision. However, in most cases WorkSafe does not know what happens after it completes its audits.

273. One issue is that the WorkSafe team conducting the audits does not have access to the relevant claim file once the Quality Decision Audit has been finalised.

274. Second, WorkSafe in the past has not followed up with the self-insurer to determine whether its recommendations on individual claims have been implemented. In February 2023, WorkSafe advised the investigation it would implement a new practice of verifying whether the self-insurer had implemented the recommendations. However, it would only do this on claims where the self-insurer agreed with WorkSafe's findings. WorkSafe stated it did not consider it had the power to take any action where a self-insurer disagrees. So, this new approach is still limited.

275. WorkSafe is also improving the timeliness of Quality Decision Audits for self-insurers. Audits currently occur up to six months after the decision. At that stage, some decisions have already been the subject of conciliation and been ruled a genuine dispute. WorkSafe explained as time passes and disputes escalate, it is harder to get a self-insurer to change their position.

276. Case study 14 demonstrates a self-insurer not giving appropriate weight to a medical opinion. Despite WorkSafe finding the self-insurer and their agent were wrong, and that the decision to reject the claim was unsustainable, no action was taken when the self-insurer disagreed.

Case study 14: Web searches used to deny claim, WorkSafe says this is wrong but takes no further action

A process worker made a claim for a mental injury.

The self-insurer's agent obtained an IME report to determine liability. The report stated the worker developed a medical condition 'in response to a situation with a co-worker that had arisen in the workplace'. Records from the worker's treating healthcare provider and a circumstance investigation corroborated that the injury was work-related.

An email from the agent to the self-insurer stated the treating healthcare provider's 'notes do suggest that [the worker's medical condition] is associated with interactions with [another employee]'.

Nevertheless, the agent issued two notices to the worker rejecting the claim. The second notice stated one of the reasons for rejection was evidence obtained via internet searches.

The worker was taking prescribed medication for an unrelated medical condition. The self-insurer conducted web searches it claimed brought to light that possible side effects of this drug were similar to the injured worker's symptoms.

WorkSafe completed a Quality Decision Audit and determined that decision was not supported by the evidence. WorkSafe assessed that the information available at the time of the decision indicated a new injury had been sustained as a result of work.

The self-insurer argued its position the worker's symptoms were medication-related. WorkSafe responded:

> It is not considered appropriate to utilise Google searches to obtain information about potential side effects and causes of conditions when determining liability and that medical opinions should only be considered in these instances.

The self-insurer refused to change its decision and our review of the file did not show any further action by WorkSafe.

277. Case study 15 provides another example of where the decision of a self-insurer, and their agent, was wrong. Even though the self-insurer's agent agreed with WorkSafe's Quality Decision Audit finding flaws in the decision, it was not changed.

Case study 15: 'None of the grounds are supported by the evidence'

A worker claimed weekly payments and medical expenses for a mental injury following alleged bullying at work.

The self-insurer's agent rejected the claim on eight grounds. In its decision letter, the agent selectively quoted an IME report, including that other matters might be contributing to the worker's condition. The letter left out the work-related circumstances reported by the injured worker.

The Quality Decision Audit by WorkSafe concluded that '... none of the grounds are supported by the evidence ...'. WorkSafe found:

- the circumstance report confirmed an interpersonal conflict with a colleague and an incident between them had occurred
- the worker ceased work following the confirmed incident
- the IME supported that a medical condition was sustained due to the worker's perception of bullying.

WorkSafe said 'all the evidence confirms that the worker sustained [an injury] related to employment so [their] condition would be compensable'.

WorkSafe also stated the rejection notice sent to the worker did not meet requirements as it did not explain the decision or link the grounds for refusal to the evidence, and was confusing.

The agent accepted WorkSafe's assessment.

As the agent had not advised WorkSafe of a change in its decision, the investigation reviewed the file.

We found the agent did not overturn its decision. Rather, during conciliation, the agent maintained the decision to reject the claim but offered the injured worker eight weekly payments and $4,000 in medical expenses to settle the matter. The injured worker accepted.

The file also revealed the worker needed further medical treatment after the settlement was reached. The agent said any further treatment would need to be funded by the worker.

The worker was also having difficulty returning to work because they were required to return to the same role, with the same staff, despite the IME report stating the worker should not return to that workplace and recommending a transfer. As the claim was rejected, and the self-insurer did not admit any liability, it did not have to assist the injured worker to return to work.

278. While WorkSafe does not have the power to direct self-insurers, it does have the power to consider self-insurer's claim management performance as part of its renewals process. At this time it also considers the occupational health and safety performance and the financial sustainability of the self-insurer.

279. Quality Decision Audits are a useful source of data for WorkSafe in this regard, as the claims are audited in detail by WorkSafe's own claims specialists. This material has been used in only a few renewal processes since 2022.

Health checks

280. WorkSafe's 'health checks' are used to monitor the introduction of new legislative requirements or when a theme emerges from audits or other oversight activities.

281. Health checks are conducted ad-hoc across both parts of the scheme – WorkSafe agents and self-insurers. In 2021 for example WorkSafe conducted a health check to look at IMEs who had been engaged by, or on behalf of, a self-insurer in the past year. WorkSafe did so as they had received information that self-insurers and their agents were using non-approved doctors to complete IME reports.

282. WorkSafe found more than one in 20 medical examinations it reviewed were conducted using a non-approved IME. WorkSafe reminded self-insurers and their agents such reports would be invalid under the WIRC Act.

283. WorkSafe has continued to monitor this without further issues being identified.

284. This demonstrates health checks can be an effective mechanism for change, when regulatory activity identifies an emerging issue.

Injured worker surveys

285. WorkSafe actively seeks feedback from injured workers. Every year it surveys a selection of workers on an array of topics including overall satisfaction, communication, independent medical examinations, health and wellbeing and returning to work. The surveys cover both WorkSafe agents and self-insurers and result in individual and aggregate 'all [WorkSafe] agent' or 'all self-insurer' scores.

286. Some self-insurers have very few claims. WorkSafe considers the minimum number of respondents required for a meaningful survey result is 20. Self-insurers with fewer claims do not receive individual results, but their claims are included in aggregate scores.

287. WorkSafe considers 75 per cent a strong satisfaction score. Historically, self-insurers' scores have remained around 10 per cent lower than the 'all agents' score. 'All agents' scores ranged from 71–74 per cent between 2019 and 2022. 'All Self-insurer' scores during the same period ranged from 62-64 per cent.

288. Survey data showed many self-insurers' average scores below 75 per cent in the past seven years. Only one with a score of 76.5 per cent exceeded the average satisfaction level of the 'all agents' score across this period.

289. There is scope for self-insurers to influence the result of surveys. Self-insurers are asked to identify any claimants who should be legitimately excluded on the grounds they have threatened to harm themself or others, or because of current litigation.

290. Figure 7 shows an email chain in which a claims staff member from a self-insurer's agent asks a senior manager for a worker to be excluded from the survey because they complained to a Government Minister. The self-insurer agent's spreadsheet to WorkSafe said the reason was 'Risk of harm to self. Notable behaviour'.

291. Figure 8 shows the response from another of the self-insurer agent's claims officers seeking all injured workers whose claims they had rejected or terminated be excluded from the satisfaction survey. In the end, the self-insurer agent did not ask WorkSafe to exclude the four workers from the survey because agent management did not consider the email request from the claims officer when finalising the list of workers to exclude.

292. In response to the draft report, the self-insurer agent said extra emails it held provided further context. The agent submitted that under time pressure to get the information to WorkSafe, the manager providing the list did not wait for staff input or consider the requests by staff referenced in these emails. The manager simply excluded all injured workers with flags on the self-insurer agent's system identifying them as at risk of harm, having known aggressive or threatening behaviours, or 'do not contact' requests. This raises questions about how injured workers are excluded from satisfaction surveys, and WorkSafe's oversight of this process.

293. WorkSafe told the investigation it ultimately excluded 'a handful' of the 68 workers the self-insurer agent requested be excluded but did not provide further details of why. The emails and the attempts to remove injured workers from the survey list by the self-insurer agent staff indicate WorkSafe needs to do more to ensure lists are validated and exclusions are necessary.

Figure 7: Emails between self-insurer agent's staff discussing exclusion of worker from satisfaction survey for complaining to Minister

From: [Agent Claims Team Leader]
Sent: Tuesday, 22 February 2022 3:50 PM
To: [Agent Claims staff]
Cc: [Agent Claims staff]
Subject: RE: [Self-insurer] Injured Worker Survey
Importance: High

Hi team,

Please see a list of claims up for Injured worker survey that I need reviewed asap.
I require you all to go through the list of your claims and highlight which ones are not appropriate to be contacted.
Reasons could include

- Litigation, common law
- Threat of harm to self or others

Once identified please provide me with an email listing which claims are not appropriate to be contacted.

Regards,

[Agent Claims Team Leader]

From: [Agent Senior Manager]
Sent: Wednesday, 23 February 2022 10:44 AM
To: [Agent Claims Team Leader] [Agent Claims staff]
Cc: [Agent Claims staff]
Subject: RE: [Self-insurer] Injured Worker Survey
Importance: High

Hi team,

I need this information back asap, as this is due to WorkSafe this morning and I don't have any extensions.

Apologies for the short notice, we didn't have much time to complete this. For your claims if there is any worker who you think it would be inappropriate to contact (suicide risk, aggressive behaviour, do not contact requested).

Please email me back with that claim number and a note as to the reason for exclusion.

Thanks heaps,

[Agent Senior Manager]

Your feedback is critical to helping us improve your customer experience
You may receive a survey from [Agent] about your experience. Completing this survey helps us to better understand how we can improve our customer service so I encourage you to respond.

If you have any concerns that have not been able to be resolved you can email [Agent email].

Figure 7: Emails between self-insurer agent's staff discussing exclusion of worker from satisfaction survey for complaining to Minister – continued

From: [Agent Claims Officer]
Sent: Wednesday, 23 February 2022 12:16 PM
To: [Agent Senior Manager]
Cc: [Agent Claims staff]
Subject: RE: [Self-insurer] Injured Worker Survey

Hi [Agent Senior Manager],

I've had a look through the claims and have two that possibly shouldn't be contacted.

[Claim number] – [Name of injured worker]

This claim was recently transferred over to me. However, could see that the [injured worker] submitted a complaint to the Minister handling worker comp and was being managed by yourself and [Agent Claims Staff].

[Claim number] – [Name of injured worker]
[Injured worker] has recently resigned from [self-insurer] and is not in a healthy head space.

[The injured worker has stated suicidal ideation] …

Kind regards,

[Agent Claims Officer]

Remember to include a claim number on all your correspondence with [agent], you'll help us make sure we process your information quickly

Source: Self-insurer's agent

Figure 8: Email from self-insurer agent's officer to manager asking to block workers with rejected or terminated claims from completing satisfaction survey

From: [Agent Claims Officer]
Sent: Wednesday, 23 February 2022 9:34 AM
To: [Agent Team Leader]
Cc: [Agent Claims staff]
Subject: RE: [self-insurer] Injured Worker Survey

Hi [Team Leader]

I have highlighted my rejected or terminated claims in yellow. I think it's not reasonable to request that they complete the survey as they no longer have any entitlements and this will impact the survey.

Do not hesitate to contact me if you'd like to discuss this or anything else further.

Kind regards,

[Agent Claims Officer]

Your feedback is critical to helping us improve your customer experience

Source: Self-insurer's agent

294. WorkSafe's staff discuss the survey results with self-insurers and include them in yearly reports. WorkSafe added that:

> … where the results for an individual self-insurer are markedly different to a previous survey result … [WorkSafe] may request the self-insurer provide an explanation and a remedial plan to address the survey result.

295. Practice example 2 shows an instance where WorkSafe acted following a drop in satisfaction among a self-insurer's injured workers. While WorkSafe took some action, its subsequent lack of follow-up allowed problems to continue without effective intervention for years.

Practice example 2: WorkSafe asks self-insurer to improve low worker satisfaction, but fails to follow-up

WorkSafe regularly conducts surveys of injured workers to measure perceived satisfaction. Participants are questioned about key elements of service, and are also asked to provide a 'prompted satisfaction' rating for their overall experience.

In 2017-18, the 'prompted satisfaction' rating for one self-insurer was 45 per cent. This increased the next year to 72 per cent, but fell to 51 per cent in 2019-20. Detailed results indicated some surveyed workers felt they weren't kept well-informed, and were not always listened to or well understood. Some also indicated they experienced slow service, and perceived bias.

WorkSafe asked the self-insurer if there were any mitigating factors contributing to the declines, and what improvement actions the self-insurer would take.

The self-insurer said the COVID-19 pandemic and information technology issues had affected its scores. It advised it had implemented its own online injured worker survey to be conducted twice a year to monitor sentiment and identify issues. It also advised a central administration team would ensure injured workers had a consistent location to submit information.

There appears to have been no further communication between WorkSafe and the self-insurer about the issue until after the 2020-21 survey.

By this time, the 'prompted satisfaction' score had dipped to 50 per cent.

A WorkSafe report on this noted a 'general downward pattern' and stated:

> There were four themes of almost equal importance in driving dissatisfaction with service this wave; a perception of uncaring or unhelpful service, not enough communication or information being provided, unfair treatment and poor consideration of injuries.

This is reflected in some of the comments made by injured workers in the survey:

> I had recommendations about my workload. [The self-insurer] ignored this. They were trying to force me to do what my doctor had advised against.
>
> They seem to be worried about their own welfare and not mine.
>
> Continuing issues with payments and pressure to get back to full duties.
>
> [The self-insurer] has a complete lack of understanding of my injuries and tries every conceivable loophole in an attempt to dishonour their responsibilities under the Act
>
> [The self-insurer] will do anything to say it's not WorkCover.

WorkSafe again asked the self-insurer about any mitigating factors and measures to address issues. However, when asked by the investigation, WorkSafe could not locate the response. Again, there was no follow-up.

The poor results continued in 2021-22 with prompted satisfaction remaining at 50 per cent. Again, WorkSafe sought a response from the self-insurer, and again, WorkSafe did not have a copy of the response.

Despite more than five years of poor results in injured worker surveys, WorkSafe did not take any further action or require the self-insurer to take any specific action.

296. In addition to the informal discussions and communications WorkSafe has with self-insurers about their results, the surveys are meant to inform the reapproval process.

297. WorkSafe's guidelines note when assessing for being 'fit and proper' it will generally consider the survey results for 'service score' and 'overall prompted satisfaction'. It is also required to consider 'any programs the self-insurer has put in place to address the overall satisfaction of injured workers'.

298. In Practice example 2, the downward trend and below-par scores of the self-insurer did not seem to influence the reapproval decision. WorkSafe needs to address this issue.

Complaints

299. At any point in the claims process, an injured worker can complain to WorkSafe about the management of their claim. This complaint process was centralised and better resourced following the Ombudsman's 2019 investigation.

300. WorkSafe has created detailed specific guidance material for its complaints staff for complaints about self-insurers.

301. WorkSafe received 169 complaints – an average of about 65 per year – about self-insurers between 1 December 2019 and 30 May 2022.

302. We compared self-insurers' percentage of complaints to their share of the self-insurance market to see if they were over-represented in complaints. As with Quality Decision Audits, complaint numbers for most self-insurers did not align with market share. For some self-insurers complaint numbers were much higher and for others much lower than expected. Eleven self-insurers drew no complaints.

303. Complaint numbers are not always a good representation of performance, or worker satisfaction. For example, some injured workers may be discouraged from complaining to WorkSafe or the Ombudsman, while other self-insurers may actively promote these options. Accordingly, WorkSafe must do more to interrogate this data alongside other sources of information such as surveys, health checks and audits to form a comprehensive view of where problems lie and where to target its resources.

304. BlueScope told the investigation that, given the number of claims self-insurers would have received during this period, it could be concluded most claimants were satisfied with their experience.

305. Our analysis showed of the 169 complaints, 34 were substantiated by WorkSafe, either partially or in full.

306. The substantiated complaints related to 13 self-insurers, 11 of whom are still currently approved as self-insurers.

307. WorkSafe told us that when complaints are substantiated:

- WorkSafe notifies the self-insurer
- the complaint forms part of the self-insurer's performance assessment documented in an annual report card to each self-insurer
- the complaint is considered as part of the approval renewal process.

308. We reviewed three recent yearly reports for self-insurers with substantiated complaints and found in five cases WorkSafe failed to mention them. The CEO receiving their annual report card should be provided with this essential information.

309. Positively, we also saw evidence that WorkSafe acts promptly to assess complaints, draws them to the attention of the self-insurer, and seeks a practical resolution.

310. WorkSafe's *External Guideline #3: Assessment of application for renewal of approval as a self-insurer* notes that:

> WorkSafe will generally consider the following information and indicators for being fit and proper:
>
> - The number and nature of complaints
> - Whether or not complaints have been substantiated
> - Whether there are recurring themes in complaints
> - Whether there are any issues or trends arising from complaints.

311. In practice, complaints may have little impact on reapproval. Practice example 3 shows how complaints about a self-insurer were identified but the maximum term for reapproval was granted anyway.

Practice example 3: Many complaints but self-insurer still approved for maximum six-year term

A self-insurer applied to renew their approval.

During the initial approval term WorkSafe had received a high number of complaints about the self-insurer, which employs a significant number of staff. Twelve of the 31 complaints received over a three-year period were substantiated, including four about non-compliance with the legislation.

As part of WorkSafe's assessment, it used five indicative performance benchmarks to decide if the self-insurer should get the maximum reapproval term. The self-insurer failed to meet two of these benchmarks.

Complaints are considered as part of the 'audit performance' benchmark, which the self-insurer did not meet. They also only partially met the 'incidence of injury' benchmark.

Despite these results, WorkSafe granted the maximum six-year approval term, which involves less oversight than the standard four-year approval.

WIC Feedback

312. WIC is well placed to provide information about issues with self-insurer's claims management practices.

313. This aligns with WorkSafe's *External Guideline #3 – Assessment of application for renewal of approval as a self-insurer* which says that as part of renewal applications they will consider self-insurer conduct at conciliation including:

    - timely and proper participation and cooperation with WIC
    - Prompt implementation of conciliation agreements and directives
    - any other issues raised by WIC.

314. WorkSafe told the investigation that they speak with WIC staff regularly and are always open to feedback. It acknowledged that it only formally seeks WIC's feedback on self-insurer conduct at the time of renewal of approval. Only formally requesting information at the renewal stage is problematic and this is another lost opportunity for WorkSafe, especially if the self-insurer is approved for a six-year term.

315. The investigation found an example where WIC was concerned about issues with a self-insurer's conduct at a conciliation held in June 2021, yet WorkSafe did not become aware until 20 months later when they sought feedback as a part of approval renewal.

Practice example 4: Self-insurer's 'most difficult' conduct at conciliation

In November 2022, WorkSafe sought information from WIC about a self-insurer to help decide on reapproval.

In February 2023, WIC provided details of several cases involving the self-insurer it had tried to conciliate in recent years. WIC said during these conciliations, claims management staff:

- engaged in an adversarial way
- behaved in a way that was 'aggressive and inconsistent with its obligations to engage in our process and support appropriate entitlements'
- made efforts to prevent referrals to the Medical Panel
- involved lawyers early in the process
- failed to make meaningful efforts to resolve the dispute.

A Conciliation Officer commented to WorkSafe:

> I can say with equal confidence and disappointment [this self-insurer] is probably the most difficult self-insurer we deal with …
>
> I have spoken with [claims staff] on a number of occasions, when [Conciliation Officers] have escalated disputes to me. These conversations have highlighted [the claims staff's] consistent failure to engage meaningfully in the dispute resolution process … [they have] regularly employed an adversarial approach by engaging [a lawyer] to communicate on [their] behalf. [Their] focus on worker 'credit' issues is predictably obstructive.
>
> [The claims' staff] seem to take the lodgement of claims personally and therefore has great difficulty applying an objective and constructive approach to the resolution of disputes.

WorkSafe advised that it escalated this issue and the self-insurer met with WIC soon after the matter was raised with WorkSafe to attempt to resolve the issue.

316. It is concerning that WorkSafe was not aware of this serious criticism for such a long time.

317. WIC can offer feedback on its own initiative, although in practice they consider this to conflict, to a degree, with their independent role. WIC suggested that although WorkSafe is receptive to feedback, the regulator was perhaps at times unable to act because of the limitations of its oversight powers.

318. WorkSafe acknowledged if WIC raised concerns of repeated issues with a self-insurer, WIC would be advised to raise this directly with the self-insurer.

319. As the regulator, WorkSafe should ensure systems are in place for WIC to notify it of performance and conduct concerns at conciliation. Self-insurers must then be informed of serious issues promptly to give them the opportunity to address concerns. WorkSafe has specific obligations to ensure self-insurers are 'fit and proper' throughout the life of their approvals.

Reapproving self-insurers

320. At the end of their initial term of approval, self-insurers apply for reapproval. WorkSafe must be satisfied that they continue to be 'fit and proper'.

321. WorkSafe tells self-insurers they must:

    - have appropriate resources in place to ensure high performance in administering claims
    - conform with WorkSafe's audit standards
    - have a strong history in claims management, occupational rehabilitation and return to work
    - comply with the WIRC Act
    - participate appropriately in conciliation
    - have strong results in worker satisfaction surveys
    - have few substantiated complaints, which should be resolved in a timely manner.

322. The reapproval process is a significant oversight mechanism. The list above indicates most of the monitoring activities conducted by WorkSafe will be factored into its reapproval decision. WorkSafe tells self-insurers it expects them to demonstrate a high standard and continuous improvement. This instruction needs to be matched by a firm regulatory approach by WorkSafe when the evidence shows otherwise.

323. WorkSafe told the investigation it undertakes a comprehensive assessment of whether a self-insurer remains 'fit and proper'. However, not all the information WorkSafe collects through its monitoring activities is considered.

324. WorkSafe's 'comprehensive assessment' at reapproval did not consider the quality of self-insurer decision-making on claims until 2022, despite WorkSafe collecting detailed information about this since 2019. Quality Decision Audit fails indicate problems ranging from poor communication with injured workers, to repeated breaches of the Claims Manual and the WIRC Act.

325. WorkSafe also has a useful source of information in self-insurers' responses to its negative Quality Decision Audit findings. While self-insurers do not always respond, the nature and tone of received responses ought to be considered more by WorkSafe during the reapproval process, particularly where they demonstrate limited understanding of sustainable decision-making.

326. WorkSafe is also meant to consider whether self-insurers genuinely engage in conciliation. We found no evidence of a strong regulatory response when self-insurers, their agents or their legal teams, behave in a way that is contrary to the guidelines or intentions of conciliation.

327. In Case study 13, where a self-insurer agent tried to get a genuine dispute declared without having to conciliate, WorkSafe reviewed the case and found the self-insurer had:

> … [a] reluctance … to attend face-to-face conferences at conciliation due to resource issues … and at conciliation … they were [noted by WIC to be] uncooperative, obstructive and failed to provide material in a timely manner.

328. Despite this, WorkSafe found the self-insurer was 'fit and proper'. WorkSafe decided the poor attitude to conciliation and other performance issues could be addressed by placing a condition on the reapproval. In this instance the self-insurer was reapproved for a standard four-year term, but we also saw self-insurers with poor performance granted six-year terms.

329. WorkSafe has stated they reapprove self-insurers with performance issues as they do not wish to take a 'punitive approach'. They want to collaborate with and educate self-insurers to improve practices. While this can be constructive, some of the case studies in this report raise the question of just how bad a self-insurer's conduct needs to be before their approval is reviewed, made conditional or revoked.

Discretion to approve for six years instead of four

330. At the time of reapproval, WorkSafe also decides the length of the new term. The standard term is four years, but WorkSafe can approve a term of six years. The investigation was troubled by WorkSafe's tendency to use its discretion to approve six-year terms for self-insurers with claims management performance issues.

331. There are advantages to securing a six-year term and self-insurers would understandably prefer it. Both the reapproval process itself and the audit regime are less frequent.

332. The six-year term should be reserved for consistently high performing self-insurers with a proven track record of best practice.

333. However, WorkSafe's guideline for reapproval states:

> In applying its discretion to grant a self-insurer an approval for a six-year period, WorkSafe will consider the self-insurer's performance against indicative performance benchmarks. A self-insurer may be recommended for a six-year period of approval, even if all the indicative performance benchmarks have not been met.

334. The investigation saw other examples of WorkSafe approving six-year terms for self-insurers that were not strong performers.

Practice example 5: WorkSafe reapproved self-insurer for six-year term despite compliance issues

About six years ago, the self-insurer was nearing the end of its term and applied for reapproval.

WorkSafe's assessment found the self-insurer did not meet occupational health and safety related performance benchmarks used to consider a six-year approval term because:

- the OHS audit found non-compliance in 13 key criteria; the benchmark is 'four or fewer'
- it had a 32 per cent non-compliance rating on the remaining audit criteria; the benchmark is 15 per cent
- it had three recurring safety system failures over the course of their current approval.

The team responsible for the assessment recommended a standard four-year term be approved.

Other WorkSafe managers 'carefully considered' the team's recommendation but advised a six-year term. In a briefing, WorkSafe's CEO was told such a recommendation would be unusual:

> Since the introduction of legislative changes allowing the exercising of discretion to provide a six-year approval, the discretion has been rarely (and only recently) exercised for renewing self-insurers who did not meet the 'primary' six-year considerations.
>
> The main risk associated with granting [this self-insurer] a six-year approval is that other self-insurers may see your decision regarding [this self-insurer]as being inconsistent with previous renewal decisions, creating pressure on future decisions. The option to grant [this self-insurer] a four-year would be based on sound WorkSafe guidelines and would also be consistent with the majority of previous renewal decisions.

The WorkSafe CEO was told the self-insurer had 'fully addressed' the non-compliance and was 'considered a general good performer'. The CEO was advised that granting this self-insurer a six-year term was likely to be consistent with a new guideline that had not been written yet:

> the recommendation to grant [the self-insurer] a six-year approval is consistent with changes that may be implemented in the future.

335. A couple of years ago, WorkSafe audited a self-insurer prior to its renewal. The self-insurer received a compliance rating at the bottom of Tier 2 for its Claims Management Audit. They received some poor results in key areas – less than 10 per cent compliance for accurately calculating pay rates and about 30 per cent for providing injured workers with all appropriate information.

336. WorkSafe assessed the self-insurer as having sufficient resources to manage claims and being 'fit and proper'. The self-insurer only met two of the four benchmarks relevant to it for consideration of a six-year term. It partially met a third and failed to meet the fourth. Nevertheless, WorkSafe granted a six-year term.

337. WorkSafe places a great deal of faith in the good intentions of self-insurers even when it sometimes has information to the contrary. As detailed in Case study 16, WorkSafe started prosecuting a self-insurer for repeated case management failures and alleged breaches of the WIRC Act. When giving the self-insurer notice of its reapproval, WorkSafe explained the decision to grant the maximum six years was in part because it believed the self-insurer would not commit further offences.

338. If the discretion to give a six-year term instead of the standard four is exercised so often that it is now actually the exception for a self-insurer to be granted a standard four-year term, then WorkSafe's risk-based approach to regulation needs revision. Their approach ought to be based on only the top performers being approved for the maximum term, not this being the standard. Otherwise the effectiveness of discretion and the usefulness of one of the few levers available to WorkSafe to encourage improvement is undermined.

Managing poor performance by self-insurers

339. There are two main mechanisms WorkSafe can use to regulate self-insurers outside of the reapproval process: section 384 reviews which can lead to approval being revoked, and enforcement actions.

'Fit and proper' review under section 384 of the WIRC Act

340. WorkSafe has the power to review the approval of a self-insurer 'at any time'. If it is 'no longer satisfied' that the self-insurer is 'fit and proper' it must conduct a review under section 384 of the WIRC Act.

341. Other situations which trigger a review are set out in section 384 of the WIRC Act, including when self-insurers experience liquidity problems, or are subject to merger, acquisition, restructure, or foreign ownership.

342. These reviews are broad in scope. WorkSafe can use existing performance reports, audits, and consultations with external bodies to verify relevant information. In some cases, WorkSafe may convene a panel of senior staff to consider the material obtained and hear submissions from stakeholders before making recommendations.

343. After the review, WorkSafe can impose conditions on the self-insurer or revoke their approval if no longer satisfied that the self-insurer is 'fit and proper'.

344. In practice, revocation of a self-insurer's approval under the WIRC Act has never been pursued because of a self-insurer's claims management practices. WorkSafe said:

> To the best of our knowledge, there is no evidence that WorkSafe made a decision to terminate/revoke a self-insurer or not re-approve a self-insurer due to issues with claims management in the last twenty years.

345. This is despite WorkSafe identifying repeated issues in claims management with some self-insurers, including errors calculating entitlements appropriately, poor conduct at conciliation, decisions not made in accordance with the WIRC Act and failures to comply with Directions as highlighted in the case studies.

346. WorkSafe has only conducted one section 384 review due to claims management practices.

Practice example 6: WorkSafe's concerns about self-insurer and its agent prompt 'fit and proper' review, conditions removed after objections.

WorkSafe conducted a review to determine if the self-insurer was 'fit and proper' after compliance issues.

The non-compliance and claims management issues included:

- a self-audit showing errors in calculating injured workers pay more than 50 per cent of the time
- a Quality Decision Audit of four cases with a 75 per cent overall pass but a zero per cent pass rate for 'initial decisions' the self-insurer later incorrectly described in correspondence with WorkSafe as a '100% compliance rate'
- a second Quality Decision Audit of 15 cases with a 47 per cent pass rate (the self-insurer disagreed with all except one of WorkSafe's assessments and changed none)
- a WIC assessment a decision was 'unsustainable'
- feedback from WIC about the self-insurer's conduct at conciliation.

WorkSafe also revoked an agent's approval to manage the claim. WorkSafe said a remedial action plan to address the systemic pay calculation issues was 'not necessary'.

Ultimately WorkSafe allowed the self-insurer to continue on the conditions it:

- provide copies of its decisions and payment calculations to WorkSafe every month
- inform WorkSafe if its 'resources for administering claims' changed
- ensure appropriate representation and attendance at conciliation, including conduct in accordance with the Ministerial Guidelines.

Eight months later at reapproval, the self-insurer told WorkSafe the conditions were 'disproportionate and unnecessarily onerous' and should be removed or amended. WorkSafe agreed to some of the requests, including that all conditions be removed after a further three months rather than remain in place for the four-year term.

WorkSafe said the decision to remove these conditions followed a review. WorkSafe was satisfied the self-insurer's performance in calculating pay and Quality Decision Audits had significantly improved. WorkSafe noted that after the conditions were withdrawn, the self-insurer remained subject to normal regulatory oversight.

347. In Practice example 6, WorkSafe could have constructed conditions that required meaningful and measurable changes to the self-insurer's practice at conciliation to manage the risk to injured workers. WorkSafe did not do this, a lost opportunity.

348. The ability to impose conditions on self-insurers is a powerful tool. Many of the issues highlighted in the case studies throughout this report could usefully have been subject to a formal review.

Enforcement action

349. As a last resort, WorkSafe can take enforcement action to prosecute self-insurers alleged to have committed offences under the WIRC Act. In practice this happens very rarely.

350. When deciding whether to prosecute and what enforcement action should be taken, WorkSafe considers the sufficiency of the evidence and the public interest, in accordance with its General Prosecution Guidelines and its Compliance and Enforcement Policy.

351. Prosecutions of self-insurers who commit offences under the WIRC Act can attract a financial penalty, and some carry possible prison terms.

352. According to its prosecution guidelines, WorkSafe is targeting 'offences by employers that unduly delay a worker's access to entitlements, for example, failing to make weekly payments and 'breaches by self-insurers'.

Case study 16: Self-insurer refuses to make payments, even when ordered to do so, but WorkSafe drops prosecution

An injured worker lodged a complex claim but their self-insurer rejected it.

The worker took the matter to conciliation two months later. As a result, the self-insurer withdrew its decision and accepted the claim.

Nearly three months later, after WIC engaged in negotiations and sent a draft Direction, the self-insurer wrote to the worker advising it had accepted the claim for weekly payments and medical expenses. The same day, the worker received a second letter advising it was terminating all entitlements based on new evidence.

The worker said they complained to WorkSafe about the management of their claim. The worker again took the matter to conciliation. This took another three months. The worker described this as 'an awful experience'.

WIC directed the self-insurer to pay the injured worker weekly payments and said there was 'no arguable case [for] denial of liability'. This obliged the self-insurer to make the payments within seven days unless the decision was overturned.

Sixteen days after the Direction was issued, the worker's representative contacted the self-insurer as payments had not been made. The self-insurer said it was appealing WIC's decision at court, and would not make interim payments.

WorkSafe became aware and asked the self-insurer to make payments. The self-insurer refused, arguing because past appeals were determined within seven days (with seven days to pay) it would not pay this worker. This appeal was taking longer due to COVID-related delays.

The self-insurer described the court delay as putting it in 'an untenable position through no fault of our own'. The situation left the injured worker out of pocket until the self-insurer lost the appeal and started making payments – 10 months after the claim was made.

WorkSafe began prosecuting the self-insurer for two offences under the WIRC Act. After nine months, the self-insurer agreed to an Enforceable Undertaking, requiring it to take certain actions in return for not facing a prosecution.

The self-insurer acknowledged the 'alleged contraventions of the law'. They also agreed to training staff, reporting WIC Directions, and donating $10,000 to a community legal centre. The self-insurer told the investigation it deeply regretted the episode and had taken steps to mitigate the prospects of any recurrence.

353. As shown in Case study 16, WorkSafe may accept a written undertaking given by a self-insurer for breaches of the WIRC Act, excluding the most serious offences, such as those which carry a term of imprisonment. The prosecution is then discontinued.

354. When weighing whether to prosecute, WorkSafe is required to consider the public interest. It should take into account the nature and circumstances of the offending and the characteristics of the offender. WorkSafe should also give regard to its own guidelines for prosecution and consider 'the extent to which the alleged offender has acted in accordance with any advice given by WorkSafe in relation to its obligations'.

355. The public interest test reasonably includes considering whether prosecution would act as a specific deterrent to the self-insurer, and a general deterrent to other self-insurers.

Conclusions

356. This investigation was quite targeted in scope and focused on a relatively small number of self-insurer cases. Overall, some self-insurers are performing well and delivering the benefits the system intends, such as immediate and continuous care informed by knowledge of the workplace. However, the cases we examined in detail exposed large differences in practice and capability.

357. The current claims management process and oversight of self-insurers does not always produce fair or equitable outcomes for workers.

358. Injured workers, advocates and sector experts told us that financial settlements, early intervention programs and dispute resolution processes can all be misused. Despite clear feedback from WIC about the failure by some identified self-insurers to engage meaningfully at conciliation, the current regulatory regime is not able to stamp out this conduct. Injured worker surveys and complaints can also be distorted and have a diminished value if they are not accessible to all workers and do not result in action from WorkSafe to address recurring and serious issues.

359. Our case studies highlight examples where self-insurers can learn from poor outcomes, as well as positive practices that show what can be achieved with the right approach. Most self-insurers and their agents acknowledged the case studies identify opportunities to improve claims outcomes or practices.

360. Some self-insurers told the investigation that WorkSafe operates constructively and collaboratively and implements a strong regulatory program for self-insurance that includes various assurance processes across data, claims and disputes. The investigation found WorkSafe could do more in its role as regulator of self-insurers. While WorkSafe's level of responsibility differs for self-insurers compared to the WorkSafe agent model, they are nevertheless ultimately responsible for ensuring that self-insurers comply with legislation and act with integrity to protect injured workers.

361. Despite having robust powers, expertise and performance-monitoring systems, WorkSafe has not acted swiftly or in a sufficiently targeted way to address some issues with self-insurers who do the wrong thing. It seems WorkSafe has been reluctant to use its existing compliance mechanisms to enforce performance standards. In some cases, WorkSafe has not followed up to confirm the implementation of its own recommendations about decisions which did not comply with the WIRC Act. There are instances where WorkSafe reapproved self-insurers, often for longer than standard terms, without resolving performance issues. It also does not define best-practice claims management.

362. There are some flaws with WorkSafe's default position of education and collaboration with self-insurers. This position works well when self-insurers align their approach to workers compensation with their obligations under the legislation, and they have the insight and capability to change. However, this approach should be balanced with punitive measures to enforce standards when required, sending the message that poor performance will not be tolerated, and that the regulator is watching.

363. There are many regulatory tools available to WorkSafe that could be used more effectively, not least the review and reapprovals processes. The investigation found too often WorkSafe approved self-insurers for the maximum six-year term without evidence of exemplary performance to justify these decisions. In some cases, there were known compliance

issues with these self-insurers. If others see there are no consequences for poor performance, a poor ethical climate can fester.

364. WorkSafe should be empowered to direct self-insurers, as it does its agents, to overturn decisions that are unsustainable or wrong. Without this direction power, WorkSafe is ultimately hamstrung as a regulator if self-insurers or their agents ignore their recommendations or advice. This can force injured workers, who may have no income and be seriously unwell, into contesting their rights in court.

365. WorkSafe presented compelling arguments for having a direction power. It would address a fundamental gap which is limiting the rights and outcomes for injured workers of self-insurers in Victoria. While WorkSafe has reportedly had internal discussions about the issue, disappointingly, it appears not to have taken any meaningful steps to urge amendment to the legislation despite sound public policy reasons for doing so.

366. Improvements and positive changes have been made to the workers compensation system since our first investigation of WorkSafe agents' practices in 2016. WIC's new arbitration power is one, but this is yet to be tested. WorkSafe's use of its ability (through WCIRS) to direct its agents to change an unsustainable decision has led to a system-wide uplift in practice.

367. It is unclear how much change self-insurers have embraced voluntarily given they were not the focus of past investigations, and WorkSafe's different regulatory approach. Some self-insurers consider the current arrangements with WorkSafe are reasonable and claim a proven track record of collaboration with WorkSafe.

368. The evidence gathered in this investigation suggests that the current arrangements do not produce consistent, quality outcomes for injured workers. Where there are gaps, it is important that WorkSafe has the power to direct self-insurers in the way it can with its agents.

369. It is clear WorkSafe needs to conduct a comprehensive review of all self-insurers, and this should include how they engage with WorkSafe. The issues identified in this report may not apply to all self-insurers, and there may be other practices that warrant attention because they do not support or protect injured workers as intended by the legislation.

370. WorkSafe has a central role and under-used potential as a transformative leader and regulator for self-insurers. The investigation identified opportunities to ensure WorkSafe supports self-insurers to understand and implement best practice; lifts benchmarking; and makes quality assurance and public accountability a priority.

371. Until all workers in Victoria who have the right to claim workers compensation also have the same rights when they disagree with a decision, the system will remain fundamentally unfair. Self-insurers say they want independence to offer more to their valued employees. The proof of these intentions is evident every time an injured worker makes a claim.

372. Some workplace injuries are catastrophic. Some people are never able to work again. So, when a worker is having their worst day at work, self-insurers need to bring their best. In the public interest, all Victorian workers deserve the protection of a fair, equitable and accountable statutory compensation scheme.

Responses to the investigation

373. While 22 self-insurers did not offer a substantial response to the investigation's draft report, those who did demonstrated an openness to making continuous improvements.

Figure 9: Comments from self-insurers

"We appreciate receiving the Ombudsman's findings and will maintain ongoing review of our practices to ensure our injured employees (and former employees) continue to receive procedural fairness together with fair and equitable treatment."

– Viva Energy

"[Agent] Gallagher Bassett endorses the preliminary conclusions contained in the draft report and is committed to working with our self-insured clients to implement recommendations that might flow from these conclusions."

– Gallagher Bassett

"In 2022, [we] completed an end-to-end review of Injury Management and Workers Compensation … a strong focus was placed on injury & illness prevention, severity reduction and an industry best practice lens on recovery and return to work processes. … [We have learnt that] we have the opportunity to … focus on enhanced team member experience that is consistent across the Group."

– Woolworths

"We have reviewed the report in detail and support the preliminary conclusions of the investigation … We are in the process of transforming our approach to Workplace Health and Safety, including the rehabilitation and compensation activities … As a result we have independently started to make changes across our organisation that align to your draft report."

– Paper Australia

"We wholeheartedly agree that if best practice is embedded in performance standards, the rights of injured workers will be better protected."

– Mondelez

"We … are committed to high standards and leading strategies in all aspects of business operations, including workplace health and safety, maintaining a positive culture and supporting the general well-being of employees."

– Wesfarmers

"We will build [your recommendations] into our Workers Compensation policies to ensure that we manage claims to the best standard we can."

– Food Investments

Source: Self-insurers responses to our draft report

374. Some self-insurers were displeased with the Ombudsman's decision to withhold the names of self-insurers involved in case studies and practice examples. They were not themselves the subject of these examples and wanted the Ombudsman to make this clear in her report. This was not possible as it had the potential to identify the injured workers in the case studies. The Ombudsman is committed to transparency and recommends WorkSafe make public performance information for all self-insurers.

375. Two self-insurers opposed legislative and practice changes enabling WorkSafe to have the power to direct a self-insurer to change unsustainable decisions.

376. Healius argued the power was unnecessary. It stated the draft report showed 'no evidence of widespread inappropriate behaviour by self-insurers' so tools already at WorkSafe's disposal such as education, auditing and conditions on approvals were adequate, and that arbitration needs to 'be given time to work'. Healius said directing a self-insurer would be 'inappropriate' in situations where the self-insurer had legal opinion that the grounds for rejecting liability were defendable in court.

377. BlueScope also objected, claiming no other Australian workers compensation scheme regulator was empowered to direct a self-insurer's decision-making. BlueScope stated such an approach was 'at odds with the fundamental principle of direct ownership of claims decisions and cost borne by self-insurers'. Further, it said WorkSafe were 'no better positioned to interpret complex matters than an insurer, and ultimately a matter may need to be determined in a legal forum'.

378. In saying this, BlueScope agreed injured workers should have access to WCIRS, the team in WorkSafe that reviews disputed decisions of WorkSafe agents and can direct them to overturn a decision. BlueScope also made a commitment to 'improving the experience and outcomes for injured workers'. It acknowledged the complexity of workers compensation and that the 'sometimes-difficult task of recovery should not be impeded by poor claims management'.

379. WorkSafe committed to implementing the recommendations directed to it in this report. WorkSafe believes that it has demonstrated a commitment to improving its oversight of self-insurers. However, it acknowledges that when claims management fails there is an impact upon workers, families and workplaces. While the majority of claims managed by self-insurers meet regulatory and community expectations, WorkSafe stated that it remains resolved to address the issues identified in this report.

380. The Minister for WorkSafe and the TAC responded to the investigation's draft report. The Minister acknowledged the impact inappropriate claims management can have on injured workers and their families and supported the intent of the recommendation to the government to review the WIRC Act. The Minister identified this recommendation is:

> designed to improve regulatory oversight of self-insurers and result in fair and equitable outcomes for injured workers that are employed by self-insurers.

Opinion

381. The Minister stated WorkSafe is fulfilling its obligations in relation to its regulatory oversight of self-insurers, especially in financial liability. Nevertheless, the Minister indicated a willingness to review approval and oversight arrangements in other Australian jurisdictions to identify improvements. The Minister also noted the significant impact WCIRS has had on the quality of WorkSafe agent decisions and promised to:

> work with WorkSafe to explore the potential to extend this mechanism, and its underlying operating principles, to the self-insurance context.

382. As part of its key functions, WorkSafe must ensure self-insurers deliver claims management in accordance with laws designed to protect workers and support them to return to work. WorkSafe is responsible for approving and monitoring self-insurers, developing and enforcing performance standards and promoting good decision-making under the WIRC Act, including acting compatibly with human rights under the Charter of Rights Act.

383. Pursuant to section 23(1)(g) of the Ombudsman Act, the Ombudsman is of the opinion that the actions of WorkSafe in relation to regulation and oversight of self-insurers were wrong in that WorkSafe did not take adequate action to oversee or otherwise regulate self-insurers to promote compliance and performance.

384. This is relevant to cases highlighted in this investigation where WorkSafe was or should have been aware that a self-insurer's, or their agent's, decisions or conduct were contrary to law, the Claims Manual or WorkSafe guidelines, including its sustainable decision-making framework.

Recommendations

Pursuant to section 23(2) of the Ombudsman Act, the Ombudsman recommends the following actions.

To improve regulatory oversight of self-insurers

It is recommended that the Victorian Government and the relevant Minister:

Recommendation 1

Review the *Workplace Injury Rehabilitation and Compensation Act 2013* (Vic) and related Ministerial Orders to:

a. empower WorkSafe to independently review disputed decisions when requested by injured workers of self-insurers following unsuccessful conciliation, and overturn decisions that do not have a reasonable prospect of success at court

b . ensure that compliance mechanisms available to WorkSafe more adequately respond to non-compliance by self-insurers.

The review should include consideration of effective options such as mandatory codes of conduct and approval processes used in other jurisdictions.

To improve the experience and outcomes for injured workers

It is recommended that WorkSafe:

Recommendation 2

Conduct a review of all self-insurers' claims management practices to ensure they align with legislative requirements and the conduct expected of public authorities.

Recommendation 3

Make use of the information collected through audits, injured worker surveys, complaints and other available sources, to better inform the approval and reapproval of self-insurers, including the term of the approval.

To promote better transparency and accountability of self-insurers

It is recommended that WorkSafe:

Recommendation 4

Publish information about self-insurers including:

a. approval conditions

b. tier ratings and approval terms

c. claims management performance information such as injured worker survey results and audit outcomes

d. significant compliance and enforcement activity.

Appendix 1: The investigation

Authority to investigate

385. Under the *Ombudsman Act 1973* (Vic) the Ombudsman's jurisdiction extends to investigating administrative action taken by or in an authority, and whether an administrative action is incompatible with a human right set out in the *Charter of Rights and Responsibilities Act 2006* (Vic).

386. This investigation was conducted under section 16A of the Ombudsman Act, which provides the Ombudsman may conduct an own motion investigation into any administrative action taken by or in an authority.

387. Being a public statutory body as defined in the Ombudsman Act, WorkSafe is an authority within the Ombudsman's jurisdiction. As specified entities under item 18 of Schedule 1 to the Act, self-insurers are also authorities subject to the Ombudsman's jurisdiction.

What the investigation involved

388. On 27 May 2022, the Ombudsman notified the relevant Minister, Chief Executive Officer of WorkSafe, Chair of WorkSafe's Board of Directors and the Chief Executive Officer of the Accident Compensation Conciliation Service (now WIC) of her intention to investigate this matter.

389. Between 27 and 30 May 2022, the Ombudsman notified the Principal Officer of each current Victorian self-insurer of her intention to investigate this matter.

390. The investigation involved:

- Reviewing legislation, including:
  - *Workplace Injury and Rehabilitation and Compensation Act 2013* (Vic)
  - *Accident Compensation Act 1985* (Vic)
  - *Charter of Human Rights and Responsibilities Act 2006* (Vic)
  - *Ministerial Order – Terms and Conditions of Approval as a Self-Insurer (April 2016)*
  - *Ministerial Guidelines in Respect of Conciliation (August 2022)*.
- Reviewing 6,695 pages of WorkSafe's documents, policies and procedures, including:
  - WorkSafe Claims Manual
  - WorkSafe Claims Management Audit – Information pack 2022
  - External Guidelines:
    - #2 – *Assessment of initial application for approval as a self-insurer*
    - #3 – *Assessment of application for renewal of approval as a self-insurer*
    - #4 – *Application for approval of a person to act as an agent of a self-insurer*
    - #6 – *Self-insurer Self-audit program 2021-2022*
    - #11A – *Self-insurance oversight framework for claims management*
    - #14 – *Resources for managing claims*
    - #16 – *Claims management policies for self-insurers*
    - #19 – *Review of self-insurer's approval*

    - WorkSafe Complaints Management Policy
    - Sustainable Decision-Making Reference Guide.
- Reviewing other WorkSafe documents, including:
    - Self-insurer Performance Snapshots (SIPS)
    - Quality Decision Making Audits (Quality Decision Audits)
    - Claims Management Audits.
- Engaging with the Workplace Injury Commission (WIC), and obtaining and reviewing WIC documents and data, including:
    - conciliation files
    - reports
    - emails
    - annual reports.
- Receiving information from various sources (including submissions) regarding about 240 potential claim files.
- Issuing summonses to 12 self-insurers and one self-insurer agent to produce selected claim files, claims management data and emails of selected staff; reviewing the summonsed material.
- There were 867,998 items obtained, including:
    - 87 individual claim files
    - 165,420 emails
    - 48,509 documents
    - 8,613 Excel spreadsheets
- Receiving and considering written submissions from 45 parties, including:
    - 20 injured workers, or family members and advocates
    - Workplace Injury Commission
    - Victorian Trades Hall Council
    - Australian Manufacturing Workers Union
    - Australian Workers' Union
    - Transport Workers' Union of Australia
    - Shop, Distributive and Allied Employees' Association
    - Australian Nursing and Midwifery Federation
    - Flight Attendants' Association of Australia
    - Australian Lawyers' Alliance
    - Australian Services Union
    - Law Institute of Victoria
    - United Workers Union
    - Health care providers
    - Self-Insurance Association of Victoria
    - BlueScope Steel Ltd
    - Coles Group Ltd
    - Crown Resorts Ltd
    - CSR Ltd
    - Qantas Airways Ltd
    - Royal Automobile Club of Victoria (RACV) Ltd
    - Viva Energy Group Ltd
    - Healthy Working Lives Research Group, School of Public Health and Preventive Medicine, Monash University
    - Employees Mutual Ltd.

Appendix 2: List of current self-insurers

Figure 10: List of Victorian self-insurers, March 2023

Alcoa of Australia Limited
Amcor Ltd
BHP Group Limited ('BHP')
BlueScope Steel Ltd ('BlueScope')
BP Australia Group Pty Ltd
Brambles Ltd
Brickworks Ltd
Carter Holt Harvey Building Products Pty Ltd
Coles Group Ltd ('Coles')
CSR Ltd
ExxonMobil Australia Pty Ltd
Food Investments Pty Ltd ('Food Investments')
Hanson Australia (Holdings) Pty Ltd ('Hanson')
Healius Ltd (formerly Primary Health Care Ltd) ('Healius')
Inghams Group Ltd
Liberty Holdings Australia Ltd
Mars Wrigley Australia Holdings Pty Ltd
Melbourne Water Corporation
Mondelez Australia Holdings Pty Ltd ('Mondelez')
Myer Holdings Ltd ('Myer')
Paper Australia Pty Ltd ('Paper Australia')
Philip Morris (Australia) Ltd
Qantas Airways Ltd ('Qantas')
Robert Bosch (Australia) Pty Ltd
Royal Automobile Club of Victoria (RACV) Ltd ('RACV')
SS Silver Pty Ltd (formerly Crown Resorts Ltd) ('Crown')

TLC Aged Care Pty Ltd ('TLC Aged Care')
Toll Holdings Ltd
Toyota Motor Corporation Australia Ltd
University of Melbourne
Viva Energy Group Ltd ('Viva Energy')
Wesfarmers Ltd ('Wesfarmers')
Westpac Banking Corporation ('Westpac')
Woolworths Group Ltd ('Woolworths')

Source: Victorian Ombudsman

Appendix 3: WorkSafe compliance ratings of self-insurers

Figure 11: Compliance ratings of self-insurers (by WorkSafe Tier) at 14 December 2022

Self-insurer	Claims Management Audit compliance rating (year)
Tier 1	
Alcoa of Australia Limited	100% (2018)
Amcor Ltd	97% (2018)
BP Australia Group Pty Ltd	95% (2019)
Brambles Ltd	97% (2022)
Brickworks Ltd	96% (2018)
CSR Ltd	97% (2022)
ExxonMobil Australia Pty Ltd	100% (2018)
Food Investments Pty Ltd	97% (2022)
Liberty Holdings Australia Ltd	98% (2020)
Melbourne Water Corporation	98% (2019)
Mondelez Australia Holdings Pty Ltd	71% (2022)
Myer Holdings Ltd	95% (2021)
Paper Australia Pty Ltd	96% (2022)
Philip Morris (Australia) Ltd	95% (2022)
Qantas Airways Ltd	93% (2017)
Robert Bosch (Australia) Pty Ltd	97% (2018)
Royal Automobile Club of Victoria (RACV) Ltd	96% (2020)
Viva Energy Group Ltd	99% (2022)

Tier 2	
BlueScope Steel Ltd	91% (2018)
Carter Holt Harvey Building Products Pty Ltd	100% (2022)
Coles Group Ltd	90% (2020)
Hanson Australia (Holdings) Pty Ltd	90% (2018)
Healius Ltd (formerly Primary Health Care Ltd)	93% (2020)
Inghams Group Ltd	80% (2019)
Mars Wrigley Australia Holdings Pty Ltd	92% (2019)
SS Silver Pty Ltd (formerly Crown Resorts Ltd)	99% (2021)
TLC Aged Care Pty Ltd	82% (2020)
Toll Holdings Ltd	92% (2022)
Toyota Motor Corporation Australia Ltd	89% (2017)
University of Melbourne	93% (2022)
Wesfarmers Ltd	82% (2020)
Westpac Banking Corporation	91% (2021)
Woolworths Group Ltd	80% (2017)
No tier (no auditable activity)	
BHP Group Limited	NA

Source: WorkSafe Claims Management Audits

Appendix 4: Improvements made in response to the Ombudsman's prior investigations

Figure 12: Improvements to the oversight of self-insurers made since 2019

Change	When	Benefit
Quality Decision Audits	2019	WorkSafe began reviewing self-insurers' claims management decisions as part of its 'sustainable decision-making framework'. Reviews are conducted annually on a sample of adverse claim decisions to confirm self-insurers' decisions align with the framework.
Centralised WorkSafe complaints	March 2020	WorkSafe established a central complaints service which acts as a single point of contact for end-to-end complaint management. This aims to enable a consistent approach for complaints about agents or self-insurers.
Claims Manual requirements for making sustainable decisions	April 2020	WorkSafe has developed and delivered specific modules about sustainable decision-making to self-insurers.
Better oversight of IMEs	September 2020	WorkSafe shares information about IMEs to ensure practice standards are reinforced.
Quality Decision Audit enhancements	2022	Outcomes of Quality Decision Audits are included in WorkSafe's assessment of whether a self-insurer is 'fit and proper'
WIC arbitration	September 2022	A low-cost, less formal binding dispute resolution option before court.
Further Quality Decision Audit enhancements	February 2023	Reporting and verification steps added to the Quality Decision Audit process. Where a self-insurer accepts WorkSafe's assessment a decision is unsustainable WorkSafe requires evidence of actions taken to remedy the matter.

Source: Victorian Ombudsman

Victorian Ombudsman's Parliamentary Reports tabled since April 2014

2023

Complaint handling casebook: Resolving issues informally
May 2023

Councils and complaints: Glen Eira City Council's approach to contractor work
April 2023

Good Practice Guide: Complaint handling in a crisis
February 2023

2022

Ombudsman's recommendations – fourth report
September 2022

Investigation into a former youth worker's unauthorised access to private information about children
September 2022

Investigation of a matter referred from the Legislative Council on 9 February 2022 Part 1
July 2022

Joint investigation with IBAC
Operation Watts, a joint investigation into allegations of serious corrupt conduct involving Victorian public officers, including Members of Parliament
July 2022

Investigation into complaint handling in the Victorian social housing sector
July 2022

Report on investigations into the use of force at the Metropolitan Remand Centre and the Melbourne Assessment Prison
June 2022

Investigation into Environment Protection Authority decisions on West Gate Tunnel Project spoil disposal
May 2022

2021

Investigation into decision-making under the Victorian Border Crossing Permit Directions
December 2021

Investigation into allegations of collusion with property developers at Kingston City Council
October 2021

The Ombudsman for Human Rights: A Casebook
August 2021

Councils and complaints – A good practice guide 2nd edition
July 2021

Investigation into good practice when conducting prison disciplinary hearing
July 2021

Investigation into Melton City Council's engagement of IT company, MK Datanet Pty Ltd
June 2021

Investigation into how local councils respond to ratepayers in financial hardship
May 2021

Investigation into the Department of Jobs, Precincts and Regions' administration of the Business Support Fund
April 2021

Outsourcing of parking fine internal reviews – a follow-up report
March 2021

Investigation of protected disclosure complaints regarding the former Principal of a Victorian public school
February 2021

2020

Investigation into the detention and treatment of public housing residents arising from a COVID-19 'hard lockdown' in July 2020

December 2020

Investigation into complaints about assaults of five children living in Child Protection residential care units.

October 2020

Investigation into corporate credit card misuse at Warrnambool City Council

October 2020

Investigation into review of parking fines by the City of Melbourne.

September 2020

Investigation into the planning and delivery of the Western Highway duplication project

July 2020

Ombudsman's recommendations – third report

June 2020

Investigations into allegations of nepotism in government schools

May 2020

Investigation of alleged improper conduct by Executive Officers at Ballarat City Council

May 2020

Investigation into three councils' outsourcing of parking fine internal reviews

February 2020

2019

Investigation of matters referred from the Legislative Assembly on 8 August 2018

December 2019

WorkSafe 2: Follow-up investigation into the management of complex workers compensation claims

December 2019

Investigation into improper conduct by a Council employee at the Mildura Cemetery Trust

November 2019

Revisiting councils and complaints

October 2019

OPCAT in Victoria: A thematic investigation of practices related to solitary confinement of children and young people

September 2019

Investigation into Wellington Shire Council's handling of Ninety Mile Beach subdivisions

August 2019

Investigation into State Trustees

June 2019

Investigation of a complaint about Ambulance Victoria

May 2019

Fines Victoria complaints

April 2019

VicRoads complaints

February 2019

Victorian Ombudsman's Parliamentary Reports tabled since April 2014

2018

Investigation into the imprisonment of a woman found unfit to stand trial
October 2018

Investigation into allegations of improper conduct by officers at Goulburn Murray Water
October 2018

Investigation of three protected disclosure complaints regarding Bendigo South East College
September 2018

Investigation of allegations referred by Parliament's Legal and Social Issues Committee, arising from its inquiry into youth justice centres in Victoria
September 2018

Complaints to the Ombudsman: resolving them early
July 2018

Ombudsman's recommendations – second report
July 2018

Investigation into child sex offender Robert Whitehead's involvement with Puffing Billy and other railway bodies
June 2018

Investigation into the administration of the Fairness Fund for taxi and hire car licence holders
June 2018

Investigation into Maribyrnong City Council's internal review practices for disability parking infringements
April 2018

Investigation into Wodonga City Council's overcharging of a waste management levy
April 2018

Investigation of a matter referred from the Legislative Council on 25 November 2015
March 2018

2017

Investigation into the financial support provided to kinship carers
December 2017

Implementing OPCAT in Victoria: report and inspection of the Dame Phyllis Frost Centre
November 2017

Investigation into the management of maintenance claims against public housing tenants
October 2017

Investigation into the management and protection of disability group home residents by the Department of Health and Human Services and Autism Plus
September 2017

Enquiry into the provision of alcohol and drug rehabilitation services following contact with the criminal justice system
September 2017

Investigation into Victorian government school expulsions
August 2017

Report into allegations of conflict of interest of an officer at the Metropolitan Fire and Emergency Services Board
June 2017

Apologies
April 2017

Investigation into allegations of improper conduct by officers at the Mount Buller and Mount Stirling Resort Management Board

March 2017

Report on youth justice facilities at the Grevillea unit of Barwon Prison, Malmsbury and Parkville

February 2017

Investigation into the Registry of Births, Deaths and Marriages' handling of a complaint

January 2017

2016

Investigation into the transparency of local government decision making

December 2016

Ombudsman enquiries: Resolving complaints informally

October 2016

Investigation into the management of complex workers compensation claims and WorkSafe oversight

September 2016

Report on recommendations

June 2016

Investigation into Casey City Council's Special Charge Scheme for Market Lane

June 2016

Investigation into the misuse of council resources

June 2016

Investigation into public transport fare evasion enforcement

May 2016

2015

Reporting and investigation of allegations of abuse in the disability sector: Phase 2 – incident reporting

December 2015

Investigation of a protected disclosure complaint regarding allegations of improper conduct by councillors associated with political donations

November 2015

Investigation into the rehabilitation and reintegration of prisoners in Victoria

September 2015

Conflict of interest by an Executive Officer in the Department of Education and Training

September 2015

Reporting and investigation of allegations of abuse in the disability sector: Phase 1 – the effectiveness of statutory oversight

June 2015

Investigation into allegations of improper conduct by officers of VicRoads

June 2015

Investigation into Department of Health oversight of Mentone Gardens, a Supported Residential Service

April 2015

Councils and complaints – A report on current practice and issues

February 2015

Investigation into an incident of alleged excessive force used by authorised officers

February 2015

2014

Investigation following concerns raised by Community Visitors about a mental health facility

October 2014

Investigation into allegations of improper conduct in the Office of Living Victoria

August 2014

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