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

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

Deborah Glass OBE
Ombudsman

3 December 2019

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Foreword

'... they want to make money ... it's a private business. And the best way for a private business is get people who are on compensation, off compensation.'

– Conciliation Officer

Does anything change after an Ombudsman investigation?

In almost every case I have dealt with in my five years in the role the answer is yes, and meaningfully so: unfair laws, policies and procedures have been replaced, new systems have been introduced, in some cases thousands of dollars have been paid to people wrongfully disentitled.

In 2016 I tabled a report into WorkSafe agents' handling of complex claims, which concluded that while the whole system was not broken, the handling of complex claims – the most difficult and expensive – needed fundamental reform. The report was widely welcomed by many and WorkSafe accepted all 15 recommendations made to it, with the support of the responsible Minister.

But did anything change?

Complaints to the Ombudsman can be a good indicator. In the case of WorkSafe complaints, despite the implementation by WorkSafe of all 15 recommendations, the complaints have continued, raising the same themes: unreasonable decision making by agents, inadequate oversight by WorkSafe.

While I monitor the implementation of all my recommendations, this is the first time I have launched a fresh investigation into the same issue. All Ombudsman complaints involve people's individual stories, but the WorkSafe complaints were and are particularly painful. I said in 2016 these cases involve people's lives, and the human cost should never be forgotten; that human cost continues to this day.

I launched this second investigation in May 2018 on the back of a continued influx of complaints and anecdotal evidence that not enough had changed. Sadly, that has proven to be true.

Agents are still unreasonably terminating complex claims: cherry picking evidence, doctor shopping, relying on Independent Medical Examiners (IMEs) over treating doctors even when evidence is unclear, contradictory or inconclusive – or ignoring it if it didn't support termination.

If anything, the evidence strongly suggests that much of the impact of my 2016 report has been to drive these practices underground. Agent staff were told to be careful what they put in writing – in case the Ombudsman sees it. Staff were advised to use words like 'entitlement reviews' in their emails rather than 'termination'.

But while this meant less overt evidence of decisions being made for financial incentives, this was the only logical explanation for some of them: agents who came to conciliation not prepared to conciliate beyond a derisory sum; maintaining those decisions knowing they would be overturned by a court, on the basis that many workers would simply give up.

From the evidence in this report, it would appear that my 2016 investigation only scratched the surface.

New issues were also identified in the files we reviewed, and confirmed in interviews, including the use of surveillance without adequate justification. Such an invasion of people's privacy is only permitted if there is some evidence of worker dishonesty, but we found numerous examples of surveillance being used without a shred of evidence to justify it.

Take the case of Sophia, an aged care worker, who had injured her back at work. The agent used surveillance to check her mobility. Even though the surveillance report confirmed she walked with a limp throughout, the agent considered extending it. The surveillance must have been intrusive, as Sophia asked the agent if they were doing it. Even more troublingly, the agent denied it and told her if she had concerns about being followed she should go to the police.

We also saw significant evidence of unfair return to work practices: many requiring a worker to attend occupational rehabilitation in wholly unsuitable circumstances, such as the man experiencing severe psychotic hallucinations, or the homeless man in hospital after attempting self-harm, and whose non-compliance notice was sent to the residential address he had been obliged to leave despite knowing he was homeless.

> *'For the injured worker, it's like a court. They're traumatised, they're stressed … they're the only person in the room not paid to be there … '*
>
> – Conciliation Officer

The workers affected in the cases we reviewed included nurses, teachers, police officers, aged care and childcare workers, truck drivers, baggage handlers and tradesmen. The emotional toll was unequivocal; the cost not only to them and their families, but to society, should not be underestimated.

Many of the decisions and actions we saw were not only unjust, unreasonable and wrong. Some were downright immoral and unethical.

It provides little consolation to say not every decision we saw was bad. Given the impact on people's lives, good decision making cannot be left to chance, or an individual agent's better instincts.

What is WorkSafe doing about this?

They audit decisions, handle complaints, survey injured workers and oversee the IME system. We saw improvement in some areas. But we also found questionable audit passes on decisions that were plainly not sustainable; workers being referred to conciliation or court despite clearly inadequate or unreasonable agent decision making; and insufficient oversight of the IME system.

The system is failing to deliver just outcomes to too many people; agents continue to make unreasonable decisions, the dispute process is time consuming, stressful and costly, and Worksafe is too often unwilling or unable to deal.

I said in 2016 that the system needs a better safety net for the vulnerable. In 2019 we need it more than ever. If the problems are persisting despite the adoption of my previous recommendations, the reforms were plainly not fundamental enough.

The financial viability of the scheme is imperative; but the balance between financial sustainability and fairness for injured workers has tilted too far away from the latter.

It is time for the change that makes a difference. I am pleased the government has accepted my two key recommendations: an independent review of the agent model to determine how and by whom complex claims should be managed, and to introduce a new dispute resolution process which allows for binding determinations.

In the meantime, I welcome WorkSafe's commitment to establish a dedicated team to review disputed decisions and use its powers to issue directions to agents when decisions are not sustainable. For the sake of the next generation of injured workers, and the wider community that bears the cost, we should not have to investigate this issue again.

Deborah Glass

Ombudsman

Executive summary

1. This investigation looked at the compensation and support provided to people injured at work in Victoria, particularly those with complex injuries. This follows an earlier investigation by the Ombudsman in 2016 which found the scheme had failed some particularly vulnerable people.

2. Victoria's workers compensation scheme, also known as 'WorkCover', provides a range of entitlements to people who are injured at work under the *Workplace Injury Rehabilitation and Compensation Act 2013* (Vic). Entitlements include 'weekly payments' for loss of income if they are unable to work and payment of the reasonable costs of medical treatment and other rehabilitative services directly related to their injury.

3. The scheme is funded by compulsory employer insurance and administered by WorkSafe. WorkSafe is responsible for ensuring appropriate compensation is paid to injured workers, while also maintaining a financially sustainable scheme.

4. WorkSafe does not manage WorkCover claims itself, instead outsourcing this to five claims agents. The agents are commercial organisations and as a result have a vested interest in the outcome of individual claims. Notwithstanding this, agents are required to stand in the shoes of WorkSafe and make independent decisions on claims in line with the Act.

The Ombudsman's 2016 investigation

5. In 2016, the Ombudsman investigated WorkSafe and its agents, focussing on agents' management of 'complex claims'. These claims involve workers who were unable to work long term and/or required long term medical treatment. While these claims do not represent the majority, research has shown that these workers are likely to have complex health conditions and represent a substantial and disproportionately high cost to the scheme and broader society.

6. The investigation found cases of unreasonable decision making on complex claims across all five agents, the evidence of which the Ombudsman said was 'too strong to be explained away as a few "bad apples"'. This included numerous examples of agents 'cherry-picking' evidence to support a decision, while disregarding overwhelming evidence to the contrary. In many cases, agents were found to defend unreasonable decisions when injured workers disputed them, despite knowing they would likely be overturned.

7. The investigation acknowledged that as commercial organisations, it was reasonable for the agents to expect to profit from managing WorkCover claims. However, the evidence suggested that in the case of complex claims, financial reward and penalty measures in agents' contracts with WorkSafe were driving a focus on terminating and rejecting claims to maximise profit, at the expense of sound decision making.

8. The investigation also identified deficiencies in WorkSafe's oversight of the scheme, particularly in relation to agent decision making on complex claims.

9. The Ombudsman made 15 recommendations to WorkSafe which included:

    - improving WorkSafe's oversight of complex claims and its use of information from complaints, stakeholder feedback and dispute outcomes to identify potential systemic issues
    - reviewing the financial reward and penalty measures to increase agents' focus on quality decisions and sustainable return to work outcomes for injured workers
    - providing training and additional guidance to agent staff.

10. The Ombudsman also made two recommendations to the Victorian Government, which WorkSafe said it did not support. These related to the process for injured workers to dispute claim decisions, which involves conciliation and then court.

Follow-up investigation

11. While WorkSafe and the agents have implemented many changes since the 2016 investigation, the Ombudsman continues to receive many complaints about WorkSafe and its agents, with nearly 700 complaints received in 2017-18 and about 800 in 2018-19.

12. In May 2018, the Ombudsman decided to conduct a 'follow-up' investigation to examine whether the implementation of the recommendations from the 2016 investigation had improved agent practices and decision making and the effectiveness of WorkSafe's oversight.

13. This follow-up investigation concentrated on agent decision making on complex claims in 2017-18, which were primarily long term claims where an injured worker had not worked and had been receiving weekly payments for 130 weeks or more (two and a half years). As at 30 June 2018, these claims represented about a quarter of the 18,519 active weekly payments in the scheme, or about seven per cent of the total 63,085 active claims in the scheme (including those involving medical treatment only).

14. The investigation involved:

    - reviewing 102 complex claim files in depth, some of which were randomly selected
    - reviewing WorkSafe's handling of 51 complaints received in 2017-18 about agent decisions and Independent Medical Examiners (IMEs), about half of which were randomly selected
    - meeting with WorkSafe during the investigation and interviewing 16 witnesses, including seven Conciliation Officers and the then Convenor of Medical Panels
    - reviewing other information, including a sample of agent staff email records, policies and procedures, research reports, data, written submissions from stakeholders and complaints to the Ombudsman.

15. The investigation also asked WorkSafe to review a number of decisions on the complex claim files reviewed, which appeared unreasonable but had not been overturned through the dispute process. As a result, WorkSafe and the agents withdrew 30 decisions across 19 claims and back-paid about $70,000 collectively to two injured workers.

Unreasonable decision making by agents

16. Although witnesses reported to this investigation a temporary 'marked change' in agent behaviour after the Ombudsman's 2016 report was released, the Ombudsman identified continuing issues with unreasonable agent decision making on complex claims.

17. The evidence obtained suggests that the Ombudsman's 2016 recommendations were not enough to change agent behaviour and stop unreasonable decision making on complex claims. After two investigations by the Ombudsman and a number of reviews commissioned by WorkSafe, the evidence points to this being a systemic problem.

Unreasonable use of evidence

18. Agents may consider a range of evidence when making claim decisions, including medical reports from IMEs or a worker's treating doctors; information from an occupational rehabilitation provider; 'circumstance' investigation reports and surveillance footage of an injured worker.

19. Agents are required to adhere to 'principles of good administrative decision making', which include that agents must consider all matters relevant to a decision; make decisions supported by the best available evidence; and give 'proper, genuine and realistic consideration' to the merits of a decision.

20. This investigation found that since 2016, agents have continued to unreasonably use evidence to terminate or reject complex claims in some cases by:

    - selectively using evidence, while ignoring other available information – even where the medical opinion relied on was unclear, contradictory or inconclusive
    - conducting surveillance of workers without adequate evidence they were misrepresenting their injury
    - selectively using IMEs and 'doctor shopping', despite new measures introduced to prevent such behaviour
    - providing incomplete or inaccurate information to IMEs
    - posing leading questions to IMEs and workers' treating doctors
    - relying on an opinion from an IME from the incorrect specialty.

Unfair return to work practices

21. A key objective of the workers compensation scheme is to provide 'effective occupational rehabilitation' and 'increase the provision of suitable employment to workers who are injured to enable their early return to work'.

22. Injured workers have 'return to work' obligations, which include that they must make reasonable efforts to return to work and actively use an occupational rehabilitation service. If a worker does not reasonably comply with their obligations, an agent may issue a non-compliance notice, which can impact the worker's entitlements.

23. In the sample of complex claims reviewed, this investigation identified several non-compliance notices which had been unreasonably or incorrectly issued. This included cases where:

    - workers were required to participate in occupational rehabilitation at inappropriate stages of their recovery, such as a case where a worker was experiencing severe psychotic hallucinations

- agents failed to genuinely consider workers' individual circumstances and the reasonableness of their non-participation, including a case where a worker had just been released from hospital after attempting self-harm and had become homeless
- agents incorrectly issued notices under the legislation.

24. The investigation also received evidence that agents sometimes issued non-compliance notices with a focus on liability management. This included evidence from a WorkSafe-commissioned review that occupational rehabilitation consultants perceived in some cases that referrals to their services were 'not in the interest of the injured worker and were being used as a tool to cut benefits'.

Agents acting unreasonably during conciliation

25. This investigation also looked at agents' actions with respect to claim decisions disputed at conciliation.

26. When a worker requests conciliation, agents are required to review the disputed decision and withdraw it before conciliation if it would not have a reasonable prospect of success at court (ie not be 'sustainable'). However, a Conciliation Officer is only able to direct an agent to overturn their decision where there is 'no arguable case', which is a lower threshold.

27. While overall the number of disputes at conciliation has reduced since the Ombudsman's 2016 investigation, the rate at which decisions are withdrawn or changed through the dispute process remains high. In 2017-18, about half of the decisions disputed at conciliation and 70 per cent of decisions that proceeded to court were varied or overturned.

28. Although the dispute process should provide a 'safety net', the investigation found that unreasonable decisions are slipping through the cracks. Agents continue to defend 'arguable' decisions during conciliation, even if they would not be 'sustainable' at court, rendering Conciliation Officers hamstrung to resolve such disputes. Conciliation Officers also reported particular difficulties resolving factual disputes. The result is that injured workers are left to contemplate the costly, stressful and time-consuming path to court if they wish to dispute a decision further. Most workers simply give up.

Decisions contrary to binding Medical Panel opinions

29. Where a dispute involves a medical question, a Conciliation Officer or court may refer questions to a Medical Panel. A Panel's opinion must be adopted, applied and accepted as 'final and conclusive' by all parties.

30. WorkSafe told the investigation that where an agent seeks to revisit the same issue considered by a Medical Panel, it expects the agent to demonstrate there has been a 'material change' in the worker's situation since the Panel's opinion. This may include, for example, improvement in symptoms as a result of further treatment or an increase in the worker's skills as a result of retraining.

31. In the complex claims reviewed by this investigation, agents generally waited at least 12 months after a Medical Panel before re-assessing a worker's capacity. While this is positive, the investigation identified several complex claims where agents terminated workers' entitlements without sufficient evidence of a 'material change' in the worker's condition since a Medical Panel opinion.

The effect of financial rewards and penalties on agent decisions

32. This investigation also revisited the financial rewards and penalties WorkSafe pays agents, based on their performance against key measures.

33. Since the Ombudsman's 2016 investigation, WorkSafe has made a number of changes to these, which included reducing the rewards and penalties for terminating claims, and increasing the rewards for quality decisions.

34. The investigation found limited overt evidence in the complex claim files and sample of agent staff emails reviewed of the financial rewards and penalties influencing agent decisions. However, the investigation received evidence that some agent staff have made efforts to conceal certain behaviours and practices identified by the Ombudsman's 2016 investigation, including agents' focus on managing liabilities.

35. Although less documentary evidence was identified, compared with the 2016 investigation, this investigation still found evidence showing:

    - agents' continued focus on terminating claims and maximising profit. This included agent staff emails where staff referred to claims which achieved a financial reward as 'wins'; congratulated staff for terminating claims; discussed the monetary value to the agent of terminating individual claims; and referred to targets for terminating claims
    - the influence of the rewards and penalties on agents' offers at conciliation, which meant that offers were not always informed by the merits of a decision.

36. This evidence, when combined with the extent of unreasonable decision making on complex claims identified by the investigation, raises questions about the suitability of commercial organisations to manage complex claims.

WorkSafe's oversight

37. Although WorkSafe delegates the management of claims to the agents, WorkSafe has a role in overseeing agents to ensure injured workers receive appropriate compensation and are not 'wrongfully disentitled'.

38. WorkSafe has made a number of changes to its oversight mechanisms since 2016. However, the investigation found that WorkSafe is still not optimally using them to address unreasonable agent decision making on individual complex claims and to identify and respond to systemic issues.

39. WorkSafe's process for auditing the quality of agent decisions has improved since 2016. However, the investigation found that WorkSafe has not always held agents accountable for unsustainable decisions identified through the audits. In its 2017-18 audits, the investigation found instances where WorkSafe:

    - passed questionable decisions where the agent had only one piece of supporting evidence
    - re-assessed failed decisions as 'passes' when disputed by the agent, even if they would not hold up at court
    - did not require the agents to overturn most of the failed decisions.

40. Complaints and stakeholder feedback also offer WorkSafe opportunities to check agents' performance and identify areas for improvement; however, the investigation found that its role in complaints about agent decisions is unclear. On the one hand, WorkSafe considers agents maintain authority on the vast majority of decisions and that the dispute process is the appropriate mechanism for an injured worker to dispute an agent decision. On the other hand, WorkSafe has the power to direct an agent to change a decision and has established a procedure for when it identifies a worker has been 'wrongfully disentitled'.

41. The investigation found that this has led to inconsistent approaches in the way WorkSafe handles complaints, including cases where WorkSafe:

    - referred workers to conciliation, even though WorkSafe identified concerns with the agent's decision and could have resolved the complaint itself
    - accepted agent responses without questioning whether they were correct or reasonable.

42. WorkSafe appears reluctant to adequately deal with unreasonable agent decision making when it is brought to their attention, which raises the troubling prospect that WorkSafe feels beholden to the agents and dependent on their participation to deliver a financially viable scheme.

43. Given WorkSafe's statutory responsibility to ensure appropriate compensation is paid to injured workers 'in the most socially and economically appropriate manner, as expeditiously as possible', it must do more.

Recommendations

44. Nothing short of wholesale changes to the system will address the issues identified by both the 2016 investigation and the current one.

45. The Ombudsman therefore recommended the Victorian Government:

    - commission an independent review of the agent model to determine how and by whom complex claims should be managed
    - introduce a new dispute resolution process which allows for binding determinations on the merits of claim decisions; is inexpensive; and provides timely outcomes.

46. The Minister for Workplace Safety, the Honourable Jill Hennessy MP said the Victorian Government accepted both recommendations, stating she was 'committed to reform' and 'disturbed by the findings' of the investigation.

47. Given the time it will take to implement these recommendations, the Ombudsman also made 13 recommendations to WorkSafe to address the immediate issues identified by the investigation. This includes a recommendation that WorkSafe establish a dedicated business unit to independently review disputed decisions when requested by workers following unsuccessful conciliation. WorkSafe accepted all 13 recommendations.

Background

48. This investigation looked at the compensation and support provided to people injured at work in Victoria, particularly those with complex injuries who are unable to return to work long term. This follows an earlier investigation by the Ombudsman in 2016 which found the scheme set up to provide this compensation and support had failed some particularly vulnerable people.

49. Victoria's workers compensation scheme, also known as 'WorkCover', provides a range of entitlements to people who are injured at work under the *Workplace Injury Rehabilitation and Compensation Act 2013* (Vic) (WIRC Act).

50. The scheme is funded by compulsory employer insurance and administered by the Victorian WorkCover Authority, operating as WorkSafe Victoria (WorkSafe). WorkSafe is responsible for ensuring appropriate compensation is paid to injured workers, while also maintaining a financially sustainable scheme.

51. WorkSafe does not manage WorkCover claims itself, instead outsourcing this to five claims agents. WorkSafe oversees the scheme, including agents' management of claims.

The Ombudsman's 2016 investigation

52. In 2016, the Ombudsman investigated WorkSafe and its agents to look at whether:

    - agents had unreasonably rejected or terminated injured workers' claims
    - agent decisions were motivated by financial performance incentives offered by WorkSafe
    - WorkSafe provided effective oversight of the scheme.

53. The investigation was prompted by:

    - an increasing number of complaints to the Ombudsman
    - an increasing number of disputed claim decisions
    - consultation with stakeholders, which suggested individual complaints were a sign of a more widespread problem and that agent decisions may be financially motivated.

54. The investigation focussed on agents' management of 'complex claims', involving workers who were unable to work long term and/or required long term medical treatment.

55. While complex claims do not represent the majority, research has shown that these workers are likely to have complex health conditions and represent a substantial and disproportionately high cost to the scheme and broader society.[1]

56. The investigation looked at agent decision making during 2014-15 and 2015-16.

What we found

57. The investigation found cases of unreasonable decision making on complex claims across all five agents, the evidence of which the Ombudsman said was 'too strong to be explained away as a few "bad apples"'. This included numerous examples of agents 'cherry-picking' evidence to support a decision, while disregarding overwhelming evidence to the contrary. In many cases, agents were found to defend unreasonable decisions when injured workers disputed them, despite knowing they would likely be overturned.

1 Dr Elizabeth Kilgour and Dr Agnieszka Kosny, Institute for Safety, Compensation and Recovery Research (ISCRR), *Victorian Injured Worker Outcomes Study, Study 1 – A qualitative enquiry into outcomes for injured workers in Victoria who have longer term claims*, Final Report, April 2018.

58. The investigation acknowledged that as commercial organisations, it was reasonable for the agents to expect to make a profit. However, the evidence suggested that in the case of complex claims, financial reward and penalty measures in agents' contracts with WorkSafe were driving a focus on terminating and rejecting claims to maximise profit, at the expense of good decision making.

59. The investigation also identified deficiencies in WorkSafe's oversight of the scheme, particularly in relation to agent decision making on complex claims.

What we recommended

60. The Ombudsman made 15 recommendations to WorkSafe which included:

    - improving WorkSafe's oversight of complex claims and its use of information from complaints, stakeholder feedback and dispute outcomes to identify potential systemic issues
    - reviewing the financial reward and penalty measures to increase agents' focus on quality decisions and sustainable return to work outcomes for injured workers
    - providing training and additional guidance to agent staff.

61. The Ombudsman made two recommendations to the State Government:

    - review the process for injured workers to dispute claim decisions, which involves conciliation and then court, to ensure the process is fair and timely
    - increase Conciliation Officers' powers to direct agents to overturn a decision.

62. WorkSafe said it did not support these two recommendations. Although introducing an additional arbitration process[2] following unsuccessful conciliation may produce more timely outcomes for workers (compared to court), WorkSafe said this would:

    - 'add another layer of complexity and cost to the system'
    - be 'contrary to the general objective of reducing the level of disputation'.

63. WorkSafe also said it did not support increasing Conciliation Officers' powers to direct because it would 'fundamentally and detrimentally' affect their 'capacity to mediate negotiated outcomes', and would make the process 'considerably more adversarial'.

How WorkSafe implemented the recommendations

64. WorkSafe has implemented all 15 of the Ombudsman's recommendations, with some work ongoing. Among other things, WorkSafe said it has:

    - adjusted the financial reward and penalty measures and provided training to agent staff
    - improved its process for auditing the quality of agent decisions
    - introduced a 'recovery assistance pilot', which provides tailored case management to injured workers who have been receiving compensation for more than four years
    - improved internal reporting on and monitoring of dispute outcomes
    - revised its complaints management framework and increased reporting of complaints data
    - improved its oversight of Independent Medical Examiners (IMEs) and agents' use of them.

2 Arbitration is an alternative dispute resolution process where parties present arguments and evidence to an independent third party, the arbitrator, who makes a binding determination.

Actions taken by agents

65. There were five agents subject to the Ombudsman's 2016 investigation; however, one of them, QBE, was replaced by a new agent, EML Vic Pty Ltd on 30 June 2016. The other four agents remained the same, meaning the current agents are:

    - Allianz Australia Worker's Compensation (Victoria) Limited (Allianz)
    - CGU Workers Compensation (Vic) Limited (CGU)
    - EML Vic Pty Ltd (EML)
    - Gallagher Bassett Services Workers Compensation Vic Pty Ltd (Gallagher Bassett)
    - Xchanging Integrated Services Victoria Pty Ltd (Xchanging).

66. Although the Ombudsman did not make any recommendations to agents, these agents said they changed some practices and processes following the Ombudsman's 2016 investigation. This included:

    - improving staff capability and organisational culture, including training and new specialised roles to support case management
    - changing processes for endorsing and reviewing terminations
    - introducing new initiatives, including transition support to injured workers exiting the scheme and mobile case management.

Follow-up investigation

67. While WorkSafe and the agents have implemented many changes since the 2016 investigation, the Ombudsman continues to receive many complaints about WorkSafe and its agents, with nearly 700 complaints received in 2017-18 and about 800 in 2018-19.

68. In May 2018, the Ombudsman decided to conduct a follow-up investigation to examine whether the implementation of the recommendations from her 2016 investigation had improved:

    - agent practices and decision making
    - the effectiveness of WorkSafe's oversight.

69. The Ombudsman notified the then Chair and Chief Executive of WorkSafe, the Minister for Finance and the General Managers of the five agents on 31 May 2018 of her intention to conduct the follow-up investigation. The Ombudsman also notified the then Acting Senior Conciliation Officer at the Accident Compensation Conciliation Service (ACCS), which is not a subject of the investigation but is a key stakeholder within the scheme.

70. This follow-up investigation concentrated on agent decision making on complex claims in 2017-18, which were primarily long term claims where an injured worker had not worked and had been receiving weekly payments for 130 weeks or more (two and a half years). As at 30 June 2018, there were 4,544 active claims which had exceeded 130 weeks of weekly payments. This represented about a quarter of the 18,519 active weekly payments claims in the scheme, or about seven per cent of the total 63,085 active claims in the scheme (including those involving medical treatment only).

71. The investigation also looked at WorkSafe's oversight during 2017-18, with a focus on:

- financial reward and penalty measures
- quality decision making audits
- handling of complaints about agent decisions and IMEs
- the IME system.

Authority to investigate

72. The Ombudsman investigates administrative actions by Victorian public authorities. The definition of an 'authority' includes WorkSafe and the five agents by virtue of items 13, 16 and 17 of Schedule 1 to the *Ombudsman Act 1973* (Vic).

73. The investigation was conducted as an 'own motion' investigation under section 16A of the Ombudsman Act. The Ombudsman often uses this power to investigate possible systemic problems in public authorities.

How we investigated

74. The investigation reviewed 102 complex claim files in depth, which included the following types of decisions:

- 20 terminations of workers' weekly payments at 130 weeks, which were randomly selected from lists of disputed and undisputed decisions
- 25 notices issued to long term claimants for failing to comply with their return to work obligations,[3] including:
    - 15 randomly selected warning notices
    - 10 disputed suspension and termination notices
- all nine terminations of long term claimants' weekly payments, where a Medical Panel found less than two years prior that they were indefinitely incapacitated for all work[4]
- 28 decisions selected based on complaints to the Ombudsman or stakeholder feedback
- 20 terminations of weekly payments audited by WorkSafe.

75. The way claims were selected for review during this investigation differed from the Ombudsman's 2016 investigation, where all claims reviewed were selected based on concerns and complaints about agents' handling.

76. The investigation also reviewed:

- information from WorkSafe and the agents regarding changes implemented since the Ombudsman's 2016 investigation
- WorkSafe's handling of 51 complaints received in 2017-18 about agent decisions and IMEs, 22 of which were randomly selected
- email records of 20 staff across the five agents for the period 1 March 2018 to 15 June 2018
- information from WorkSafe, including policies and procedures, research reports, data, WorkSafe's contracts with the agents and reports from its audits of agent decisions
- written submissions and other information from Maurice Blackburn, the Police Association Victoria, an academic involved in workers compensation research and a number of injured workers or their support persons
- complaints the Ombudsman received in 2017-18 about the agents and WorkSafe.

3 These notices were selected as a focus area for the investigation based on trends in complaints to the Ombudsman about these notices.

4 The sample that fell within the investigation's scope for this category was too small to randomly select claims. As such, all nine claims that fell within scope were reviewed.

77. The investigation met with WorkSafe during the investigation and interviewed 16 witnesses, including:

- seven Conciliation Officers who oversee injured workers' disputes of claim decisions, and whose tenures ranged from six to 26 years[5]
- other stakeholders including:
    - the then Convenor of Medical Panels, who oversees independent panels which provide binding medical opinions
    - a WorkSafe Clinical Advisor, whose role is to provide advice on medical issues
    - two representatives of the Australian Medical Association
    - two worker representatives
    - two representatives of IMEs
    - a former agent employee.[6]

78. In response to a draft of this report (the draft report), WorkSafe raised concerns about the 'evidentiary basis' of some of the comments included in the report by the seven 'unnamed' Conciliation Officers and the one former agent employee. WorkSafe said:

> In our submission, it is not appropriate to include … [anecdotal] comments in your report because the comments lack an appropriate evidentiary basis. They are largely expressions of opinion by persons who are not qualified as experts and in addition, the selection of stakeholders quoted are not representative of all stakeholders who have a role and interest in the workers compensation scheme.
>
> We are concerned that the Draft Report includes these types of prejudicial comments of unnamed Conciliation Officers making assumptions about the apparent state of mind of agent staff in making statutory decisions, but without reference in the quotes to specific supporting evidence or cases. It is not clear how the rationale and motivations of the witnesses has been tested.
>
> The quotes are from a very small sample of witnesses and they do not accurately reflect WorkSafe's experience in dealing with the vast majority of agent staff in taking a responsible and concerned approach to managing claims and assisting injured workers.
>
> Your final report may fairly discuss the same issues and concerns relying on the case studies and documentary evidence without reproducing these unbalanced quotes from unnamed sources.

79. Gallagher Bassett also raised concerns in its response to the draft report about the '[u]nbalanced selection of witnesses':

> [E]ach type of witness brings a level of bias to the inquiry, from those supportive of injured workers (worker representatives, including a plaintiff law firm) to those with particular philosophical positions … What is lacking in this investigation is the balancing views of those working in claims management, being WorkSafe and agent witnesses.
>
> The use of non-specific opinion evidence from unnamed witnesses is problematic especially when it becomes the foundation of a finding of improper behaviour. The probative value of anonymous opinion, unsupported by reference to particular claims, to which an agent cannot respond, is outweighed by the significant prejudice it causes.

5 The investigation also received a written submission from an eighth Conciliation Officer.

6 Two employer groups were contacted and afforded the opportunity to provide information to the investigation, but did not elect to do so.

80. Although the Conciliation Officers interviewed have been de-identified in this report, they did not provide evidence anonymously to the investigation. The Ombudsman remains of the view that their evidence is relevant to the investigation and this report, noting:

- the function Conciliation Officers perform in resolving disputes about claims decisions, which enables them to make firsthand observations about agent decision making and behaviour
- the independent role of Conciliation Officers
- the experience of the Conciliation Officers interviewed, whose tenures ranged from six to 26 years.

81. The Ombudsman also considers it relevant to include the evidence of the former agent employee interviewed during the investigation, given their direct experience in managing claims.

82. Additionally:

- No evidence of bias was apparent in the interviews of these witnesses, conducted by Ombudsman officers; they appeared to have no motive for providing evidence other than their concerns about the system in which they worked.
- The investigation did not rely on witness evidence in isolation; rather it was corroborated by other evidence obtained by the investigation.
- Under the Ombudsman Act, the Ombudsman may investigate in such a manner as she thinks fit and is not bound by the rules of evidence which apply to legal proceedings. Notwithstanding this, the Ombudsman considers the credibility, reliability and relevance of evidence received, as well as the weight that should be attached to it.

83. Although the investigation did not interview agent staff, the Ombudsman provided the agents the opportunity to submit information to the investigation, including details of changes they have made since 2016. The investigation also contacted two employer groups and gave them the opportunity to provide information, but no response was received.

Informal resolution of 30 claim decisions

84. Following the review of claim files, the investigation asked WorkSafe to review decisions on 23 claims which appeared unreasonable but had not been overturned through the dispute process. WorkSafe's reviews resulted in the withdrawal of 25 decisions across 16 claim files and the back-payment of about $70,000 collectively to two injured workers.[7]

85. In addition, the investigation sought information from WorkSafe about 49 decisions WorkSafe audited in 2017-18. This resulted in the withdrawal of a further five decisions across three claims and the reinstatement of the workers' entitlements.

86. The decisions were withdrawn because WorkSafe considered they were not appropriately issued and/or would not be sustainable if disputed at court. Some of these feature in the case studies throughout this report.

7 The majority of the notices withdrawn did not result in back-payments to workers because they were notices issued to workers for their failure to comply with return to work obligations. Although most of these did not have an immediate impact on workers' entitlements, they could be used against them in the future as evidence of repeat non-compliance.

Procedural fairness and privacy

87. This report contains adverse comments about WorkSafe, five agents and an IME. In accordance with section 25A of the Ombudsman Act, the Ombudsman gave WorkSafe, the five agents and the IME a reasonable opportunity to respond to the draft report. This report fairly sets out the IME's response dated 13 September 2019; responses from WorkSafe, Xchanging, Gallagher Bassett and EML dated 16 October 2019; Allianz's responses dated 16 and 25 October 2019; and CGU's response dated 17 October 2019.

88. General comments WorkSafe and the agents made in response to the draft report are outlined in Appendices 1 and 2. Comments in relation to specific issues or case studies have been incorporated into the relevant sections throughout the report.

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

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

90. This report also contains 59 case studies describing the experiences of 51 injured workers and their families, all of whom have been de-identified for privacy reasons. While some individuals may be able to identify themselves in the report, the Ombudsman considers it is in the public interest to include these stories.

About the workers compensation scheme

91. In Victoria, a person injured at work can make a WorkCover claim for:

    - 'weekly payments' for loss of income if they are unable to work
    - payment of the reasonable costs of medical treatment and other rehabilitative services directly related to their injury.

92. This includes workers who have a pre-existing injury or disease which has been aggravated by work.[8]

93. The scheme operates on a 'no fault' basis, meaning employees are covered if they are injured at work, regardless of who is at fault.

94. Other types of claims an injured worker can make include:

    - an 'impairment benefit' claim for a once-off lump sum payment, where a worker has a permanent impairment as a result of their injury
    - a common law claim for pain and suffering and/or economic loss where a worker sustains a serious injury and someone other than the worker is at fault.[9]

Evolution of the scheme

95. To understand the current landscape, it helps to appreciate the evolution of the scheme and the considerable reforms it has undergone over the last century. These reforms have been the end-product of successive governments trying to strike the right balance between financial viability and adequate compensation for injured workers.

8 The definition of an 'injury' in the WIRC Act includes 'a recurrence, aggravation, acceleration, exacerbation or deterioration of any pre-existing injury or disease'. The worker's employment must be a 'significant contributing factor' to be eligible for compensation.

9 Impairment benefit claims and common law claims are outside the scope of this investigation.

96. The most notable government intervention into workers compensation occurred in 1914 when new legislation made employers liable for accidental injuries that workers sustained in the course of employment. Employers were required to obtain insurance from either a state or approved private insurer to cover such injuries. Prior to this, workers could only seek compensation for injuries where employers were at fault or found to be negligent.

97. From 1914 up until the 1980s, the scheme underwent a number of changes but remained underwritten by private insurers. This eventually resulted in 'soaring premiums' and the 'inadequacy of compensation payments for injured workers'.[10]

98. Consequently, in the mid-1980s there was a call for change which led to the creation of a new scheme known as 'WorkCare', characterised by a mix of public scheme regulation and private claims administration. This reformed scheme focussed on prevention, rehabilitation and compensation as a way of reducing the social costs of workplace accidents.

99. The WorkCare scheme experienced 'turbulent teething problems' and underwent 'multiple modifications' over the next two and a half decades, before eventually evolving into the current scheme today known as 'WorkCover'.[11]

WorkSafe

100. WorkSafe is the State Government authority responsible for overseeing the workers compensation scheme and administering the WIRC Act.

101. WorkSafe's objectives under section 492 of the WIRC Act include:

- managing the scheme 'as effectively, efficiently and economically as is possible'
- managing the scheme in a 'financially viable manner'
- ensuring appropriate compensation is paid to injured workers 'in the most socially and economically appropriate manner and as expeditiously as possible'.

102. WorkSafe's functions under section 493 include:

- receiving, assessing and accepting or rejecting claims for compensation
- paying compensation to injured workers entitled to it under the Act
- promoting the effective occupational rehabilitation of injured workers and their early return to work
- encouraging the provision of suitable employment opportunities to injured workers
- providing insurance and determining, collecting and recovering premiums
- ensuring the scheme is 'competitive and fully funded'.

103. WorkSafe delegates most of its claim management and premium collection functions to the agents, who are engaged via a common contract. WorkSafe pays the agents a fee to perform these functions, in addition to financial rewards and penalties associated with performance measures.[12]

10 Marianna Stylianou, Institute for Safety, Compensation and Recovery Research (ISCRR), *To strike a balance': a history of Victoria's Workers' Compensation Scheme, 1985 – 2010*, Research report, June 2011.

11 Ibid.

12 The financial rewards and penalties are further discussed on page 142.

104. While WorkSafe does not directly manage claims, the WIRC Act states:

- WorkSafe is directly liable to an injured worker to pay compensation and damages in accordance with the Act (section 70).
- A function or power performed or exercised by an agent is taken to have been performed or exercised by WorkSafe (section 500(4)).
- Agents must act in accordance with the terms and conditions of their contract and any written directions by WorkSafe (section 501(2)). WorkSafe may terminate an agent's appointment if they fail to comply with any of these (section 501(4)).

105. WorkSafe oversees agents' management of claims through a number of different mechanisms, including performance reporting, audits of the quality of decisions, complaint handling and targeted 'health checks' of claims management issues.

Agents

106. Agents are responsible for the management of WorkCover claims, which includes:

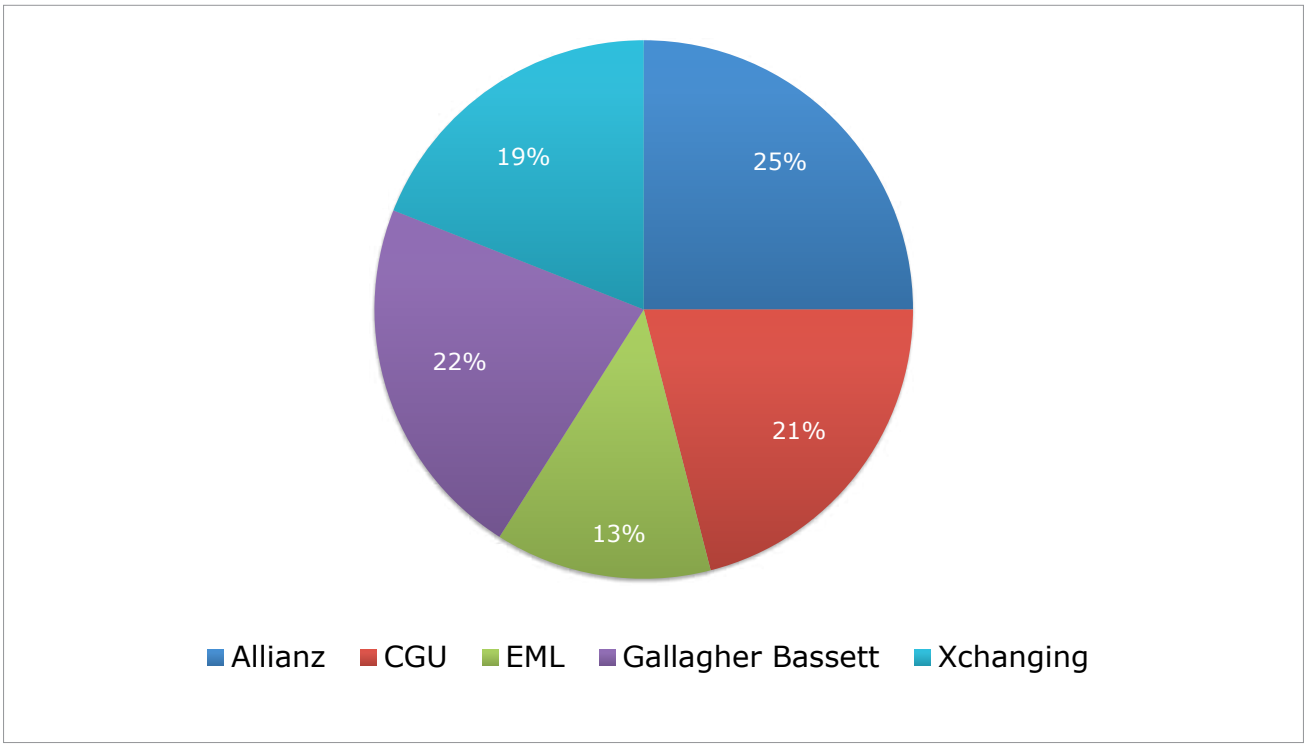
- receiving claims
- assessing them to determine what compensation an injured worker is entitled to
- managing accepted claims
- defending disputed claim decisions at conciliation and court.

107. WorkSafe's contract with the current agents runs for five years, commencing on 1 July 2016 and ending on 30 June 2021.

108. As employers choose the agent by which they are insured, agents' share of the workers compensation market varies.

109. The current agents held the below percentage share of the market (based on premium) at 30 June 2018:

Agent market share as at 30 June 2018



Source: WorkSafe Victoria

110. Each of the agents employ specialist staff to assist case managers, including:

- Technical Managers/Advisors, who provide technical advice and review decisions which are adverse to a worker's entitlements
- Injury Management Advisors, who provide expert injury management advice
- Dispute Resolution Officers, who review disputed decisions and attend conciliation.

Injured workers

111. Under section 18 of the WIRC Act, injured workers are obliged to notify their employer of their injury within 30 days of becoming aware of it. They can make a WorkCover claim by giving it to their employer or lodging it directly with their employer's agent or WorkSafe.

112. Section 20 of the Act states that injured workers who cannot work must provide a 'certificate of capacity' from their doctor to be eligible for weekly payments. If their claim is accepted, they must provide a certificate every 28 days for the duration of their incapacity, unless special circumstances exist.[13]

113. Under section 27 of the WIRC Act, injured workers are obliged to attend an examination with an IME at 'reasonable intervals'. If they have an incapacity for work, they also have return to work obligations, which include making reasonable efforts to return to work and participating in occupational rehabilitation.

IMEs

114. WorkSafe appoints IMEs to examine injured workers and provide an opinion about their condition, work capacity and treatment. Under the WIRC Act, an IME may be a:

- medical practitioner, such as an occupational physician, psychiatrist or surgeon
- registered dentist, physiotherapist, chiropractor, osteopath or psychologist.

115. Agents engage IMEs to provide an independent opinion regarding a worker's injury or capacity and may use their report to make decisions about a worker's entitlements. IMEs do not provide treatment to injured workers.

116. To be approved, IMEs must meet criteria set by WorkSafe and agree to adhere to service standards.

117. IMEs are not employees or representatives of WorkSafe or the agents. However, they are paid by the scheme for their opinion.

Treating doctors

118. An injured worker's treating doctor(s) are responsible for the overall management of their injury, including their treatment.

119. WorkSafe can pay a worker's treating doctor(s) for the reasonable costs of treatment for a work-related injury.

120. Throughout the management of a claim, agents may ask a worker's treating doctor(s) to provide reports about the progress of the worker's recovery and capacity to return to work.

13 Under section 3.2.6 of the WorkSafe Claims Manual, agents may authorise a period beyond 28 days for ongoing certificates of capacity if they believe special reasons exist. This may occur where an injured worker has a serious and/or long-term or permanent injury.

Employers

121. Employers have a number of obligations under the WIRC Act when one of their employees is injured, which include to:

    - acknowledge receipt of any WorkCover claims received and forward them onto their agent within 10 days (section 73)
    - pay an injured worker weekly payments for loss of income if their claim is accepted and they have an incapacity for work[14]
    - maintain an offer of suitable employment for 52 weeks after an injured worker starts receiving weekly payments (section 103)
    - appoint a return to work coordinator and develop return to work plans (sections 104 and 106).

Occupational rehabilitation providers

122. WorkSafe appoints occupational rehabilitation providers to provide services to workers to assist them to return to work. This may include an assessment of a worker's skills, assistance preparing a resumé and applying for jobs, or organising retraining for the worker.

123. Under the WIRC Act, agents are required to give workers a choice of three occupational rehabilitation providers.

124. While WorkSafe is responsible for the registration of these providers, agents may refer injured workers to these services direct.

125. During the period examined by this investigation, there were 29 approved providers. WorkSafe said its providers deliver services to over 10,000 injured workers each year.

Private investigation firms

126. WorkSafe appoints private investigation firms to carry out 'circumstance' (factual) investigations and conduct surveillance of injured workers.

127. Like occupational rehabilitation providers, WorkSafe registers these providers but agents can directly engage them to provide investigative services.

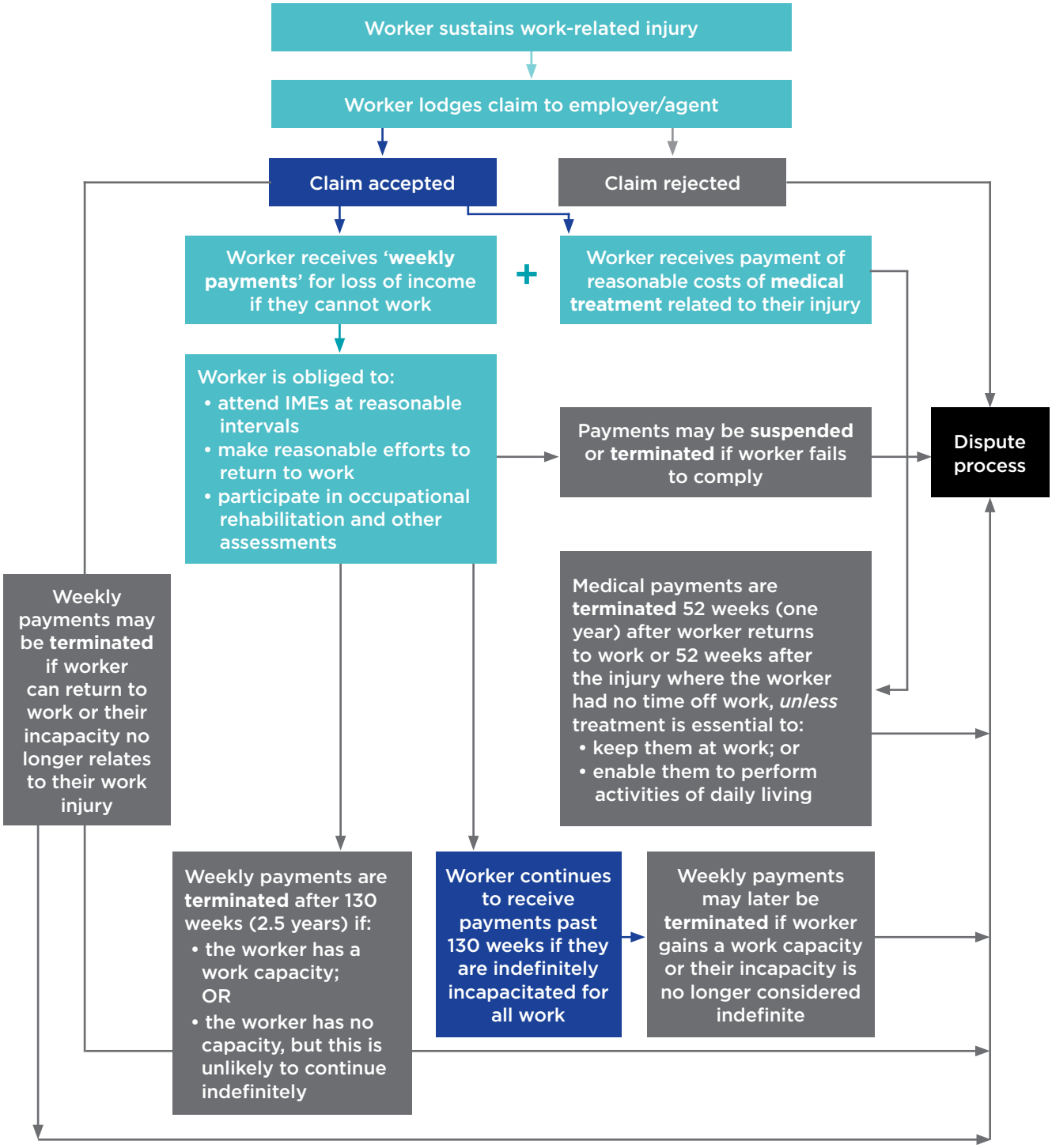
Clinical Panel and Medical Advisors

128. WorkSafe has established a Clinical Panel of medical and allied healthcare professionals who undertake reviews and provide clinical and rehabilitation advice to WorkSafe, the agents and healthcare providers.

129. In addition, there are Medical Advisors based at the agents, who provide advice to claims staff on medical issues.

14 The employer is then reimbursed by the agent where the worker's incapacity exceeds 10 days.

Claim process



Accident Compensation Conciliation Service

130. The ACCS is an independent authority established under the WIRC Act[15] that provides conciliation services at no cost to injured workers, to help resolve disputes about claim decisions. Conciliation 'facilitates the resolution of disputes by involving all parties in an informal, non-adversarial process to pursue an agreement that is fair and mutually acceptable'.[16]

131. The ACCS employs a number of Conciliation Officers who are assigned to individual disputes as an independent third party. Conciliation Officers primarily play a 'facilitative' rather than 'determinative' role in relation to the dispute and its resolution.

132. In most cases, a conciliation conference is held to allow the parties, including the injured worker, agent and sometimes the employer, to discuss the dispute, with a view to reaching an agreement about how it can be resolved.

133. Where a matter cannot be resolved by agreement, Conciliation Officers have the power to make recommendations, refer medical questions to a Medical Panel or issue a 'genuine dispute certificate' allowing the parties to go to court. In very limited circumstances, Conciliation Officers also have the power to make a direction.

134. In 2017-18, there were 13,316 disputes referred for conciliation, 59 per cent of which were resolved.

15 Prior to October 2017, the ACCS was an independent body corporate established under the *Accident Compensation Act 1985* (Vic).

16 Accident Compensation Conciliation Service (ACCS), *Annual Report 2017/18*.

Medical Panels

135. Medical Panels can be used by the ACCS 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.

136. Each Medical Panel is independent and made up of medical professionals from specialities relevant to the worker's injuries. The Panel functions as a tribunal that provides final and legally binding answers to the medical questions referred to it.[17]

137. In 2017-18, there were 3,410 referrals to a Medical Panel.

138. An agent may only review a worker's entitlements after a Medical Panel opinion if there is sufficient evidence of a 'material change' in the worker's condition.[18]

139. The Convenor of Medical Panels oversees all panel referrals and is responsible for:

- convening each panel once a referral is received, including deciding the size and specialisations of the panel
- recommending appropriate medical practitioners to the Minister for appointment as a Medical Panel member
- providing advice to the Minister about matters relating to Medical Panels.

WorkCover Assist and Union Assist

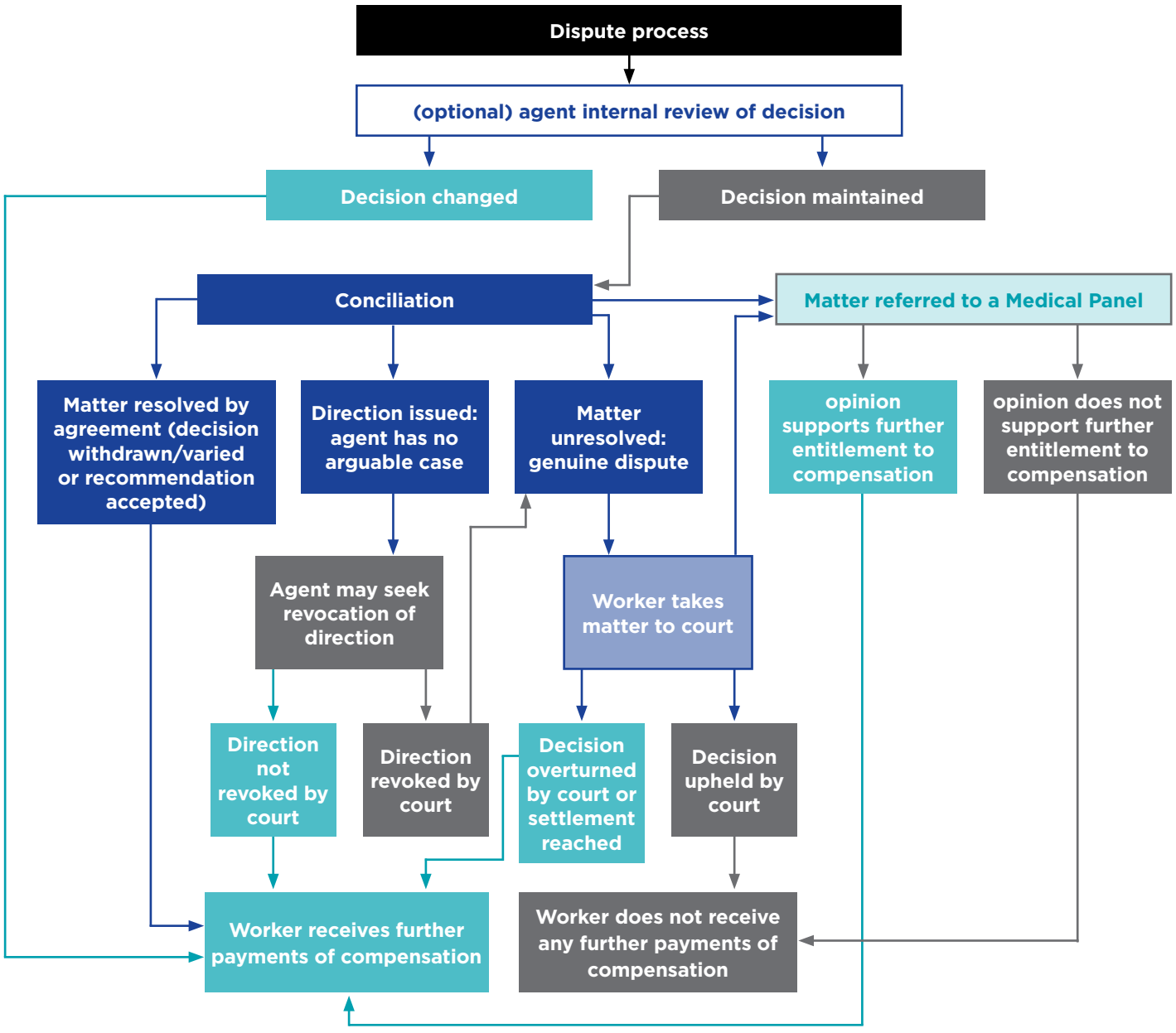
140. WorkCover Assist is a free service WorkSafe provides to assist injured workers during conciliation. This may involve explaining the process, providing technical assistance and attending a conciliation conference to support the worker.

141. Union Assist is another free service WorkSafe funds, which can assist workers during conciliation when a referral is made by a union.

17 WIRC Act, s 313(4).

18 This is further explained on page 130.

Dispute process



Key legislation and policy

WIRC Act

142. The workers compensation scheme is primarily governed by the WIRC Act, which came into operation on 1 July 2014, replacing two previous Acts.[19]

143. The WIRC Act sets out what happens when a worker is injured, including the compensation a worker is entitled to, the obligations of workers and employers, the functions of WorkSafe and the dispute process.

144. The objectives of the Act include to:

- 'reduce the incidence of accidents and diseases in the workplace'
- 'make provision for the effective occupational rehabilitation of injured workers and their early return to work'
- 'increase the provision of suitable employment to workers who are injured to enable their early return to work'
- ensure 'appropriate compensation' is paid to injured workers 'in the most socially and economically appropriate manner, as expeditiously as possible'
- 'ensure workers compensation costs are contained so as to minimise the burden on Victorian businesses'
- 'maintain a fully-funded scheme'
- 'improve the health and safety of persons at work and reduce the social and economic costs to the Victorian community of accident compensation'.

Claims Manual

145. WorkSafe has created a Claims Manual to assist agents make decisions in line with the Act. The Manual outlines detailed requirements in relation to decision making and claims management, which agents are contractually required to follow.

Ministerial Guidelines

146. Agents are also contractually required to comply with *the Ministerial Guidelines as to Authorised Agent, Self-insurer, Employer and Workers' Assistant Conduct at Conciliation Conference* (2011) (the Ministerial Guidelines), which require agents to 'take all reasonable steps to settle disputes'. They state that this includes:

- 'meaningfully and genuinely discussing all relevant issues' raised at conciliation
- 'ensuring that … [the agent] maintains only the decisions which have a reasonable prospect of success were they to proceed to Court'.

Model Litigant Guidelines

147. Through their contract with WorkSafe, agents are also required to comply with the *Victorian Government Model Litigant Guidelines* when defending decisions through the dispute process. These Guidelines set the standard for how State Government agencies should behave when involved in legal action, which includes during alternative dispute resolution processes such as conciliation.

19 The WIRC Act consolidated the *Accident Compensation Act 1985* (Vic) and the *Accident Compensation Act (WorkCover Insurance) 1993* (Vic). Claims that were made under the Accident Compensation Act continue to be dealt with under that Act.

148. The Guidelines state agencies must:

- act fairly and consistently in handling claims and legal action brought by or against the agency
- deal with legal claims promptly without causing unnecessary delay
- make an early assessment of the agency's prospects of success in the legal action
- pay legitimate claims without legal action
- when participating in alternative dispute resolution, ensure the agency's representatives:
    - have the authority to settle the matter so it can be resolved in an appropriate and timely manner
    - participate 'fully and effectively'
- not take advantage of a claimant who lacks the resources to take legal action regarding a legitimate claim
- not pursue appeals unless the agency believes it will have a reasonable prospect of success or the appeal is otherwise justified in the public interest
- consider apologising where the agency is aware that it acted 'wrongfully or improperly'.

Charter of Human Rights and Responsibilities Act 2016 (Vic)

149. WorkSafe and its agents must comply with the *Charter of Human Rights and Responsibilities Act 2016* (Vic) (the Human Rights Act) when managing WorkCover claims. However, the rights under the Human Rights Act are not absolute. WorkSafe or an agent can limit an injured worker's rights if the limitation can be 'demonstrably justified in a free and democratic society based on human dignity, equality and freedom'.

150. This means that when WorkSafe or an agent does something that impinges on a worker's right, it needs to show that it is 'demonstrably justified'. This requires consideration of 'all relevant factors', including the nature of the right, the importance and purpose of the limitation and whether there are less restrictive means available to achieve that purpose (section 7).

Part One:

Unreasonable decision making by agents

151. Agent decision making was a key focus of the Ombudsman's 2016 investigation. The investigation identified many examples of unreasonable decision making practices on complex claims across all five agents, such as 'cherry picking' evidence, 'doctor shopping' and defending indefensible decisions at conciliation.

152. The Ombudsman's recommendations from the 2016 investigation sought to improve the quality of agent decisions on complex claims to ensure the most vulnerable injured workers receive the compensation they are entitled to.

153. This follow-up investigation looked at whether agent decision making practices on complex claims have improved.

154. Witnesses interviewed during the investigation variously said they observed a temporary 'marked change' in agent behaviour after the Ombudsman's 2016 report was released, as agents seemed 'more cognisant of the scrutiny' and became 'very tentative' about making decisions. However, they said that as time passed, 'old habits came back' and it had 'slipped back to where it began'.

155. The evidence obtained during this investigation was consistent with this view. Additional issues were also identified regarding agent decision making which were not a focus of the 2016 investigation.

156. This part of the report sets out evidence this investigation obtained regarding agents' decision making practices, which included agents:

- unreasonably using evidence, such as IME reports and surveillance of injured workers
- delaying decision making
- engaging in unfair return to work practices
- acting unreasonably during conciliation
- making decisions contrary to binding Medical Panel opinions
- allowing employers to influence claims management.

Unreasonable use of evidence

Agent decision making on claims is guided by the WIRC Act as well as the WorkSafe Claims Manual, which sets out 'principles of good administrative decision making' agents must adhere to. These include that agents must:

- only make decisions authorised by the law
- consider all matters relevant to a decision
- not take into account any irrelevant considerations
- exercise discretion when appropriate
- make decisions supported by the best available evidence
- seek out additional information if it is relevant to a 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.

157. Agents may consider a range of evidence when making claim decisions, including medical reports from IMEs or a worker's treating doctors; information from an occupational rehabilitation provider; circumstance investigation reports and surveillance footage of an injured worker.

158. This investigation found that since the Ombudsman's 2016 investigation, agents have continued to unreasonably use evidence to terminate or reject complex claims in some cases by:

    - selectively using evidence
    - conducting surveillance of workers without adequate justification
    - selectively using IMEs and 'doctor shopping'
    - posing leading questions to IMEs and workers' treating doctors
    - providing incomplete or inaccurate information to IMEs
    - relying on an opinion from an IME from the incorrect specialty.

159. In addition, issues were identified regarding agents' use of evidence in rejecting mental injury claims on the basis that they were caused by 'reasonable management action'.

Selective use of evidence

160. Agents are required to make decisions 'based on and supported by the best available evidence'. However, the investigation identified a number of complex claims where agents selectively used evidence to terminate or reject workers' entitlements, while ignoring other available information. This included cases where agents:

    - relied on one IME opinion, while disregarding all other available evidence including reports from a worker's treating doctor(s)
    - ignored medical reports supporting a worker's entitlement, including those from IMEs and Medical Advisors
    - terminated a worker's weekly payments when they reached 130 weeks, without sufficient evidence.

Reliance on one IME opinion

161. Witnesses interviewed during the investigation gave evidence that agents generally preferred an IME opinion over that of a worker's treating doctor(s), particularly when the IME opinion supported a termination or rejection. Conciliation Officer A acknowledged they saw 'the worst files or the most difficult files' which could skew their view of claims management, but said:

> Unfortunately agents still defer to an IME opinion. They don't truly take into consideration all medical opinions on file. …
>
> [C]ertainly with issues that come to conciliation, more often than not, the agents, if they're relying on an … [IME] in making a decision they will stick to that decision regardless of how many treating doctors' reports may say something to the contrary.

162. Conciliation Officer B said agents relied on an IME opinion if it supported a rejection or termination, even if it was contrary to the opinion of a worker's treating doctor who was a specialist in their field. They said:

> [W]e get reports from workers' specialists. Very well renowned specialists who make comments about a worker's condition, about their capacity … And the [agents] will never change their decisions based on the worker's medical reports. You never see it. And they say things like 'we prefer to adopt the opinion of the … [IME]'. Even if that person doesn't have nearly as much qualification as the worker's own treating doctors.

163. Conciliation Officer B said these disputes were often referred to a Medical Panel, which ended up agreeing with the worker's treating specialist.

164. Conciliation Officer C said there was 'great reticence' for agents to 'look at the weight of medical evidence' and that:

> [T]he insurer will rely solely on the fact they have an … [IME] and that seems to be what – not only makes the decision … but any alteration or change to that decision is not affected really by any other report. So a worker could bring in six reports, it wouldn't necessarily make a difference … because the agent will say 'well this is what our … [IME] says'.

165. The investigation found this occurred in cases even where the IME opinion the agent relied on was unclear, contradictory or inconclusive. The then Convenor of Medical Panels raised concerns at interview about agents' reliance on inconclusive IME opinions, stating:

> [T]he IME may have said 'I think the diagnosis might be this, but I don't have enough information. I'd like to see an MRI'. [Or] 'I'd like to see some additional information in order to have a diagnosis'. And … [the IME has] gone on to answer some other questions that are probably predicated on the diagnosis, and so … the answers to those questions are probably advisory answers … not definitive answers … but the agent has acted on them anyway, rather than … going back and saying 'Okay well this is preliminary advice. We may need to go back to you [the IME] once additional information is available'.

166. Conciliation Officer E interviewed during the investigation also said:

> I think as long as an IME says something in the whole of their report that indicates for example that the worker's got … a capacity for work … even though they might be really ambiguous in what they're saying or may say the opposite in another sentence, they [the agent] will focus on the one sentence … And sometimes reports are quite confused … they go 'on the one hand this, on the one hand that' … [the agent will] just … read you out one line … [and will say] 'but we've got an arguable case'.

167. In one complex claim reviewed by the investigation, Gallagher Bassett relied on an unclear and contradictory IME opinion to terminate a worker's entitlements, despite the opinion being inconsistent with all other available medical evidence on the worker's file. Even after acknowledging deficiencies in the IME's opinion, Gallagher Bassett maintained its decision at conciliation.

Case study 1 – Termination maintained despite 'unclear' IME opinion

Mary was working in finance when she developed a mental injury from work-related stress, bullying and harassment.* In 2013, Mary made a WorkCover claim, which was accepted by her employer's agent.

Mary was examined by a Medical Panel in mid-2016 after her agent, Gallagher Bassett, terminated her entitlements. The Panel concluded Mary had a work-related mental injury which meant she was unable to return to any work, and this was likely to continue indefinitely. In forming its opinion, the Panel considered the nature and severity of Mary's mental injury, which had an ongoing effect on her cognitive function and emotional capacity to cope with employment duties; her age; her social withdrawal; and her 'unpredictable angry' outbursts in her relationships with others. Gallagher Bassett reinstated Mary's entitlements.

In mid-2017, Gallagher Bassett arranged for an IME to examine Mary. The IME concluded Mary's mental injury was 'in remission' and there had been a 'material change' in her condition since the previous Medical Panel opinion. The IME also said the cause of Mary's mental injury was no longer work-related, contrary to previous IME and Medical Panel opinions. However, the IME said Mary was receiving treatment for her mental injury which should not change, and that she was unable to return to her pre-injury work due to her 'unpredictable outburst[s] of anger, and her age' (she was in her early 60s). Without clarifying the inconsistencies in the IME's opinion, Gallagher Bassett terminated Mary's entitlements. Mary's doctor continued to certify her unfit for work.

Mary requested conciliation. When Gallagher Bassett reviewed the decision, it acknowledged internally that the IME opinion was 'unclear' and clarification was needed. Gallagher Bassett also said a Conciliation Officer 'may argue' the IME's opinion did not 'demonstrate clear material change' since the Medical Panel's examination of Mary, meaning they had to accept the Panel's opinion as still binding (see page 130 for further information on the binding nature of Medical Panel opinions and the need to demonstrate 'material change' after a panel opinion).

In early 2018, Gallagher Bassett asked the IME to provide a supplementary report to clarify whether Mary's mental injury was in remission or fully resolved, and whether her 'unpredictable emotions' were work-related. The IME provided a supplementary report in which they said Mary did not present with any symptoms of the mental injury at examination, but this did not exclude a possible 'relapse' in the future. The IME also said that the unpredictability of Mary's emotions was not work-related, and was instead personality based, contrary to the 2016 Medical Panel's opinion.

During conciliation, Mary's treating doctors provided reports indicating she remained unable to return to any form of work, now or in the future, because of her persisting work-related mental injury. Nevertheless, Gallagher Bassett maintained its decision. The matter was referred to another Medical Panel, which in mid-2018 concluded Mary had a work-related mental injury and could not return to work. Gallagher Bassett reinstated Mary's payments, six months after they were terminated.

* This case is also discussed on page 205.

168. In response to the draft report, CGU said:

> CGU will in most cases prefer the opinion of an IME to that of the treating health practitioner (who is generally a GP). This is because of the 'specialist' nature of the advice from the IME, and the fact that the IME has no existing relationship with the injured worker (which may inhibit independence).
>
> CGU acknowledges that from time-to-time, the opinions of IMEs and treating health practitioners may contradict each other. When this occurs, CGU may prefer the opinion of one IME over another practitioner, but it is not a 'cookie cutter' approach and each decision is based on its own merits at the time. Our process at CGU is that decisions should focus on three core components:
>
> 1. How recent the information is;
> 2. The relevance of all information received; and
> 3. If there is conflicting opinion, the difference in the opinion and whether further clarification should be sought.
>
> In the situation where there are multiple reports with conflicting information, and an agent uses part of one of the reports to make a decision, [it] does not mean that the use of the information is inappropriate. Reliance on a specific part of a report where there is conflicting information will be determined following consideration of the above core components for specific circumstances of the decision required/ claim.

Opinions of IMEs or Medical Advisors ignored

169. The investigation also identified instances where agents chose to ignore opinions they had requested from IMEs or Medical Advisors if they did not support a termination or rejection.

170. The Police Association Victoria raised concerns about the practice of Victoria Police's agent, Gallagher Bassett, disregarding IME reports and other 'critical evidence' which would support a member's claim. The Police Association said:

> [It] has realised if the agent obtains evidence that is contrary to the insurer's position, it is often disregarded in preference for the narrative of the employer or the [employee's] manager. If conflicting versions of an incident are reported by employer and employee during an investigation, the case is routinely rejected, regardless of available evidence to support the employee.

171. The sample of agent staff emails obtained by the investigation provided examples of agents choosing to ignore IME opinions where they were favourable to the worker, one of which is outlined on the following page.

Example

CGU staff exchanged emails about the sustainability of a termination being disputed at conciliation. One CGU employee said they thought the decision appeared 'shaky'. They noted CGU had received three opinions about the worker's condition: opinions from a Medical Advisor and the worker's treating chiropractor supported the worker having an entitlement, whereas an IME's opinion supported the termination. The CGU employee said they 'may' have an arguable decision if they rely on the one IME opinion but it may 'not necessarily [be] sustainable if this has to go to a medical panel for a binding opinion'. The employee said that to 'justify ignoring' the two opinions supporting the worker, a supplementary report should be obtained from the IME. In response to this email, a CGU Technical Advisor said:

> We appreciate the MA [Medical Advisor] opinion but this MA did not access the worker where the IME did, therefore their opinion is based only [on] information provided, where[as] the IME had information provided and a physical assessment.
>
> We would like this case argued and believe medical panel review is reasonable in answering this medical dispute.

The Conciliation Officer referred the matter to a Medical Panel and based on its opinion, CGU reinstated the worker's entitlements. This occurred about four months after the worker's claim was terminated.

In response to the draft report, CGU said:

> The email correspondence makes it clear that the Technical Advisor considered that the Medical Advisor's opinion should not be preferred over the opinion of the Independent Medical Examiner.
>
> The decision was taken in consideration of the fact that the Medical Advisor did not conduct an examination of the worker (which involves an ability to speak with the worker) and conduct a physical assessment.
>
> CGU considers this rationale to be valid and appropriate. Also, with respect to the weight of evidence, it is noted that the Medical Advisor who provided an opinion on this claim is a general practitioner whereas the Independent Medical Examiner is a specialist practitioner in an appropriate field to be able to make comment on the worker's condition and request for treatment (rheumatology).

CGU did not comment on its consideration of the opinion of the worker's treating chiropractor.

172. The following case study is an example of a complex claim reviewed by the investigation where Xchanging ignored the opinions of three WorkSafe Medical Advisors to reject a worker's request for repayment of two medical procedures.

Case study 2 – Agent ignores three medical opinions to reject treatment

Theresa, a self-employed business owner, suffered an injury to her lower back from a fall.* Theresa made a WorkCover claim in 2007 which was accepted by her agent, Xchanging. Theresa later developed a chronic pain condition.

In 2011, Theresa applied for two medical procedures to assist with ongoing pain in her lower back. Xchanging rejected the request on the basis that a previous Medical Panel in 2009 had concluded that the physical injury to her lower back injury had resolved. Theresa underwent the procedures at her own cost. She was later examined by another Medical Panel in 2017, which concluded she did not have a work-related physical injury, but continued to suffer from a work-related chronic pain disorder.

In mid-2017, Theresa requested Xchanging reimburse her for the procedures based on a report from her treating pain specialist indicating they were required and had assisted with the management of her work-related pain condition. Three months after receiving Theresa's request and obtaining additional information from her treating pain specialist, Xchanging sought advice from a WorkSafe Medical Advisor. The Medical Advisor concluded that from a medical perspective, the procedures appeared 'reasonable and appropriate' and that it was 'unlikely there could be a sustainable denial of this request to reimburse on medical grounds'.

Two weeks later, Xchanging sought an opinion from a second Medical Advisor. Before receiving a response, Xchanging rejected Theresa's request for reimbursement. Xchanging noted its previous rejection of the procedures and the 2009 Medical Panel opinion that Theresa was no longer suffering from a physical work-related injury. Xchanging said it would not reimburse her for the procedures because they were not 'reasonable' or 'necessary' for her work-related injury, nor were they a reasonable cost.

One day after the rejection, Xchanging received the second Medical Advisor's opinion which recommended approval of the request. The Medical Advisor said '[t]he worker does not necessar[il]y need to have the original physical disorder present to benefit from this treatment'. Xchanging maintained its decision despite this advice.

In late 2017, Xchanging obtained an opinion from a third Medical Advisor, who agreed with the two previous opinions and said they believed it was 'a weak argument' to reject the request because there was 'no soft tissue injury anymore'. They said the procedures were 'medically appropriate' and had provided benefit. They also said if a Medical Advisor had reviewed the case prior to Theresa undergoing the procedures, it was likely they would have been approved. Despite this opinion, Xchanging maintained its rejection.

Theresa requested conciliation and also complained to her local Member of Parliament (MP) stating she was 'furious' her pain specialist's recommendations had not been accepted. She said the first procedure 'saved my life' and the second was 'the reason I can attempt to work'. Theresa said she was 'sick of having to play defence' and 'justify' her condition.

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Xchanging provided the Conciliation Officer copies of relevant documentation for conciliation; however, not the three Medical Advisors' opinions. Evidence on Theresa's claim file showed Xchanging intended to maintain the rejection at conciliation. However, it later agreed to reimburse Theresa and withdraw its decision in mid-January 2018, as a result of Theresa's complaint to her local MP, which was referred to WorkSafe via the responsible Minister. This occurred almost six months after Theresa's initial request.

In response to the draft report, Xchanging said:

> Xchanging sought the opinions of Medical Advisors to assess the appropriateness of a requested procedure.
>
> Although the opinions of the medical advisors were sought, the final determination required a legal analysis of the matter. Xchanging did not ignore the opinions of the Medical Advisors.
>
> To resolve the dispute, Xchanging agreed to pay the worker's out-of-pocket expenses with a denial of liability.

* This case is also discussed on page 82.

173. In response to the draft report, WorkSafe said it considered the statement that agents 'ignore' IME reports is 'not an accurate overall representation of the use and application of IME reports'.

130-week terminations issued without sufficient evidence

174. Witnesses interviewed during the investigation raised specific concerns about agents unreasonably terminating workers' weekly payments at 130 weeks without sufficient evidence. In 2017-18, 451 of these terminations were issued across the scheme.

175. Injured workers who are incapacitated for work are only eligible to receive weekly payments for up to 130 weeks, unless there is evidence they are likely to have no capacity for any work for the foreseeable future (ie 'indefinitely'). Agents must terminate a worker's weekly payments at 130 weeks if the worker has a work capacity, or their incapacity is not likely to continue indefinitely.

176. In response to a recommendation from the Ombudsman's 2016 investigation, WorkSafe provided additional guidance to agents in the Claims Manual about the evidence required to terminate a worker's entitlements at 130 weeks. The Claims Manual now states that agents can only terminate weekly payments because a worker's incapacity is not likely to continue indefinitely where:

- medical opinion confirms that the worker will have a capacity for suitable employment in the foreseeable future
- the normal or expected course of recovery is that the worker will have a capacity for suitable employment based on evidence-based clinical practice and/or previous experience
- the duration of the worker's current incapacity can be defined and is proximate, eg < 9 months
- there are reasons why the worker will gain a capacity for suitable employment, eg surgery recovery, gaining a qualification etc and
- there is consistent information supporting the change of capacity.

177. Despite the clearer requirements, information provided to the investigation suggested that in some cases, agents have continued to make these decisions without the required evidence.

178. Conciliation Officer B told the investigation:

> They [the agents] are making those decisions based on those very ambivalent claims about a worker's capacity into the future. And the amount of times I've said, there's a crystal ball that's being used here to determine this person's capacity going into the future. And it's not really saying the worker will have a capacity. And yet they're basing their decisions on those IMEs that say 'they may'.

179. A worker representative similarly said at interview that they had continued to observe agents relying on inconclusive IME opinions regarding the duration of a worker's incapacity, despite the requirement that it be 'defined' and 'proximate'. They queried agents' reliance on such IME opinions and said 'realistically until we actually know what the worker can do, why do we say "maybe?"'.

180. The following case study is an example of a complex claim reviewed by the investigation where Xchanging terminated a worker's weekly payments at 130 weeks, without clear and conclusive information about when the worker could return to work.

Case study 3 – Payments terminated based on inconclusive IME opinion

Susan was working as a paramedic when in 2015 she suffered a mental injury after attending a traumatic incident.* After several unsuccessful attempts to return to work, Susan made a WorkCover claim which was accepted by her employer's agent at the time, QBE. In 2016, Susan's claim was transferred to Xchanging.

In 2017, Xchanging arranged for an IME to examine Susan and assess her capacity to return to work. The IME concluded Susan could not return to work as a paramedic, as this may exacerbate her injury. They concluded there was no work for which Susan was currently suited, but noted her motivation to undertake further study, which the IME believed she was capable of. The IME said if Susan was to attempt any further study or work, her mental condition needed to be closely monitored, and suggested she be assessed again in six months.

Xchanging requested two supplementary reports from the IME, asking them to comment on whether Susan's incapacity for work was likely to continue indefinitely. Susan had received nearly 130 weeks of weekly payments and so Xchanging needed to establish the expected duration of Susan's incapacity, to determine whether she would continue to receive weekly payments past 130 weeks.

In their supplementary reports, the IME said there was no way to predict when Susan would have a capacity for work, as it all depended on her progress 'over time'. The IME said that if Susan's mental state continued to progress, it was likely she would have a capacity to engage in work within the next 12 months. At the same time, Susan's treating doctor provided a report which said she did not have a current work capacity, but that she could be assessed again in eight to 12 weeks.

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Upon reviewing the available medical opinions, Xchanging noted it had:

- attempted to 'revert' to the IME for 'reconsideration via a supplementary report' but this was 'not supportive of the claimant having a CWC [current work capacity]' within 12 months
- a teleconference with Susan's treating doctor and 'came close however, no upgrade in capacity nor was the GP able to advise that the claimant may have a capacity in 12 … months'.

A week later, Xchanging terminated Susan's weekly payments at 130 weeks on the basis of the IME's opinion, which it said indicated her incapacity was unlikely to continue indefinitely.

Susan requested conciliation. Upon reviewing the decision, Xchanging's Dispute Resolution Officer concluded the decision was not sustainable. Xchanging withdrew the termination and reinstated Susan's weekly payments.

In its response to the draft report, Xchanging highlighted that the decision was made as a result of 'an error in legal interpretation' and said:

> The decision maker needed to consider whether the worker's incapacity was indefinite. The IME stated quite clearly that the worker's ongoing incapacity was conditional upon a range of recovery factors. This statement (when interpreted correctly) supports a decision to continue payment of weekly entitlements.
>
> The interpretation error was identified by the Dispute Resolution Manager (DRM) who withdrew the decision prior to the conciliation conference and before the injured worker's payments had ceased.

* This case is also discussed on page 60.

181. The investigation also identified two other examples.

Example 1

In one complex claim reviewed by the investigation,* Allianz received an IME opinion indicating the worker 'may' have a capacity to work in six to nine months if her mental injury 'significantly improved'. In a supplementary report, the IME concluded the worker 'may' have a capacity 'in the future', but only if the worker received treatment and her condition improved.

Despite the uncertainty around the worker's condition, likelihood of improvement and duration of her incapacity, Allianz relied on the IME's reports to terminate the worker's weekly payments at 130 weeks. WorkSafe reviewed the decision following a request by the Ombudsman's investigation and concluded it was not supported by sufficient evidence. Allianz withdrew the termination and reinstated the worker's weekly payments.

* This case is also discussed on page 92.

Example 2

In another case, EML terminated a worker's weekly payments at 130 weeks, relying on the worker's GP's opinion that she had a work capacity.* EML ignored an IME opinion it received indicating the worker was indefinitely incapacitated for all work based on her work-related shoulder injury. The decision failed a WorkSafe audit because the evidence did not support the grounds used. EML withdrew the termination and reinstated the worker's entitlements (WorkSafe's audits of the quality of agent decisions are further discussed on page 156).

* This case is also discussed on page 61.

Use of surveillance without adequate justification

182. Agents may use surveillance as a claims management tool to 'discreetly determine a worker's activities and capabilities'. WorkSafe has a panel of registered private investigation firms that agents can engage to covertly watch a worker's activities and movements, which may be recorded through photographs, video footage and observation logs. Private investigators may also undertake searches of workers' social media accounts (or those of their family members), as well as other publicly available information about them.

183. In 2017-18, the agents collectively spent nearly $9 million on surveillance.[20]

184. According to the WorkSafe Claims Manual, agents are only permitted to conduct surveillance of a worker if there is 'adequate evidence' they may be misrepresenting their injury, claiming excessive injuries, malingering or involved in committing fraud (for example, working while also receiving WorkCover payments). Noting the privacy implications of surveillance, agents also must have:

    - considered or tried less intrusive methods of investigation and found them to be 'ineffective or inadequate'
    - assessed the benefits of obtaining the surveillance as outweighing 'to a substantial degree' the intrusion on the worker's privacy
    - considered an individual's right to privacy and reputation under the Human Rights Act, unless a limitation of the right is 'demonstrably justifiable' taking into account 'all relevant factors'.

185. Agents' use of surveillance was not examined in the Ombudsman's 2016 investigation, nor was it a focus of this investigation. However, when reviewing complex claims files for this investigation, numerous instances were identified where agents conducted surveillance of a worker without adequate justification.

186. In some cases, agents did not record any reasons for the surveillance, other than a statement that it had been approved by a manager. In other cases, agents recorded reasons, however, they did not reflect the criteria in the Claims Manual.

187. Examples of reasons that agents conducted surveillance in the complex claims reviewed are outlined on the following pages.

20 This does not include surveillance arranged by WorkSafe's panel law firms for court proceedings.

Example 1

CGU wanted to 'see' if a worker was 'active', 'what he gets up to with his day to day activities and i[f] he [was] residing else where apart from his address' and to 'check how worker presents himself to those that know of injury v[ersus] those who don't'.

Example 2

Allianz wanted to determine a worker's 'daily activity level and ensure that this … [was] consistent with medical opinions', which occurred one month after Allianz withdrew its termination of the worker's payments at conciliation because it was not sustainable.

Example 3

Gallagher Bassett wanted to confirm the hours being worked by a worker who had returned to work part-time, despite her providing payslips reflecting this and there being no evidence she was working different hours to those claimed.

Example 4

Xchanging wanted to determine if a worker's capacity to walk was restricted to 10 minutes as reported to an IME, despite no evidence this was untrue.

In response to the draft report, Xchanging said it considered it had 'evidence to support a line of enquiry about the worker's capacity to walk', which included a medical certificate and IME report. Xchanging did not give any further details about why it considered these documents provided adequate justification for conducting surveillance in line with the requirements of the WorkSafe Claims Manual.

The investigation notes that the IME report referenced by Xchanging stated that the worker had the capacity to work for up to five hours per week, however, the worker's treating doctor had only certified them for one hour of work per week. The IME also said there was a 'discordance between the lack of imaging findings and … [the worker's] symptoms' and that the worker was 'reporting high levels of pain and functional incapacity despite significant levels of medication'. However, the worker was previously diagnosed with chronic pain syndrome by a Medical Panel, which can cause persistent pain without any physical basis.

In the absence of evidence that a worker may be misrepresenting their injury, the investigation does not consider that a difference in medical opinion or reports by a worker of significant restrictions meet the criteria for conducting surveillance outlined in the Claims Manual.

Example 5

A worker had 'a history of roles that could afford an opportunity for cash work' and EML needed to 'exclude this and obtain a better understanding of his capacity', despite no evidence the worker had returned to work or had a capacity to do so.

In response to the draft report EML outlined the full justification for the surveillance, which it said was:

> The purpose of this period of observations is to confirm the worker's incapacity outside of a clinical examination setting.
>
> The worker has been assessed to have a lumbar spine condition.
>
> We are particularly interested in any footage of the worker: sitting, standing, walking, squatting, bending, twisting, lifting, pushing/pulling, getting in and out of a car, driving etc.
>
> Please note that the worker has a history of employment as a plant operator and truck driver. Any footage of machinery or a truck at the worker's place of residence is of particular interest ...

EML's further comments do not justify the use of surveillance in this case in line with the requirements of the Claims Manual, noting the absence of evidence the worker was misrepresenting their injury.

EML highlighted that an IME concluded, after reviewing material obtained from the surveillance, that the worker had a 'greater physical capacity than ... [they] admit[ted]'. However, this does not justify EML's decision to conduct the surveillance in the first place.

EML also said it conducts weekly checks and regular compliance audits regarding staff use of surveillance, especially for mental injury claims, and that:

> EML regards the use of surveillance as an important tool (that needs) to be used cautiously, and (is used) when there is no other practical way of determining a worker's true functional capacity outside of the clinical setting. As an Agent of WorkSafe, we are required to detect scheme abuse.

However, in the absence of adequate evidence suggesting a worker may be misrepresenting their injury, the use of surveillance to determine a worker's 'true functional capacity outside of the clinical setting' is inconsistent with the criteria in the WorkSafe Claims Manual.

188. In the following case study, Gallagher Bassett conducted surveillance of a worker, so it could then 'discuss terminating the claim'. This occurred despite the absence of evidence on the worker's claim file to suggest she had been dishonest about her work capacity.

Case study 4 – 'Further period of surveillance would be interesting'

Sophia was working in aged care when she injured her back at work. She also later developed a pain disorder as a result of her injury. In several emails and file notes on Sophia's claim file, Gallagher Bassett discussed using surveillance to terminate Sophia's entitlements. In many instances this occurred in communication with Sophia's employer. In one email to Sophia's employer, Gallagher Bassett said:

> We have also engaged surveillance, if the reports confirm Sophia is more mobile than she noted this will be sent back to … [the IME] for him to provide his comments and opinion on whether she is fit for pre injury hours and duties – if this is the case we can discuss terminating the claim.

A surveillance report provided to Gallagher Bassett stated Sophia appeared 'incapacitated' and walked with a limp for the entire period of surveillance. In response to the report, Gallagher Bassett said it needed to consider whether a further period of surveillance was required or if referral to an IME was 'more preferable'.

Sophia later asked Gallagher Bassett if it had arranged surveillance of her. Gallagher Bassett said it had not and encouraged Sophia to 'contact police' if she was concerned. In a file note about the conversation, Gallagher Bassett noted Sophia said her mental health was 'very poor' and she needed to end the call.

Gallagher Bassett subsequently suspended and attempted to terminate Sophia's weekly payments. Sophia requested conciliation. Upon reviewing the decisions, Gallagher Bassett suggested a 'further period of surveillance would be interesting' but did not provide further justification. Gallagher Bassett subsequently withdrew its suspension and termination at conciliation. Gallagher Bassett then arranged for Sophia to be examined by an IME and upon receiving the report, said to her employer:

> I note some interesting reading in the report regarding … [Sophia's] activities at home including weeding and painting. What are your thoughts on commencing activities surveillance to confirm [her] activities whilst at home?

This was despite the IME stating in their report that they believed the activities were within her capabilities. Gallagher Bassett did not proceed with further surveillance straight away, instead arranging for her to be examined by two IMEs about six months later. Both IMEs said Sophia had no capacity for any work and could not say when she might be able to return.

A few months later, Gallagher Bassett arranged for further surveillance of Sophia to be conducted. The reasons recorded were 'confirmation of CWC [current work capacity] / incapacity'. Sophia was not sighted leaving her home during the further surveillance, which was conducted over three days outside her home. In response to the draft report, Gallagher Bassett said:

> [T]he use of surveillance in this case study, and the use of the heading "Further period of surveillance would be interesting", implies improper action. It is apparent that the action was undertaken in order to test ongoing entitlement and the result confirms that the surveillance action was not a case of improper decision making.

However, there was no evidence on Sophia's claim file indicating Gallagher Bassett had sufficient justification to conduct surveillance of her, in line with the requirements of the WorkSafe Claims Manual.

189. Witnesses raised concerns with the investigation about agents' use of surveillance for terminations and queried the weight that should be afforded to surveillance material, given it only provides a 'snapshot' of a worker's activities at a point in time and can sometimes be open to subjective interpretation.

190. A former agent employee said at interview that while the General Manager of the agent had 'put out an instruction' about using surveillance 'properly and appropriately and only when justified', middle management 'offline' said:

> We need to do more surveillance and we need to do surveillance on people with mental injury claims and we need to discover if they're working or if they're faking it.

191. The former agent employee reiterated the message from middle management was 'more and more surveillance please', which they said was 'inappropriate a lot of the time' and took away from 'the focus of genuinely helping someone'. When investigators queried the reason for this instruction, the former employee said:

> To get the termination … the instruction from middle management was … get surveillance, get the independent medical examination, get the IME to comment on the surveillance and get the termination to try to prove that somebody's work capacity was far greater than what they were presenting in the IME.

192. The then Convenor of Medical Panels highlighted the importance of viewing surveillance material 'fairly', 'appropriately' and 'objectively', stating:

> [I]t might be that they've got multiple IME opinions saying 'no current work capacity' but … the agent might obtain two minutes of footage where the person's seen reaching for the boot of the car and putting the car boot down and they want to make an adverse decision [termination]. The IME might say 'oh well, that changes my opinion, they've suddenly got a work capacity'. And it might be that it reaches the Medical Panel, and the Medical Panel says 'well, this is only two minutes and it's one movement' … it's about understanding how to view material fairly and appropriately and objectively.

193. They further said:

> One of the things that we look at very rigorously when we look at DVD surveillance on a Medical Panel is 'Yes, that's what we saw. But are there things here, are there gaps here where there could be things that we're not seeing but which were captured, which were relevant to this matter?' So it's about looking at the surveillance … in a very analytical way … because it may tell a particular story but it may not be a representative story.

194. The then Convenor said Medical Panels see cases where agents have relied on surveillance to terminate a worker's entitlements. He said that in about two thirds of those matters, the Panel:

- did not consider the surveillance useful in their assessment of the worker or
- considered it useful, but ultimately concluded the worker had no work capacity.

195. Conciliation Officer G said at interview agents sometimes used surveillance that was inconsequential, and described an example:

> [T]here was some surveillance that was really nothing. The man went to the shop to buy himself a couple of cans of something. Got in his car, didn't bend his back, as far as I could see, and the IME saw that and said 'oh, he can do a lot more than he's telling everyone he can'. Which just isn't right.
> ...
> People are allowed to go to the shop. I mean they'd done surveillance over four days, and one day he went out for 20 minutes out of those four days. And so it's this inability to put things in context but rather just take something they [the agent] think is helpful [and then] run it through an IME.

196. A worker representative similarly said that agents often conduct 15 hours of surveillance and use three minutes of video footage against the worker. They said agents provide 'snippets' of a surveillance report to IMEs, along with a request for a supplementary report, to 'question the credibility of the worker' and see if it changes their initial opinion.

197. Conciliation Officer B said agents provide surveillance material to IMEs which can sometimes 'completely change their opinion', despite the surveillance material just showing the worker 'living their life as best as they can, not actually going out and dancing'.

198. In response to the draft report, Gallagher Bassett said:

> Inclusion of the narrative around the efficacy of surveillance evidence ... appears to be outside the scope of the investigation, and aimed at the question of whether the tool of surveillance has a role to play in claims management.

199. The following case study is an example where an agent used surveillance to terminate a worker's entitlements, despite an IME having reviewed the surveillance material and finding the worker could not return to work. This case also highlights issues around the subjective interpretation of surveillance material.

Case study 5 – Worker's payments terminated after surveillance is sent to a second IME for an opinion

Alexandra was working as a nurse when in 2004 she injured her back.* Alexandra ceased work and made a WorkCover claim which was accepted by her employer's agent, Allianz.

In 2014, Alexandra was assessed by a Medical Panel after Allianz terminated her entitlements. The Medical Panel found she was unable to return to work for the foreseeable future as a result of her injury. In forming its opinion, the Panel said it considered the extent of her back injury which 'severely limited her capacity for employment', her age (she was in her late 50s), her rural place of residence, her inability to drive long distances, her prolonged absence from work and the absence of any occupational rehabilitation. Alexandra's payments were reinstated based on the Panel's opinion.

In late 2015 and early 2016, Allianz arranged for two 15-hour periods of surveillance to be conducted of Alexandra. The reason recorded for the surveillance on both occasions was '[t]o confirm how the worker is currently presenting and if this shows that the worker is performing beyond her capacity'. There was no evidence Alexandra was misrepresenting her injury.

Allianz also referred Alexandra to an occupational physician IME in 2016 and provided him copies of the surveillance reports. The IME concluded Alexandra was still suffering from the physical injuries diagnosed by the 2014 Medical Panel. He said Alexandra did not have a work capacity and this was likely to continue indefinitely, noting there had been no material improvement since the Medical Panel opinion and her pain had actually worsened. Regarding the surveillance, the IME said Alexandra's history of injuries and presentation at the examination were 'consistent' with the surveillance material. While the IME noted Alexandra appeared to flex her back at a greater range in the surveillance footage than during the examination, he said this did not change his opinion about Alexandra's incapacity for work.

In mid-2017, Allianz arranged further surveillance of Alexandra. Allianz justified this based on 'discrepancies' in Alexandra's presentation in the 2014 Medical Panel examination and surveillance in 2016. It noted that Alexandra told the Medical Panel she could only stand for about 15-20 minutes, however, she was seen 'actively shopping, carrying grocery shopping bags for 2 hours'. This was despite the surveillance having already been reviewed by the IME, who said it did not alter his opinion that Alexandra was indefinitely incapacitated for work. Also, it was incorrect that she was seen shopping for two hours; instead it was 20 minutes.

In late 2017, Allianz arranged for Alexandra to be examined by a different occupational physician IME and provided the 2016 surveillance material to him, highlighting the 'increased flexion' shown. The surveillance material was obtained about one and a half years prior and Allianz did not mention the first IME's opinion regarding the surveillance material (although it provided a copy of the IME's report). The second IME concluded Alexandra had a 'partially resolved' physical injury and chronic pain, but said she could return to work with restrictions. The IME said there had been a 'significant change' in Alexandra's condition since the 2014 Medical Panel, but did not properly explain this.

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In late 2017, Allianz terminated Alexandra's entitlement to weekly payments on the basis that she was no longer incapacitated for work, or alternatively if she was, this would not continue indefinitely. Allianz primarily relied on the second IME's report to support its decision and did not refer to the first IME's report.

Alexandra requested conciliation. Upon reviewing the decision, Allianz questioned whether the second IME's reasons for 'material change' were 'sufficient' considering the previous Medical Panel opinion (see page 130 for further information on the binding nature of a Medical Panel opinion and the need to demonstrate 'material change' after a panel opinion).

In early 2018, Allianz obtained further surveillance of Alexandra. The surveillance report said Alexandra's whereabouts could not be determined during two days of surveillance as she was not observed at her property. However, the report said she was subsequently seen 'walking freely' following her attendance at an IME appointment.

At conciliation, the matter was referred to another Medical Panel, which in mid-2018, concluded Alexandra was suffering from a severe back injury, including 'irreversible postural changes' and loss of spinal movements, caused by the work incident in 2004. The Panel concluded Alexandra had no current work capacity and this was likely to continue indefinitely. The Panel viewed the 2018 surveillance footage provided by Allianz, which it said showed Alexandra walking with her 'spine bent forwards and to her left'. This was in contrast to the surveillance report the private investigator completed who said she was seen 'walking freely'. The Panel disagreed with the second IME's opinion about the severity of Alexandra's condition and her ability to work. Allianz reinstated Alexandra's weekly entitlements.

In response to the draft report, Allianz said:

> Allianz acknowledges it was unreasonable to send outdated surveillance footage to an IME, and … we have made a number of changes to our internal processes relating to surveillance.
>
> While, currently we would not tolerate the use of old surveillance footage being used in such a manner, the information provided to the second IME for pre-reading prior to the appointment contained full surveillance reports, including the dates they were obtained, and also previous IME reports. No attempt was made to conceal the age of the surveillance or previous medical opinions.

Allianz also provided details of its quality controls regarding the use of surveillance, which include an internal framework, approval processes and compliance reviews.

* This case is also discussed on pages 55 and 70.

200. The investigation provided WorkSafe a list of 19 complex claims where issues were identified regarding agents' use of surveillance. WorkSafe said it reviewed these claims and 'did not identify any significant issues about the appropriate use of surveillance'. However, it said 'some quality issues were identified particularly around documenting reasons for undertaking surveillance'.

Selective use of IMEs

201. Agents' selection of an IME to examine an injured worker should primarily be based on matching the speciality of the IME to the worker's injury, medical treatment, and return to work or claim issue to be resolved. WorkSafe states that where possible, agents should consider arranging an examination with an IME who has previously examined a worker, noting that:

> IME familiarity with worker can also support IME in providing opinion and enhance worker experience, eg the IME can comment on how the worker's condition has changed over time

202. WorkSafe states that agents must also ensure that:

- selection of an IME is undertaken in a 'fair and equitable manner without preference to particular IMEs'
- they are not motivated by the opportunity to obtain an opinion from an IME who is considered to hold particular views on specific medical conditions or treatment issues.

203. The Ombudsman's 2016 investigation identified cases where, contrary to these requirements:

- agents' choice of IMEs was motivated by or based on a belief the IME would provide an opinion that would support a termination or rejection
- agents had engaged in 'doctor shopping' by seeking opinions from multiple different IMEs, where previous IMEs' opinions did not allow the agent to terminate or reject a worker's claim.

204. Since then, measures have been introduced to prevent such behaviour, which include:

- centralising all bookings for psychiatric IME examinations to WorkSafe[21]
- monthly reporting of IME usage by each of the agents to identify and address any overuse of certain IMEs.

205. In response to the draft report, WorkSafe also highlighted that agents are required to provide IME reports to a worker's treating doctors to 'provide greater transparency on information contained in [the] report'.

206. A former agent employee interviewed during the investigation discussed the introduction of monthly reporting on IME usage, stating that the results were shared among staff, along with an instruction from senior management to 'share the load and not continually select the same individual [IME]'.

207. The sample of agent staff email records obtained by the investigation also suggested that the introduction of this reporting had led to a focus on ensuring an even spread of IME usage. For example, an email from an Allianz manager highlighted Allianz's aim to 'reduce the over utilisation of any particular IME' and encouraged staff to 'spread the use around and to not be too overzealous' with certain IMEs. In response, another manager wrote:

> Let's ensure we keep this in mind when receiving IME reports. We get a good one from someone we don't use that much - let's send them some more. Important to note, this is not aimed at using IMEs that get us outcomes, but the purpose is … a report that is very thorough in relation to their opinions that can be utilised to help support … [injured workers] back to work/ health.

21 This is further discussed on page 209.

208. While the new measures appear to have increased scrutiny of IME usage and reduced the opportunities for selective use of IMEs, the investigation received evidence suggesting the practices identified by the Ombudsman's 2016 investigation have continued to occur in some cases.

209. A former agent employee interviewed during the investigation said agent staff kept 'offline' lists of IMEs who had provided an opinion that resulted in a termination or rejection. They said:

> There would also be conversations about … 'that's the best doctor for that type of injury' … 'that's the best doctor that's going to tell you about a knee injury [that] isn't related to work' and 'that's the best doctor to tell you that carpal tunnel isn't work-related'. 'That's the best doctor that's going to tell you that back surgery isn't appropriate'.

210. The Ombudsman received a complaint in mid-2017 from another former employee of one of the other agents who said this also occurred, stating:

> The branch manager advised of the last ombudsman findings in which the agent[s] were not to use 'preferred providers' of … [IMEs] and were not allowed to keep a list of … [IMEs] most likely to terminate claims and give the insurer a favoured outcome. The branch manager said … 'although this is the case each team still have this list of preferred providers for IMEs we are just more discreet about this and which folders they were kept in'. She thought that was funny.

211. At the time, the Ombudsman referred this matter to WorkSafe, which in turn referred the matter to the agent. The agent said it was 'unable to find evidence to substantiate the allegations made'.

212. The sample of agent staff emails obtained by the investigation also suggested in some cases, agents' selection of IMEs may have been motivated by a belief that the IME would provide an opinion favourable to the agent. For example, an email from a CGU Technical Advisor to other CGU employees said:

Subject: Dr [redacted] IME

Hi Guys,

Two outcomes that [redacted] and I have done in the last two days resulting in terminations of claims from one doctor, Dr [redacted]

Can we please use him more.

213. A CGU Manager sent an email in response stating:

RE: Dr [redacted] IME

From:
To: [redacted]

Cc: [redacted]

Date: Wed, 02 May 2018 14:12:02 +1000
Attachments: image001.png (10.2 kB)

Everyone delete this email now

214. Witnesses interviewed during the investigation spoke about agents' reliance on IMEs who often provided favourable opinions to them. Conciliation Officer C said, while they did not see every IME report:

> [I]t's quite true that we see reports from certain IMEs and it's almost like … you could write the report for them, because you know what the report is going to say.

215. Conciliation Officer G said reports from particular occupational physician IMEs often provided favourable opinions to agents and said:

> I think that category of doctor is problematic because it's a bit of one size fits all … it's a cookie cutter approach, you could substitute the worker's name and you're pretty much reading the same thing.
> …
> [I]t's frustrating because I think that the choices are still made around these doctors … it validates this very mean-spirited approach to claims. And if upon scrutiny by a Panel accords they're not accepted, how is it that WorkSafe still endorses what they do? And agents get to choose to insert them in these processes that only create hurdles. The question is whether the worker has the energy to clear the hurdles.

216. The then Convenor of Medical Panels also said Medical Panels saw 'patterns … of approach with particular IMEs'. He said he could only comment on the proportion of IMEs' names seen in referrals to Medical Panels, but said 'we do certainly see patterns'.

217. Conciliation Officer B said from the disputes they see at conciliation, they had observed there were a number of IMEs who 'always provide very agent-friendly reports'. They said they believed there was 'still a particular drive to use them [IMEs] in a dishonest way', when agents 'know that they're going to get a certain opinion' from some IMEs.

218. Conciliation Officer F said they believed there were 'still certainly preferred IMEs' and they 'would have a perception that most of those IMEs are not going to be in favour of the worker'.

219. In response to the draft report, Gallagher Bassett said:

> The conclusion … that abuse of the IME selection process is continuing is based upon the unspecified opinion evidence of anonymous former agent employees and is unsupported by any corroborative evidence. Indeed, the only evidence on this issue … supports the effectiveness of changes since 2016. The reported opinions of the conciliation officers and the Convenor of Medical Panels relates to the quality of IME reports, not alleged abuse of IME selection. The allegation by a conciliation officer of agent "dishonesty" in selection of IMEs … is so extreme, unsupported and prejudicial that it ought to have been excluded from the draft report.

220. CGU said in response to the draft report:

> [I]n appointing an IME, the intent is to obtain a specialist opinion about an injury, recovery strategy, prognosis and treatment pathways to inform and assist in the return to work of an injured worker.
>
> The selection of an IME is based on specialty, and availability. It is commented in the draft report that agents 'doctor shop', however the determination of which IME to use is more specifically based around the:
>
> - Speciality as it relates to the injury;
> - Quality of reporting (historical assessment), including timeliness of the delivery of the report;
> - Availability of the IME at the time (to prevent delays); and
> - Rate of usage of a particular IME (so as not to incur criticism of preference or over-use).

‘Doctor shopping’

221. The investigation also identified complex claims where there was a perception that agents had engaged in ‘doctor shopping’ for an IME opinion to support a termination or rejection.

222. This included examples of potential ‘doctor shopping’ WorkSafe highlighted in its audits of agent decision making in 2017-18. Examples of its comments from these audits are outlined below.

223. In one complex claim, Xchanging sent a worker to a variety of different IMEs over a period of about 15 years, until it received an opinion suggesting the worker may be able to return to work. This was despite the weight of medical evidence suggesting she was severely and possibly permanently incapacitated for work as a result of her work-related injuries.

Comments from WorkSafe audits 2017-18

‘IME … is of the opinion that the worker’s injury was misdiagnosed and was never related to employment in any way. Previous IMEs … and treating GP are of the opinion that the worker’s condition is work related and surgery has been approved on claim. It is not clear from the notice why the opinion of … [the latest IME] was considered to have more weight than other opinions previously obtained. Given IMEs were previously obtained from different practitioners, this gives the perception of opinion shopping particularly as the latest IME has been used to terminate the claim.’

‘2 IMEs with different practitioners within 3 months, this gives the impression of opinion shopping.’

‘While CWC [current work capacity] has been demonstrated, 2 IMEs within a short period of time with differing opinions gives the perception of doctor shopping.’

Case study 6 – Agent 'doctor shops' for opinion suggesting severely incapacitated worker can return to work

Lena was working as a finance officer when in 2002 she suffered a serious stress-related heart condition at work.* Lena made a WorkCover claim, which was accepted by her employer's agent. Lena later developed a secondary mental injury.

Between 2002 and 2015, the agent managing Lena's claim, Xchanging, sent her to multiple different IMEs to assess her physical and mental injuries. They included a cardiologist, neuropsychologist and multiple psychiatrists and occupational physicians. Based on their reports, Xchanging acknowledged the severity of Lena's work-related injuries meant she had no capacity for work and further IME reviews were 'unlikely to achieve or advance the claim any [further]'.

During this period, Lena was also assessed as having a 51 percent 'whole person impairment'[22] which was permanent.

Xchanging continued to arrange IME reviews. In late 2016 and early 2017, Xchanging sent Lena to three IMEs:

- A cardiologist, who said Lena had a work capacity from a physical point of view but noted previous psychiatric reports were pessimistic about her ability to return to work.
- A psychiatrist, who initially said Lena could not return to 'any form of work at all', however, changed their opinion upon receiving a copy of the cardiologist's report. The psychiatrist did not explain what had changed for Lena, given 14 years' worth of psychiatric reports concluded she was indefinitely incapacitated.
- A sports and exercise medicine physician, who said Lena had a work capacity from a purely musculoskeletal point of view, but noted musculoskeletal conditions were not part of Lena's compensable injuries and the IME had no expertise in cardiac and psychiatric conditions.

Xchanging did not arrange for Lena to be re-examined by a neuropsychologist and instead relied on the three IME opinions above to refer her to occupational rehabilitation.

Lena's GP wrote to Xchanging in late 2017 raising concerns about Xchanging's management of her claim, stating:

> I see … [Lena] frequently, know her and the family well, and I a[m] certain she will never be fit for gainful employment, mainly because of her psychological state, but there is no doubt she has permanent damage to her cardiovascular system.
>
> As is the way of some insurance companies, Xchanging have pushed … [Lena] to multiple doctors of Xchanging's choice, paid by them, and eventually finding some who find, in a single consult, that she should be sent back to work. I could not disagree more with their predictable opinions – … [Lena] will not cope with future employment which involves any physical or psychological stress. This frequent reassessment is very stressful to her, and undoubtedly, by increasing her anxiety, is deleterious to her health.

Continued on next page…

22 'Whole person impairment' refers to permanent impairment of any body part, system or function to the extent that it permanently impairs the worker as a whole person.

Xchanging then wrote to Lena's treating psychiatrist providing a copy of the 2016 and 2017 IME reports. The psychiatrist told Xchanging they believed Lena had no work capacity and said to clarify the psychiatric opinions, it was important for a neuropsychologist to reassess Lena.

Also in late 2017, Lena's treating cardiologist informed Xchanging Lena had suffered further complications with her heart condition and had undergone an emergency procedure as a result. Xchanging retrospectively approved the surgery. The treating cardiologist also told Xchanging they understood there was 'consensus of everyone' that Lena was 'not capable of work in any capacity' considering her cardiovascular and psychological issues had not resolved.

A neuropsychologist IME re-examined Lena in early 2018 and found her psychological function had been significantly compromised for more than 15 years. The IME concluded Lena's condition was virtually identical to the previous assessment and said it was unlikely she would ever be able to return to work. As a result, Xchanging accepted Lena was indefinitely incapacitated and ceased her occupational rehabilitation services.

In response to the draft report, Xchanging said:

> The original claim lodged in 2002 for … [the heart condition] resulted in a number of secondary conditions being claimed.
>
> Xchanging is obliged to periodically review these medical conditions and obtain an objective overview of the relationship of the medical issues to those initially claimed.
>
> Xchanging required the input of multiple medical specialists in this highly complex matter.
>
> Opinions were sought from a cardiologist, occupational physician and psychiatrist. Xchanging referred the worker to occupational rehabilitation services based on these medical opinions.
>
> Upon the request of the treating psychiatrist, Xchanging arranged a neuropsychologist assessment. Occupational rehabilitation services were ceased based on this opinion. No adverse decision was made in this case.
>
> Xchanging agrees with the definition of doctor shopping in … [the report] "where agents have engaged in doctor shopping to support a termination or rejection".
>
> This case does not meet this definition.

Although Xchanging did not terminate the worker's entitlements in this case, file notes on Lena's claim file showed Xchanging considered whether a termination could be achieved. Xchanging also required Lena to participate in occupational rehabilitation which had a detrimental impact on her health and wellbeing.

* This case is also discussed on page 209.

Another example

In another complex claim* reviewed by the investigation, Allianz referred a worker to an occupational physician IME after a previous IME of the same specialty and a Medical Panel said the worker's incapacity was indefinite. Allianz provided the second IME with surveillance material from one and a half years prior. This material had already been viewed by the previous IME, who maintained their opinion about the worker's incapacity. Allianz ignored the first IME's opinion that the worker had worsened since being examined by a Medical Panel, instead relying on the second IME's opinion to terminate the worker's entitlements. This was later overturned by a Medical Panel who disagreed with the IME.

In response to the draft report, Allianz acknowledged it was unreasonable to send outdated surveillance footage to an IME, but said 'no attempt was made to conceal the age of the surveillance or previous medical opinions'. It further said:

> We do not consider the case … illustrates a 'Selective use of IMEs', but rather an attempt to obtain an updated medical opinion using an available IME of the appropriate specialty while providing them with full disclosure of surveillance and medical opinion to date.

* This case is also discussed on pages 46 and 70.

224. In another case outlined below, Gallagher Bassett sent a worker to seven different IMEs within less than three years, until it received opinions which enabled it to terminate the worker's entitlements.

Case study 7 – Agent ignores neuropsychologist opinion and sends worker to different IMEs

Paul was working as a tradesman when in 2011, he injured his head, neck and back. Paul ceased work and made a WorkCover claim which was accepted by his employer's agent, Gallagher Bassett. Between 2011 and 2015, Paul was assessed by a range of medical practitioners who concluded he had suffered a mild brain injury.

In 2015, Gallagher Bassett arranged for Paul to be examined by three IMEs:

- a neuropsychologist, who concluded Paul had sustained a mild head injury and that his psychological state, in addition to some physical symptoms, prevented him from returning to work
- a psychiatrist, who concluded Paul had a psychiatric condition of a 'mild degree' and said he was able to return to work
- an occupational physician, who concluded that while Paul had aggravated a pre-existing neck condition, it had now resolved, and he had a capacity for work.

Continued on next page…

In 2016, Gallagher Bassett again arranged for Paul to be examined by three IMEs:

- the same neuropsychologist, who concluded that from a neuropsychological perspective, Paul still could not return to work and this was likely to continue indefinitely, noting that Paul's symptoms appeared worse than in 2015
- a different psychiatrist, who concluded Paul could return to work in a modified role or at a new workplace, but that Paul's pre-existing substance dependency was impeding his work capacity
- a different occupational physician IME, who concluded that from a physical perspective Paul could work, but noted he had developed a chronic pain disorder and had a 'severe psychiatric impairment and a cognitive impairment' which were inhibiting his return to work.

In 2017, Gallagher Bassett referred Paul for further examinations with two IMEs, this time only a psychiatrist and an occupational physician, both of whom had not previously examined Paul. The psychiatrist IME concluded Paul was fit to participate in occupational rehabilitation and return to work, citing his ability to 'travel overseas without a chaperone' as evidence of this. However, the unaccompanied overseas trip the IME referred to was a spontaneous one-way trip during which Paul suffered a 'psychotic episode' and was detained by overseas police while 'paranoid and hearing voices'. The occupational physician IME concluded that based on Paul's physical condition, he was able to return to work and participate in occupational rehabilitation, but asserted Paul had other issues that needed 'to be addressed by a neurologist and a psychiatrist'.

Without obtaining an up-to-date IME opinion from a neuropsychologist, Gallagher Bassett terminated Paul's weekly payments in late 2017. Gallagher Bassett relied on the opinions of the two psychiatrist IMEs and two occupational physician IMEs from 2016 and 2017, but did not mention the neuropsychologist IME's reports.

Paul requested conciliation. Paul's treating doctor provided a report for conciliation which said Paul had become 'so distressed about the process that he would rather give up on contesting payments as he … [was] almost at pension age'.

At conciliation, the matter was referred to a Medical Panel, which in mid-2018, concluded Paul had aggravated a back condition and had a mental injury, both of which were caused by work. The Panel consisted of an occupational physician, rheumatologist, neurologist and psychiatrist. The Panel concluded Paul was indefinitely incapacitated for all work and disagreed with all of the IMEs' opinions except the neuropsychologist. Based on the Medical Panel's opinion, Gallagher Bassett reinstated Paul's weekly payments, at which time he had been without payments for three months.

Leading questions to IMEs and treating doctors

225. When seeking a report from an IME or an injured worker's treating doctor, agents provide a list of questions they would like answered. These usually relate to the worker's injury, what caused it, how they are recovering, the appropriateness of their treatment, and whether they can work.

226. After receiving a report from an IME, agents may ask the IME to provide a supplementary report addressing further questions, without re-examining the worker. This may occur where less than six months has elapsed since their examination of the worker and:

    - clarification around the opinion in their original report is required
    - additional information has become available that the agent would like the IME to consider and comment on
    - there are additional questions the agent would like the IME to answer.

227. WorkSafe has developed a range of standard questions agents use in requests to both IMEs and treating doctors; however, they may also add tailored questions specific to the circumstances of a worker and their injury.

228. While it is reasonable for agents to do this, the Ombudsman's 2016 investigation found that in some cases, agents posed leading questions to IMEs to elicit a certain opinion. This included cases where agents:

    - asked IMEs to respond to questions 'without factoring the worker's age', despite the WIRC Act requiring that this be considered when assessing a worker's capacity to return to work in 'suitable employment'
    - requested supplementary reports to try to change an IME's opinion or gain further evidence to support a termination or rejection.

229. While only limited further instances were identified during this investigation of agents asking IMEs not to factor in a worker's age, further examples were identified of agents posing other leading questions to IMEs, as well as injured workers' treating doctors.

230. The following case study is one example, where Gallagher Bassett used information about a worker with post-traumatic stress disorder (PTSD) playing golf to try to change an IME's opinion.

Case study 8 – Attempt to change IME's opinion by highlighting worker's golf hobby

Damien was working as a police officer when in 2010 he developed PTSD after attending traumatic incidents.* Damien made a WorkCover claim which was accepted by his employer's agent, Gallagher Bassett. After a number of attempts to return to work, Damien ceased work altogether in 2012.

In 2016, Gallagher Bassett arranged for Damien to be examined by an IME who concluded he was suffering from chronic PTSD which was likely to be 'permanent and ongoing'. The IME said Damien had no capacity for work which was likely to continue indefinitely and he was unable to engage in occupational rehabilitation. The IME asserted that the nature of Damien's condition meant that he should be assessed 'as infrequently as possible' at the risk of exacerbating his condition when recounting traumatic events.

A year later, Gallagher Bassett arranged for a different IME to assess Damien, who concluded he continued to suffer from PTSD. The IME noted, among other things, that Damien avoided crowds, did not socialise as much as he used to, watched television and read, played golf twice a week, and occasionally went grocery shopping. The IME concluded that because of his symptoms, Damien had no work capacity, which was likely to continue 'for the foreseeable future'. The IME also said Damien could not participate in occupational rehabilitation.

Gallagher Bassett wrote to the IME requesting a supplementary report, stating:

> We note from your report that the worker plays golf on a twice weekly basis as well as on a competitive level. Given his level of commitment in regards to this activity, would this not translate to a partial capacity for suitable alternative employment or capacity to participate [in] occupational rehabilitation services, at least in this field and industry of employment i.e. sales/ customer services/grounds-maintenance especially considering your comments about the adverse impact on mental and physical health and the result in permanent disability for work.

In response, the IME said it 'requires different sets of responsibilities and self confidence to play golf recreationally and even competitively, compared to undertaking the responsibilities of a part time job'. The IME said when they saw Damien three months earlier, he did not have a capacity, but said 'it is possible that he has improved now'. The IME said '[i]n that case, it is likely that he would have capacity now, for participating in occupational rehab[iliation] services, in this field'. The basis on which the IME concluded Damien's condition may have improved in the three months since the IME's examination was unclear.

Based on the IME's supplementary report, Gallagher Bassett referred Damien to occupational rehabilitation. Damien made a complaint to WorkSafe and his local Member of Parliament about the IME and Gallagher Bassett's reliance on the supplementary report, describing the IME's comments as 'baseless' and stating the IME had provided a 'guess', not an 'opinion'. This resulted in Gallagher Bassett withdrawing the referral to occupational rehabilitation.

* This case is also discussed on page 202.

231. In another case, Allianz terminated a worker's weekly payments after leading a psychiatric IME to say the worker no longer had a work-related psychiatric incapacity, because their work-related physical injury had resolved.

Case study 9 – Agent re-emphasises same information to IME to change opinion

Dimitris was working as a tradesman when he injured his back. He ceased work in early 2016 and made a WorkCover claim, which was accepted by his employer's agent, Allianz.

In mid-2017, Allianz arranged for Dimitris to be examined by a neurosurgeon IME who concluded his back injury was no longer work-related, but instead was due to a degenerative condition. The IME said Dimitris could return to his original employment. At this time, Dimitris's treating doctors continued to certify him unfit for work and said he suffered from chronic pain, limitations in movement and his mental health had deteriorated. Without referring Dimitris for an assessment by a psychiatrist IME, Allianz terminated his weekly payments. Dimitris requested conciliation and Allianz subsequently withdrew its decision, noting it had not assessed whether he had a secondary mental injury.

In late 2017, Allianz arranged for Dimitris to be examined by a psychiatrist IME. In its request, Allianz noted it had previously terminated Dimitris's payments 'on medical information indicating the low back condition was no longer related to employment'. Allianz asked the IME to assess whether Dimitris had a work-related mental injury considering his physical condition was no longer work-related and he had experienced a separate non-work-related injury to his finger. Allianz also told the IME that there was 'a possible correlation between cessation of payments' and the 'presentation/notification of a psychological condition by a new GP'. However, this was incorrect as Allianz received information about Dimitris's mental health a few months prior to the termination.

Following his examination of Dimitris, the psychiatrist IME provided a report which concluded Dimitris was suffering from a secondary mental injury caused by pain and physical restrictions, as a result of his work-related injury. The IME said Dimitris was able to return to part-time work if supported by occupational rehabilitation services.

A month later, Allianz wrote to the psychiatrist IME re-emphasising the neurosurgeon IME's opinion that Dimitris was no longer suffering from a work-related back injury and asked them to provide a supplementary report commenting on whether Dimitris's mental injury was work-related. Allianz did not provide the psychiatrist IME any new information and the IME was already aware of the neurosurgeon IME's opinion when providing the original opinion. In response, the psychiatrist IME said 'if … [the neurosurgeon IME] considers that the work-related physical injury has resolved, then the subsequent psychiatric condition is also no longer work-related'. The psychiatrist IME did not further explain the change in their original opinion.

Allianz terminated Dimitris's entitlements to weekly payments and medical expenses a few days later. Dimitris disputed the termination at conciliation and then court, and the matter was ultimately resolved by Allianz agreeing to pay Dimitris's ongoing medical expenses.

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In response to the draft report, Allianz said:

> It is the responsibility of claims management employees to request an IME to clarify their opinion if there is any ambiguity in the report. The WorkSafe On Line Claims Manual at section 2.7.2 states that agents should review an IME report when received to ensure it addresses the questions asked. Clarifying an opinion when it is unclear, or if it seems apparent an important detail has been missed is an essential part of quality decision making.
>
> In this instance, the psychiatric IME reported that the worker was suffering a mental health injury as a response to his work-related physical injury. This seemed at odds with the physical IME opinion that the work-related condition had resolved, therefore it was reasonable for Allianz to ensure the psychiatrist IME had considered the neurosurgeon IME's opinion when providing his report.

While the neurosurgeon IME's opinion was relevant to the psychiatrist IME's examination of the worker, Allianz had already provided the psychiatrist IME considerable information about the neurosurgeon IME's opinion in its initial request. Specifically, Allianz:

- provided the psychiatrist IME a copy of the neurosurgeon IME's reports
- provided a summary of the neurosurgeon IME's opinion in its cover letter to the psychiatrist IME
- emphasised that it was seeking the psychiatrist IME's opinion about whether a work-related psychiatric condition existed, given the physical condition was no longer deemed to be work-related.

On this basis, the investigation does not accept that it was reasonable or necessary to re-emphasise the same information to the psychiatrist IME in a supplementary report request.

232. The investigation identified two other examples.

Example 1

In one case,* Xchanging requested a second supplementary report from an IME who had already concluded in two reports that the worker was incapacitated for work. Xchanging asked the IME whether the worker could undertake an after-school child care role, given the IME said she could retrain as a teacher, and was 'currently able to drive to drop off and pick up her children from school'. The IME provided a third report stating the worker could not undertake study and employment at the same time and maintained their opinion that the worker was not able to return to employment.

In response to the draft report, Xchanging said:

> The worker was undertaking re-training. The IME was asked to consider whether a form of employment relating to her re-training would be suitable. It is appropriate in the circumstances for Xchanging to ask the IME about this prospect in order to clarify the situation. While the … line of enquiry had merit, the way in which the question was framed was inappropriate.

* Further details about this claim are on page 38.

Example 2

In another complex claim,* EML requested a supplementary report from an IME who had already definitively concluded a worker could not return to any work for the foreseeable future because of her work injury. EML provided the IME further information and asked her to respond to a range of further questions. EML highlighted to the IME that the worker had terminal cancer and clarified whether the IME's opinion about the worker's work capacity only related to her work injury. The IME said they maintained their opinion that the worker was indefinitely incapacitated for all work and that they were unaware the worker had cancer as the worker did not tell them this. The IME also said:

> With the greatest of respect, I undertook an impartial, independent medical examination as a specialist occupational physician and my observation in respect of your correspondence is that a theoretical capacity on paper unfortunately, does not always translate to a practical ability to provide regular service to an employer with minimal risk of significant re-aggravation of the work-related condition.

* This case is also discussed on page 40.

233. The investigation also identified examples of agents posing leading questions to a worker's treating doctor, one of which is outlined below. In this case, CGU attempted to influence the opinion of a worker's doctor by providing leading information and exerting pressure on the doctor to certify the worker as fit for employment.

Case study 10 – Agent pressures GP to certify worker fit for work for her 'benefit'

Tanya was working as a sales manager when in 2015 she sustained a mental injury from workplace stress. She ceased work and made a WorkCover claim which was accepted by her employer's agent, CGU.

In 2016, Tanya was assessed by an IME who concluded she could not return to her pre-injury duties and hours, but 'may' be capable of part time work in a different work environment. The IME also said she had capacity to participate in occupational rehabilitation, but emphasised her work capacity was 'extremely limited'. Based on this report, CGU arranged for Tanya to participate in occupational rehabilitation; however, her GP continued to certify her unfit for work.

CGU wrote to Tanya's GP and psychologist regarding her work capacity, stating:

> I wish to clarify [Tanya's] medical capacity as your last certificate … indicates that [her] incapacity is undetermined and can only be reviewed over time … [Tanya's] claim is now 108 weeks along with little to no sign of improvement in her condition according to herself and your certificates that you keep signing off each month … [Tanya] has had and is having extensive weekly/fortnightly psychology sessions. She has just completed a diploma by herself, which suggests to me that she definitely has some work capacity.

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> Patients should generally not be certified as totally unfit for any duties as a total incapacity means the patient is unable to do any form of work/activity at all.
>
> As soon as medically feasible, the patient would benefit by being certified as fit for suitable duties. This will enable us to refer them to participate and approve supportive job-seeking or re-training/ education services. This will eliminate barriers of concern regarding fitness for participation in these services.

In response, Tanya's GP said there had been 'minor' improvement in her condition but said she was 'not ready to engage in any activity'. The GP stated Tanya's incapacity was 'not forever', however, did not specify a timeframe within which she was expected to be able to return to work. Despite this, CGU used the GP's opinion, combined with a subsequent IME opinion, to terminate Tanya's weekly payments on the basis that her incapacity was not likely to continue indefinitely. Tanya requested conciliation and the matter could not be resolved. Tanya did not take the matter to court.

In response to the draft report, CGU said:

> As an agent of WorkSafe, CGU has the responsibility of promoting effective occupational rehabilitation of injured workers and their early return to employment. To achieve return to work outcomes, CGU recognises that it is often necessary to be proactive in seeking clarification from medical practitioners where the circumstances of the worker, such as in this claim, appear to be inconsistent with medical opinion.
>
> If there is evidence to suggest a capacity exists, CGU considers it is in the interests of the worker and the scheme to explore rehabilitation options that open the prospect of a return to work outcome. Without adequate support from a worker's treating practitioner, any prospect of an early return to employment diminishes greatly.
>
> In relation to … [Tanya's] mental injury claim, she received frequent treatment with a psychologist and demonstrated an ability to successfully cope with the pressures of study having completed a … [qualification] in 2017.
>
> Despite this … [Tanya's] reported capacity remained unchanged by her treating practitioner. Rather than intending to exert pressure on the practitioner to certify the worker as fit for employment, CGU contacted … [Tanya's] treating practitioner specifically to seek clarification of the inconsistency between the factual circumstances and the reports.
>
> During an IME appointment … [Tanya] informed the specialist that she intended to use her new qualifications to return to work … The IME concluded that she had a capacity, which contradicted the opinion of her GP.

While it was not inappropriate for CGU to clarify the difference in medical opinions, the way CGU framed the request to Tanya's treating doctor was leading.

234. CGU also said in its response to the draft report:

> As a generalisation, the strategy to request a supplementary report or to ask specific questions is to seek greater clarity around components of a report, to address conflicting information between the report received and opinions of others, to seek clarification where additional information is received, and to ask questions which may not have been adequately addressed in the report.

Failure to provide documents to IMEs

235. WorkSafe requires agents to provide an IME copies of relevant documentation relating to an injured worker's injury and claim, to inform their examination of the worker. This is particularly important in complex cases where a worker has been incapacitated for a number of years or has multiple injuries, as an IME may have had no previous contact or involvement with an injured worker prior to the examination.

236. Agents are required to provide these documents to an IME at least five days before the scheduled appointment, to allow the IME enough time to prepare. WorkSafe states that agents should provide an IME:

    - details about if and when the IME has previously examined the worker
    - any previous IME reports from different IMEs that are not outdated
    - any treating doctor(s) reports, x-rays, scans, copies of radiology reports, surgical reports and assessor reports.

237. Other relevant information may include:

    - the worker's previous claim history
    - the worker's claim form and employer injury claim report
    - certificates of capacity (possibly the first and last issued)
    - employer information, including details of return to work planning and arrangements
    - occupational rehabilitation reports
    - the worker's pre-injury and/or current position description.

238. The Ombudsman's 2016 investigation identified that in some complex claims, agents failed to provide key information and reports to IMEs, which sometimes led to IMEs providing an opinion without being fully informed of the worker's circumstances. In some cases, agents then relied upon such opinions to terminate or reject the worker's claim.

239. This investigation identified further instances where this occurred, one of which is outlined in the case study on the following page. In this case, Gallagher Bassett failed to provide an IME with any information or documentation about a worker's previously accepted claim for a similar mental injury at the same workplace. Gallagher Bassett then relied on the IME's opinion to reject the worker's claim.

Case study 11 – Agent fails to provide any documents about worker's existing mental injury to IME

Jarrod was working as a transport officer when in 2016 he sustained a mental injury from bullying and victimisation at his workplace. Jarrod made a WorkCover claim in 2017 which was accepted by his employer's agent, Gallagher Bassett after investigation. This included Gallagher Bassett obtaining an investigation report which confirmed Jarrod's workplace was 'highly volatile' and bullying and harassment had occurred. It also obtained an IME report which concluded Jarrod had a mild mental injury and, while he could return to work, workplace issues needed to be resolved to ensure he did not relapse.

In mid-2017, Gallagher Bassett terminated Jarrod's weekly payments based on the IME's report indicating he was no longer incapacitated for work. WorkSafe later criticised Gallagher Bassett's reliance on this report when Jarrod made a complaint* because it had failed to consider new information about a decline in Jarrod's mental health. This related to further bullying he experienced when he returned to work, which led him to cease work again. Gallagher Bassett did not withdraw the termination in response to WorkSafe's criticism, but instead told Jarrod to submit a new claim and then arranged for him to be examined by a second IME.

Gallagher Bassett did not advise the second IME of Jarrod's previously accepted claim for a mental injury stemming from bullying and harassment at work. It also did not provide the IME any documents relating to his previous claim, including the investigation report or reports from Jarrod's treating doctor indicating he had no work capacity. The only document it provided to the second IME was Jarrod's new (second) claim form. The IME concluded Jarrod's mental injury was in 'remission' and he was able to return to work. Gallagher Bassett relied on this report to reject Jarrod's new claim, a decision which WorkSafe also criticised when Jarrod complained again.

Jarrod requested conciliation but the dispute could not be resolved, so he took the matter to court. The court referred the matter to a Medical Panel, which concluded in mid-2018 that he had no work capacity because of mental injuries caused by work. The Panel disagreed with both IMEs regarding Jarrod's condition and Gallagher Bassett reinstated Jarrod's weekly payments nearly one year after the termination.

* WorkSafe's handling of Jarrod's complaint is further detailed on page 176.

Example

In one complex claim* reviewed by the investigation involving a worker with a 'severe' spinal injury from eight years prior, Gallagher Bassett wrote to an IME requesting they examine the worker and provided relevant documentation on the same date the examination was scheduled to take place. Gallagher Bassett subsequently relied on the IME's opinion to terminate the worker's weekly payments.

* This case is also discussed on page 112.

240. The investigation also found in a number of complex claims reviewed by the investigation that agents had provided IMEs with outdated reports they had relied on to terminate workers' entitlements, even where those reports had been superseded by a contrary and binding Medical Panel opinion.

241. In addition, concerns were raised with the investigation about delays in agents providing information to IMEs prior to their examination of an injured worker. An IME representative said at interview that agents' 'lack of organisation' had caused delays in documents being provided to IMEs before an examination, which affected their ability to complete proper examinations. They said such delays were making complex cases 'untouchable' for IMEs because the volume of documents expected to be reviewed in a short period was too great.

242. The IME representative said that in about 100 cases in early 2019, the agent provided documents to the IME only two days prior to the scheduled examination. When asked what occurred if an IME did not receive the relevant documents from an agent before an examination, the IME representative said 'very often [IMEs] continue', despite having no background information about the worker's injury and claim.

Reliance on IME from incorrect specialty

243. When selecting an IME to examine an injured worker, agents must ensure they match the speciality of the IME to the worker's injury, medical treatment, and return to work or claim issues to be resolved. Agents may seek advice from a Medical Advisor about the appropriate choice of specialty if assistance is required.

244. The Ombudsman's 2016 investigation did not identify concerns about agents' choice of IMEs by speciality. However, this investigation found in a number of complex claims, agents had unreasonably terminated a worker's entitlements by relying on an opinion from an IME from the incorrect specialty. This primarily related to complex claims where a worker had originally sustained a physical injury and later developed a secondary injury, namely:

    - chronic pain syndrome
    - mental injury.

245. In several claims reviewed, agents did not arrange for an IME of the appropriate specialty to assess the secondary conditions. Instead, agents relied on an IME's opinion about the worker's physical injury to terminate their entitlements.

Chronic pain syndrome

246. A number of complex claims reviewed by the investigation involved workers who had been diagnosed with chronic pain syndrome after sustaining a physical workplace injury. Chronic pain syndrome causes persistent pain which may have no physical basis.

247. WorkSafe told the investigation that chronic pain syndrome or pain related disorders are 'challenging conditions to assess and manage as there are almost always other presenting ailments including anxiety and depression'.

248. While a psychiatrist IME or occupational physician may comment on a worker presenting with symptoms indicative of a pain disorder, WorkSafe said the appropriate IME specialty to assess such conditions and their impact on a worker's capacity to return to work is a pain specialist.

249. In a number of the complex claims reviewed by the investigation, workers were not assessed by a pain specialist IME. The impact of this was that agents relied on opinions from IMEs not qualified to assess chronic pain syndrome to make claim decisions that were adverse to workers. This practice was confined to one agent, Gallagher Bassett, however, other evidence suggested there may be opportunities to improve understanding about the assessment of chronic pain syndrome across all five agents.

250. At interview, the then Convenor of Medical Panels raised concerns about agent practices regarding the assessment of chronic pain, stating:

> [T]he chronic pain issue is a very significant area because it's an area of medicine that's not particularly well understood to start with, and where there is some uncertainty … we're seeing all sorts of management practices and approaches to diagnosis there that we find are a problem.

251. The then Convenor said not enough workers with chronic pain conditions were referred to pain specialists and, even when they were, agents had difficulty interpreting these opinions to inform decision making. The then Convenor said a 'common' error observed by Medical Panels was agents' assumption that if a worker no longer had a physical injury and was not diagnosed with a psychiatric condition then 'there's nothing'. The then Convenor said this was incorrect as 'there are conditions in between'. He said:

> [I]f the pain arises from what was originally [a] musculoskeletal injury … they need to have seen the appropriate musculoskeletal specialist, orthopaedic surgeon, neurosurgeon, rheumatologist to sort that part out. And then the chronic pain part could be … seen by a person with a pain discipline specialty. But the problem then for the agent is they've got this opinion from orthopaedic surgeons and neurosurgeons and this opinion from pain specialists, how do they put it all together?

252. The then Convenor said Medical Panels were able to better assess these conditions due to 'the luxury of being able to put together a Medical Panel which can contain musculoskeletal specialists, psychiatry, and pain specialty disciplines'. He said a Panel was able to 'come up with a much … better approach to the problem than the IME process did'.

253. The following case study is an example of a complex claim the investigation reviewed where Gallagher Bassett required a worker with a long term back injury, chronic pain disorder and mental injury to participate in occupational rehabilitation without arranging for a pain specialist IME to examine him. The worker's treating doctors said it was 'essentially futile' to try to return him to work given the permanency of his condition and that requiring him to do so was increasing his anxiety, stress and pain.

Case study 12 – Agent relies on IME opinions of incorrect specialty to send worker to occupational rehabilitation

Theodore was working as a machine operator when in the late 1990s he injured his back.* After an unsuccessful return to work, he ceased work and made a WorkCover claim, which was accepted by his employer's agent, Gallagher Bassett.

Between 2000 and 2016, Theodore was examined by five separate Medical Panels each of which concluded he was suffering from a back injury and chronic pain disorder. The Panels concluded he was indefinitely incapacitated for work. Theodore was also diagnosed with depression, anxiety and a substance abuse disorder, secondary to his physical condition.

In late 2016, Gallagher Bassett arranged for Theodore to be examined by two IMEs:

- The first IME noted that there had been a significant deterioration in Theodore's spinal movements. However, the IME concluded there was 'no physical basis for his current impairment', contrary to the findings of five previous Medical Panels. The IME concluded Theodore could engage in occupational rehabilitation and return to pre-injury duties.
- The second IME, a psychiatrist, said if Theodore's psychiatric condition was considered in isolation, he could return to work and participate in occupational rehabilitation. However, he noted Theodore's 'persistent pain' prevented him from returning to work' and this was not a psychiatric condition.

Despite both IMEs commenting on Theodore's chronic pain, which they said was neither physical nor psychiatric, Gallagher Bassett did not arrange for a pain specialist IME to examine Theodore. Instead, it relied on the two IME opinions to require Theodore to participate in occupational rehabilitation.

In early 2017, Theodore's doctor raised concerns with Gallagher Bassett, stating:

> [I]t is my firm opinion that looking at the totality of this person's situation it is unreasonable, impractical and essentially futile to attempt to return him to work. It is notable that the medical panel opinion that he received a number of years ago concluded that he was permanently incapable of work. Thus I do not understand why there is a continuing effort to change this situation. I would further believe that the situation contributes to this man's overall distress which is considerable.

Theodore's psychologist also wrote to Gallagher Bassett, stating:

> I asked for you to stop bullying and harassing … [Theodore]. From a psychological perspective these actions are causing him damage and preventing his rehabilitation from proceeding as needed. Furthermore, by increasing his anxiety and stress … [Theodore's] pain is also increasing.

Despite this advice, Gallagher Bassett continued to require Theodore to participate in occupational rehabilitation, which led Theodore to request conciliation and complain to the Ombudsman. Following enquiries by the Ombudsman, Gallagher Bassett later told Theodore he no longer needed to participate. Gallagher Bassett acknowledged in a file note that the opinions of the IMEs were 'flawed' and that Theodore's chronic pain condition had not been adequately considered.

* This case is also discussed on page 198.

254. In another complex claim reviewed by the investigation, Gallagher Bassett sent the worker to an IME of the incorrect specialty to assess her ongoing pain symptoms. Without obtaining an opinion from a pain specialist IME, Gallagher Bassett attempted to force the worker to return to work, issued her non-compliance notices for failing to return to work and then terminated her entitlements (return to work non-compliance notices are further discussed on page 84).

Case study 13 – Worker's pain symptoms assessed by IME of incorrect specialty, resulting in termination

Fatina was working as a child care worker when she injured her back and shoulder in early 2017. Fatina ceased work and made a WorkCover claim, which was accepted by her employer's agent, Gallagher Bassett.

In late 2017, Gallagher Bassett arranged for an IME to examine Fatina, who concluded she no longer had a physical injury and could return to work. However, the IME noted she had severe restriction in her back and shoulder movements, suffered from 'non-specific' pain and was seeing a pain specialist.

Without clarifying the IME's reference to Fatina's ongoing pain, Gallagher Bassett referred her to occupational rehabilitation and created a plan for her to return to work four days per week. Emails from Fatina's treating doctors expressed concern about her engagement in occupational rehabilitation because of regular 'flare ups' with her pain and asked to delay her return to work. Fatina also wrote to Gallagher Bassett on several occasions complaining of pain and said she was unable to return to work four days per week but would attempt three days. As she did not return for the four days, Gallagher Bassett issued her two non-compliance notices which resulted in suspension of her payments.

Gallagher Bassett then arranged for Fatina to be examined by a psychiatrist IME based on the other IME's comments about her non-specific pain. The IME concluded Fatina had no psychiatric disorder though acknowledged she suffered from 'recurrent pain'. The IME said from a psychiatric perspective, Fatina could return to work. Gallagher Bassett terminated Fatina's entitlements based on the IMEs' opinions that she was no longer suffering a work-related injury. Fatina requested conciliation.

At conciliation, Gallagher Bassett offered Fatina limited medical payments to resolve the dispute and 'avoid a medical panel referral', however, Fatina rejected the offer. The matter was referred to a Medical Panel which in mid-2018 concluded Fatina was suffering from a pain syndrome as a result of her largely resolved physical work-related injury, which rendered her incapacitated for work. Gallagher Bassett reinstated Fatina's entitlements based on the Panel's opinion.

WorkSafe reviewed this claim following a request by the Ombudsman's investigation and concluded Gallagher Bassett 'did not have a reasonable basis to support the non-compliance process and/or issue termination notices', and noted it had not arranged for the worker to be assessed by a pain specialist. It stated:

> The Agent also incorrectly referred the worker to a psychiatrist IME which is not the appropriate specialist to assess chronic pain. The Agent should not have issued the termination and instead arranged for the worker to be assessed by either a Neurologist or pain management specialist and then assessed the worker's ongoing entitlements.

255. Another example the investigation identified is outlined below, where Gallagher Bassett rejected a worker's request for pain consultations and required her to participate in occupational rehabilitation based on the opinion of an IME of the incorrect specialty.

Case study 14 – Funding for pain consultations rejected based on IME opinion of incorrect specialty

Colleen was working as a nurse when she injured her back in late 2013.* She continued to work and then made a WorkCover claim in mid-2014, which was accepted by her employer's agent at the time, QBE. She ceased work in late 2014 due to her injury.

In 2015, Colleen was assessed by a Medical Panel after QBE terminated her weekly payments. The Panel concluded Colleen's work injury had aggravated a pre-existing spinal condition and she was unable to work as a result. The Panel also said it was appropriate for her to engage in a pain management program.

Gallagher Bassett, which took over the management of Colleen's claim, arranged for her to be examined by two different IMEs in 2016, who both concluded she remained incapacitated.

In mid-2017, Gallagher Bassett sent Colleen to be examined by another IME, who concluded Colleen's original back injury was no longer present, although she had other back problems unrelated to her compensable injury. The IME said Colleen may have developed a chronic pain disorder, noting she was unable to be examined thoroughly because of her pain. However, the IME said this was outside their area of expertise. Gallagher Bassett requested a supplementary report from the IME clarifying whether the chronic pain condition was work-related but never received a response. Gallagher Bassett did not arrange for Colleen to be assessed by a pain specialist IME.

Colleen's treating pain specialist subsequently requested funding for further pain consultations, which Colleen had been receiving based on the 2015 Medical Panel's opinion that a pain management program was appropriate. Without receiving clarification from the IME about Colleen's chronic pain condition or referring her to a pain specialist IME, Gallagher Bassett rejected the request. At the same time, Gallagher Bassett required Colleen to participate in occupational rehabilitation and a computer course. When Colleen refused to attend because she was in pain and certified unfit by her doctor, Gallagher Bassett issued her a non-compliance warning notice.

Colleen requested conciliation; and in early 2018, a Medical Panel concluded she was suffering from a lower back injury and chronic pain syndrome. The Panel disagreed with the IME's opinion and considered it was appropriate for Colleen to continue receiving pain consultations, which Gallagher Bassett subsequently agreed to fund – seven months after the request from her specialists.

* This case is also discussed on page 182.

Secondary mental injury

256. The investigation also identified instances where there was information to suggest the worker may have suffered a secondary mental injury, but the agent did not arrange for a psychiatrist IME to assess them to ascertain the impact on work capacity and treatment needs. In some cases, agents also terminated the worker's entitlements based on their physical injury alone, without considering the possibility of a secondary mental injury.

Example 1

In one case,* Allianz required a worker with a back injury to participate in occupational rehabilitation services and terminated her weekly payments on the basis she had a work capacity, without assessing her secondary mental injury. Allianz ignored information from an occupational physician IME indicating the worker had a 'psychological impairment', but said this was outside their area of expertise. The worker had previously suffered a secondary mental injury which later resolved, and so Allianz terminated her entitlements for the mental injury. Irrespective, Allianz should have arranged for a psychiatrist to reassess the worker in light of the IME's comments, to establish whether her secondary mental injury had re-emerged. A Medical Panel later found the worker was suffering from a chronic mental injury, which combined with her 'severe' back injury, rendered her indefinitely incapacitated for work.

In response to the draft report, Allianz said:

> [This example states] ... that Allianz ignored the reference to psychological issues in the physical IME report. Allianz confirm this is correct in this instance. Allianz has since corrected our internal practices in accordance with WorkSafe Quality Decision Measure guidelines [so] our policy is that any mention of psychological issues is followed up and a psychiatric IME considered.

* This case is also discussed on pages 46 and 55.

Example 2

In another case,* Gallagher Bassett required a worker with a back injury and secondary mental injury to participate in occupational rehabilitation without seeking an IME opinion on her capacity to do so from a psychiatric perspective. When she did not participate, it issued her a non-compliance warning notice despite information from an IME indicating she had a psychological impairment which was outside their area of expertise; a report from her treating doctor; and findings of a previous Medical Panel that the worker had a chronic mental injury associated with chronic pain from her back injury. The worker complained to WorkSafe that she was 'very distressed' about having to participate in occupational rehabilitation, which resulted in Gallagher Bassett arranging for her to be examined by a psychiatrist IME. The IME concluded the worker was unfit for work and could not participate in occupational rehabilitation. As a result, Gallagher Bassett ceased the worker's occupational rehabilitation.

* This case is also discussed on page 181.

257. WorkSafe's audits of agent decisions in 2017-18 also highlighted examples where agents had not adequately assessed a worker's secondary mental injury. This included a case (see page 162) where WorkSafe commented:

> The T/D [treating doctor] indicated in contact prior to the notice that the … [worker's] psychological condition was related to employment. While this was not reflected on certs [certificates of capacity] or a request for treatment received at the time of the notice, a psych IME could have been arranged to determine impact on CWC [current work capacity] as this may impact on the sustainability of the decision.

Unreasonable rejection of mental injury claims caused by 'reasonable management action'

258. While this investigation focused on 'complex claims' typically involving long-term periods of incapacity and/or medical treatment, concerns were raised with the investigation about agents' initial rejection of mental injury claims because the injury was caused 'wholly or predominantly' by 'reasonable management action'. Many of these decisions were complex in their own right due to the circumstances which gave rise to the mental injury and claim.

259. Section 40(1) of the WIRC Act states that an injured worker is not entitled to compensation in respect of a mental injury caused 'wholly or predominantly' by:

- management action taken on reasonable grounds and in a reasonable manner by a worker's employer
- a decision of an employer on reasonable grounds to take, or not to take, any management action
- any expectation by a worker that any management action would, or would not, be taken or any decision made to take, or not to take, any management action.

260. The WIRC Act states that 'management action' includes, but is not limited to:

- appraisal of a worker's performance
- counselling of a worker
- suspension or stand-down of a worker's employment
- disciplinary action
- transfer of a worker's employment
- demotion, redeployment or retrenchment
- dismissal
- promotion
- reclassification of a worker's position
- provision of leave of absence to a worker
- provision to a worker of a benefit connected with their employment
- training
- investigation by a worker's employer of any alleged misconduct of the worker, or any other person, in which the worker was involved or to which the worker was a witness
- communication in connection with any of the above.

261. Of the 1,686 mental injury claims rejected across the scheme in 2017-18, about 60 per cent of these (1,018 claims) were rejected on the 'reasonable management action' ground.

262. A number of witnesses interviewed during the investigation raised concerns about agents' application of this ground to reject mental injury claims.

263. Conciliation Officer G said they understood the rationale for the inclusion of the reasonable management ground in the Act, stating:

> I know that this is a real scheme concern, and if we're talking about keeping the thing viable, there has to be some boundaries around what's compensable and what isn't.

264. However, they said:

> What is usually overlooked is the aspects of the test, so you know, there's a couple of aspects to it. There's diagnosed injury, then it needs to have been caused wholly or predominantly by the reasonable management action, and that's generally ignored … So yes, you might identify reasonable management action and a chronology of events that suggests it's had some kind of impact. But was there really something else going on that was much more dominant that has led the worker to this injury that is compensable?

265. Conciliation Officer G further said there was 'no respect' for the policy intent of the provision and it was just about:

> Finding an argument to hold out on a claim, rather than looking constructively about what should happen, how it could be better managed, and how you really look after people's health.

266. Conciliation Officer H said agents commonly used 'factual grounds' (such as the 'reasonable management action' ground) to reject new claims 'when no factual information … [was] being relied on'. They explained that disputes involving such factual issues cannot be referred to a Medical Panel as they can only determine medical issues and said:

> My cynical self wonders whether these grounds are being … [used] in an attempt to eliminate the option of a Medical Panel referral as Agents have a clear preference for Genuine Dispute certificates in many instances, despite the costs of court.
> …
> I would argue that the Act is too broad in what constitutes 'management action' … Indeed, I think it contributes to greater disputation, longer absences from work and more overall damage to individuals and their relationship with their employer.

267. Conciliation Officer C said at interview that agents do not look at whether the injury was caused 'wholly or predominantly' by the management action. They said often management action taken by the employer was reasonable, but it was not necessarily the whole or predominant cause of the injury.

268. A worker representative similarly said at interview they had 'major concerns' regarding agents' use of the 'reasonable management action' ground to reject claims and stated that agents did not take into account 'the whole picture'.

269. The Police Association Victoria raised concerns about the high number of police officers' mental injury claims rejected on the reasonable management ground by the agent responsible for managing police claims, Gallagher Bassett. It provided a number of case examples to the investigation, one of which is outlined on the following page.

270. In this case, Gallagher Bassett rejected a worker's mental injury claim on the basis that it was wholly or predominantly caused by reasonable management action, despite the evidence suggesting the worker had experienced a relapse of previous work-related post-traumatic stress disorder (PTSD). The worker in this case was subject to performance management prior to lodging his claim, however, there was no evidence that this was the whole or predominant cause of his injury.

Case study 15 – Agent concludes police officer's PTSD caused by performance management discussions

Michael was working as a police officer when he sustained a mental injury (PTSD), as a result of attending a traumatic incident. He returned to work and suffered a relapse around 20 years later, in mid-2017, at which time he ceased work again. Michael spoke with his employer and agent, Gallagher Bassett, about reactivating his previous claim, however, was told to make a new claim.

To assess the claim, Gallagher Bassett sought information from Michael's employer and arranged a circumstance investigation, which indicated performance management discussions had occurred between Michael and his managers prior to the claim. It also indicated Michael did not disclose his prior mental injury to his managers until after these discussions.

Gallagher Bassett also arranged for an IME to examine Michael, who concluded he was suffering from PTSD. The IME noted that since initially developing PTSD about 20 years prior, Michael had experienced a number of 'episodes of aggravation' and recurrence in symptoms without any known triggers. The IME further said:

> The worker is in a role that he loves and he wants to be able to continue working and there is no intention of not going back to work, but currently he is quite symptomatic. His condition is severe enough where it is perhaps advisable for him to take a decent break of at least a period of two to three months, during which period he continues his treatment under the care of his treating psychiatrist.

Gallagher Bassett requested the IME provide a supplementary report clarifying the correlation of the current symptoms and recent events at work, and whether Michael was free of symptoms from the original mental injury. The IME said it remained his opinion that Michael was experiencing symptoms from the original mental injury which since its onset had 'run an undulating course'. The IME further said they did not think it could be said that Michael ever fully recovered and that they did not believe 'any recent events or incidents … [were] the main issues'.

Gallagher Bassett subsequently rejected Michael's claim on the basis his mental injury was caused wholly or predominantly by his employer's management action, which was conducted in a reasonable manner. In its notice to Michael, Gallagher Bassett primarily referred to the circumstance investigation report, and only included one sentence from the IME's report. It made no reference to the IME's supplementary report.

After rejecting the claim, Gallagher Bassett provided the IME a copy of the circumstance investigation report (which was not previously available) and asked the IME to provide a second supplementary report commenting on whether Michael's previous mental injury had contributed to his incapacity for work and need for treatment. The IME responded '[y]es, to both'. The IME also noted that the performance issues referred to in the investigation report would have 'most certainly been a source of stress' for Michael, contributing to the persistence and exacerbation of his symptoms. However, the IME did not state these were the whole or predominant cause of his symptoms, nor alter their original opinion.

Continued on next page...

Michael requested conciliation and upon reviewing the decision, Gallagher Bassett concluded the rejection was '[n]ot the strongest argument'. Gallagher Bassett agreed at conciliation to reinstate Michael's entitlements on his previous claim given the evidence supported that he was suffering a continuation of symptoms from the original mental injury.

WorkSafe reviewed Gallagher Bassett's decision making in this matter following a request from the Ombudsman's investigation. It concluded Gallagher Bassett should have reactivated Michael's original claim and that it was 'erroneous' for Gallagher Bassett to treat the second claim as a 'new' claim. It further said:

> Whilst the evidence indicates there was some performance management action occurring prior to the 'second' claim, there was no medical evidence to link the management action with the injury. Rather, it would appear from the available evidence that … [Michael] had not fully recovered from the original diagnosis …
>
> WorkSafe is of the view that given the circumstances of the matter, the Agent did not take timely steps to rectify the matter, or, in the alternative, determine to reactivate the existing claim to facilitate immediate support to … [Michael].
>
> WorkSafe also acknowledges that the treatment of the 'second' claim as a new claim and the subsequent rejection of that claim together with the consequent delays to reinstating the original claim likely had a regrettable impact on … [Michael].

WorkSafe also said:

> The diagnosis of PTSD, together with the intersection between management action is recognised by WorkSafe as presenting a complex and unique range of circumstances to be navigated by the injured worker, an employer and the Agent.
> …
>
> WorkSafe is currently reviewing the policy and guidelines with respect to the reactivation of existing claims to understand how its processes can be better aligned to reflect the unique aspects of this complex condition, to create a fair and equitable pathway for those who suffer from ongoing effects of PTSD.

271. In another case identified from the sample of agent staff emails obtained, CGU rejected a mental injury claim on the 'reasonable management action' ground, despite initially concluding there was no evidence to support this and acknowledging it was 'by no means a strong argument'.

Case study 16 – Sustainability of claim rejection 'pretty slim'

Lisa was working as a scientist when in early 2018, she made a WorkCover claim for a mental injury arising from workplace stress and bullying. Prior to making the claim, Lisa's position was made redundant.

To assess the claim, Lisa's employer's agent, CGU, arranged for a circumstance investigation to be conducted and sent Lisa to be examined by an IME. The IME diagnosed Lisa with a mental injury and said she was unable to return to her pre-injury work.

A CGU officer said in an email to Lisa's employer that based on the information obtained, the claim should be accepted. They said:

> The worker is suffering from an injury as per the report provided by … [the IME]. The injury appears to be connected to employment as per the information received from … [the circumstance investigation]. There is no evidence to support the worker was subject to any performance management or had intentions to do so. Whilst there is evidence to suggest that the worker's claim was lodged after her position was made redundant, it appears the worker's claim is not purely as a result of this action …
>
> Under the legislation, a claim for mental injury can be denied if the employer has undertaken management action on reasonable grounds and in a reasonable manner and that this action is wholly and predominantly the cause to the worker lodging her claim. As per the above, I have indicated that the redundancy is not the sole reason for the worker lodging her claim. Furthermore, I have concerns around the reasonableness of the action given the worker was contacted about the redundancy while she was on sick leave and given limited time to respond before the redundancy was finalised.

Lisa's employer raised concerns about the proposal to accept the claim, and the CGU officer sent a further email reiterating their opinion that the claim needed to be accepted. They stated:

> Whilst it is confirmed that there is management action in this matter (namely the decision of the employer to restructure and make Lisa's role redundant), there is insufficient information to confirm that this is the whole or predominant cause of the injury, noting that the worker ceased work and reported work related stress injury prior to this occurring. Further there is no information that the worker was aware of this occurring therefore we cannot argue that Lisa's injury was as a result of expectation that her role was being made redundant.

A Technical Specialist subsequently reviewed the claim, concluding it was 'more accept than reject' and said 'if we could reject, the likelihood of being sustainable is pretty slim'. The officer who originally assessed the claim responded stating '[i]f we could possibly get a reject out of it and let it go to Concil[iation] that would be ideal'. The Technical Specialist undertook a further review and said they thought they could reject the claim by focussing on the decision of Lisa's employer to take action around transition planning as the predominant cause of her mental injury. However, they said it was 'by no means a strong argument' and that there were 'likely to be queries around the reasonableness [of the employer's actions]'.

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The CGU officer prepared a notice rejecting the claim, which was endorsed by the Technical Specialist who said:

> When you speak to the employer I would make it really really clear that it isn't a strong decision at all, there are still some flaws with the reasonable aspect potentially and they need to be willing to look at a resolution if she appeals the decision.

Lisa did not dispute the rejection at conciliation.

In response to the draft report, WorkSafe said that after reviewing this case, it considered the decision should be overturned. WorkSafe said:

> WorkSafe has reviewed the claim and considers that there was appropriate evidence to support the Agent's decision at the time. There was medical evidence in clinical records indicating that the worker's condition was linked to the relevant management action. There was evidence from an employer witness that the management action was reasonable, noting that the worker agreed that she had advised the employer of her intention to resign. This was a complex claim involving competing versions of material facts.
>
> WorkSafe has determined that it would be appropriate to reconsider this decision and has communicated this to the Agent.

WorkSafe confirmed CGU had agreed to overturn the decision and accept Lisa's claim, with entitlements from the effective date of the rejection.

Delays in decision making

272. Concerns were raised with the investigation about delays in decision making by agents and the consequent impact on an injured worker's recovery. The concerns primarily centred on the timeliness of agents' approval or rejection of requests for:

    - reinstatement of entitlements due to further incapacity
    - treatment.

Requests for reinstatement of entitlements

273. An injured worker's entitlement to weekly payments and/or medical treatment ceases if they recover and can make a full return to work. However, if the worker subsequently suffers a relapse, they may request their agent reinstate or 'reactivate' their entitlements.

274. While an agent must decide whether to initially accept or reject a claim within a strict 28-day legislative timeframe, there are no such timeframes for reinstatement requests. This is despite workers facing similar circumstances, where they are unable to work, have limited or no income and cannot access funding for medical treatment until their claim is accepted.

275. Requests for reinstatement of entitlements can involve complex circumstances which warrant exploration before an agent is able to make a decision. This may include looking at the cause of the worker's further incapacity and whether it is related to their original work injury. While this is appropriate, the evidence obtained during the investigation showed that decision making was unreasonably delayed in some cases.

276. The Police Association Victoria told the investigation that its members have waited up to six months to have their entitlements reinstated after experiencing a relapse and highlighted the significant impact such delays can have on a worker, particularly those with a mental injury.

277. The following case study is an example of a claim highlighted by the Police Association Victoria. The worker waited six months for Gallagher Bassett to reinstate his payments, during which time the worker said he was suffering financial hardship.

Case study 17 – Police officer suffering from anxiety left waiting six months for payments to be reinstated

Anthony was working as a police officer when in 2014 he sustained a mental injury (PTSD), after witnessing traumatic incidents at work. He made a WorkCover claim which was accepted by Gallagher Bassett. By mid-2017, Anthony's PTSD resolved and he returned to work full-time. As a result, Gallagher Bassett terminated his weekly payments.

In early 2018, Anthony saw a Police Medical Officer who told him he was unfit for operational duties. Anthony ceased work and asked Gallagher Bassett to reinstate his weekly payments. He told Gallagher Bassett he had ceased work 'due to a relapse' in his PTSD, which he believed had never been 'cured'. He said he had been taking personal days off occasionally to hide his ongoing anxiety. A week later, Anthony asked Gallagher Bassett about the progress of his reinstatement request and it said it had arranged for him to be examined by an IME in about two months' time. Gallagher Bassett told Anthony it could not provide any payments to him until he had been examined by an IME.

After examining Anthony, the IME said he was now suffering from anxiety. The IME concluded Anthony's current psychiatric state was related to both his original PTSD from 2014 and recent issues in 2018 where he was told he was unfit for operational duties. The IME specifically said the 'recurrence of his anxiety was still related to the compensable injury of … 2014'. The IME said Anthony needed to continue treatment until there was a significant improvement in his anxiety.

Over the next two months, Gallagher Bassett asked the IME to consider other evidence, including an outdated report from Anthony's psychologist and information about physical non-work-related conditions which had caused Anthony to take leave from work. It asked the IME to provide two supplementary reports, however, the IME ultimately maintained their original opinion.

After waiting about five months, Anthony contacted Gallagher Bassett to ask about the status of his reinstatement request. He told Gallagher Bassett he was suffering financial hardship, which was having a considerable effect on him and his family. He said he could understand how other police officers could turn to suicide.

After receiving the second supplementary IME report, Gallagher Bassett decided to reinstate Anthony's payments, six months after his request.

In response to the draft report, Gallagher Bassett said:

> [A]n inference is made that the period of six months between request for reinstatement and payment of compensation constitutes improper delay, and fails to identify the components of the delay which might lead to a different conclusion. In this case, the delay was caused, in part, by the availability of the IME, by the necessity of clarification of the opinion and the requirement for a Centrelink release. Inferential attribution of the entire period to the inaction of the agent is misleading and inaccurate.

The investigation acknowledges the various factors Gallagher Bassett highlighted which contributed to the delay in this case, some of which may have been outside Gallagher Bassett's control. However, this case highlights the lack of legislative and policy requirements around the timeframes in which a decision must be made on a reinstatement request, and the impact delays can have on injured workers.

278. Although case study 17 relates to Gallagher Bassett, CGU highlighted the internal procedure it has introduced to deal with reinstatement requests in its response to the draft report. CGU said:

> When a request for reinstatement or reactivation is received, it needs to be thoroughly reviewed to determine if there is an entitlement to weekly compensation and/or treatment under the claim.
>
> In a lot of cases, these requests are typically for claims which have had significant time without compensation or being active. This requires an Agent to determine the cause of deterioration which may entitle them to compensation, through information gathering from several different sources (for example, practitioners, employer/s and/or independent examiners).
>
> In December 2018, CGU examined its internal review procedure of reinstatements and reactivation requests. During this assessment we made several changes to enhance our decision-making process, such as ensuring we keep the worker better informed and improving oversight of outstanding decisions within the business.
>
> CGU's expectations are that where possible, the request is assessed, and a decision made within a 28-day timeframe. For any claim where the decision has not been made within 28 days (for example, awaiting an IME report, practitioner information or worker information), the claim must be conferenced every 4 weeks until the decision has been made and to ensure the employer and injured worker are updated on the progress of the request.
>
> For any claim where the decision is not made by the 28th day, a discussion is to be held with a senior staff member and a case note added as to why a decision can't be made and any follow up actions that need to be undertaken.
>
> In addition, we have created a reinstatement and reactivation tracking database to capture ongoing reviews and improve business oversight on outstanding decisions.
>
> CGU acknowledge that this is an area of importance and we will be scheduling further training with staff to ensure they understand this and how we service these injured workers.

279. The investigation identified cases where workers resorted to requesting conciliation about an agent's failure to respond to their reinstatement request, in an attempt to get the agent to make a decision one way or the other. This resulted in workers unnecessarily being involved in the dispute process twice, as if the agent then rejected their request, they had to request conciliation again to dispute the substantive decision.

Example 1

In one complex claim, a worker requested conciliation two months after requesting his weekly payments be reinstated, based on EML's failure to make a decision. EML then rejected his reinstatement request about two months later, and the worker requested conciliation again to dispute the rejection. EML later withdrew the rejection and reinstated his payments about four months after his original request.

280. The sample of agent staff email records reviewed by the investigation also provided examples of this issue.

Example 2

An EML email referred to a request for conciliation by a worker regarding EML's failure to respond to his reinstatement request submitted more than three months prior. EML's Dispute Resolution Officer noted that further actions had been undertaken after the worker requested conciliation, but raised concerns that at conciliation they would be 'unable to elaborate on the time [EML had] taken'. The worker indicated to EML he wanted to proceed with conciliation 'to clarify and get resolution on why it … [had] taken 3 months for EML to get things in place'. Prior to the scheduled conciliation conference, EML rejected the worker's reinstatement request without any evidence. However, EML noted it had arranged for him to be examined by an IME in a few weeks' time and requested information from his treating doctor. It said it may review the decision when it received this information. The IME report EML later received indicated the worker had a work capacity so it maintained its decision. The worker disputed it at conciliation, but the matter could not be resolved. The worker did not dispute it further at court.

281. In its response to the draft report regarding the two above examples, EML said:

> [I]t should be noted, that both claims relate to reinstatement requests following a significant period since the workers last received compensation … [In Example 1 above] there was an 11-year gap … [in Example 2 there was] a 12-year gap. In both cases, acknowledgement of the reinstatement requests was prompt. Due to the significant gap since the last payment of compensation, and the fact that there was intervening employment (and not with the pre-injury employer), further evidence was required to support the reinstatements. The process was delayed by the difficulty in obtaining medical records, and in one case, the fact that the IME used to provide an assessment had been struck off the IME list by WorkSafe, part way through the evidence gathering process. In one case, the worker's current contact details were not up to date because of the large gap since receiving compensation … In each case, the workers were kept informed of the process and the reasons for the delay …

Example 3

Another email referred to conciliation requested by a worker regarding Gallagher Bassett's failure to respond to her reinstatement request submitted about five months prior. The email said the Conciliation Officer gave Gallagher Bassett until the following business day to reinstate the worker's payments or said they would issue a direction. The email noted the Conciliation Officer had highlighted that all reports from the worker's treating doctors supported an ongoing incapacity and Gallagher Bassett's own IME also supported it, so there was 'no basis to delay reinstating'. Gallagher Bassett subsequently accepted the worker's request and reinstated her payments.

282. Some of the Conciliation Officers interviewed during the investigation raised concerns about the number of requests for conciliation regarding an agent's failure to respond to a reinstatement request. In 2017-18, 174 such requests were received.

283. Conciliation Officer A said:

> [T]he agent just doesn't make a decision at all and it's not until it gets to the conciliation [conference] that they are pressured into doing something about it.

284. Conciliation Officer E suggested Conciliation Officers should have the discretion to direct that interim payments be made to a worker in cases where there is evidence supporting their reinstatement request but there are delays in decision making. They said this would reduce some of the 'harm' caused to injured workers and increase agent accountability for delays.

Requests for treatment

285. The investigation also received evidence that in some cases, agents have unreasonably delayed decisions regarding requests for treatment.

286. In 2017-18, the ACCS received 856 requests for conciliation for an agent's failure to make a decision regarding a worker's request for treatment.

287. Witnesses to the investigation raised concerns about the impact of such delays on injured workers' recovery, particularly those with a mental injury. For example, one psychiatrist providing treatment to injured workers said:

> Some claims managers do seem to sit on decisions and if I am seeing someone for a second or third time, may have no conclusion reached about the claim. This … stress can really prolong or create psychiatric disorders or maintain them far past what one would otherwise expect.

288. Another psychiatrist who treats injured workers described examples where they had experienced delays in agents' approval of treatment, which included:

- a request for funding of psychological treatment made for a worker, where the psychiatrist was asked to provide additional information, which they supplied; however, '[n]o action was taken' and the worker remained an ongoing suicide risk
- an inpatient client who consistently told the psychiatrist over the course of a year that he wanted treatment so he could go back to work; however, it took 'a year of grunt and trench warfare' for the psychiatrist to get funding for treatment.

289. A third psychiatrist said since the Ombudsman's 2016 report, their patients were 'still experiencing the same delays in getting approvals and requests for inpatient treatment' and highlighted that delaying a referral to a psychiatrist or psychologist was 'clinically unsafe'.

Example

In one complex claim reviewed by the investigation,* the worker requested conciliation regarding Xchanging's failure to respond to a request for funding of treatment after waiting three months. Xchanging decided to reject her request two weeks later, despite the available medical evidence suggesting it should be approved. The worker requested conciliation again and also complained to her local Member of Parliament about Xchanging's management of her claim. Xchanging ultimately approved her request about six months after it was originally received.

In its response to the draft report, Xchanging said:

> While Xchanging accepts there may have been a delay in the decision-making process, this was a case where retrospective approval was sought for a procedure performed two years prior to the request and four years after the original request.
>
> Xchanging was required to consider a range of complex medical, technical and legal factors before reaching a decision. These complex issues took longer than average to resolve.

* This case is also discussed on page 36.

290. Conciliation Officer A interviewed during the investigation said that agents were 'still continuing to delay decisions', particularly 'in more difficult areas like surgery' or where there was a gap in treatment.

291. Maurice Blackburn, a law firm which represents injured workers, told the investigation that it had 'certainly continued to observe inadequate processes and unfair practices' by agents which often led to injured workers experiencing delayed treatment, which in turn delayed their recovery.

292. A 2018 research report[23] relating to outcomes for injured workers in Victoria with long term claims also identified issues regarding delays in treatment approval. A number of stakeholders working in the scheme interviewed as part of the study described the process of getting treatments approved as 'onerous' and highlighted how delays in approvals 'translated directly' into delays in workers' treatment and recovery.

23 Dr Elizabeth Kilgour and Dr Agnieszka Kosny, Institute for Safety, Compensation and Recovery Research (ISCRR), *Victorian Injured Worker Outcomes Study, Study 1 – A qualitative enquiry into outcomes for injured workers in Victoria who have longer term claims*, Final Report, April 2018.

Unfair return to work practices

293. A key objective of the workers compensation scheme is to provide 'effective occupational rehabilitation' and 'increase the provision of suitable employment to workers who are injured to enable their early return to work'.

294. If a worker is unable to return to their original job due to their injury, they are assisted, when medically appropriate, to return to 'suitable employment'. Consideration of whether jobs are 'suitable' for a worker must have regard to:

    - the nature of the worker's incapacity and pre-injury employment
    - the worker's age, education, skills, work experience and place of residence
    - return to work planning documents and occupational rehabilitation services provided to the worker.[24]

295. Key stakeholders involved in a worker's return to work may include their employer, treating doctor(s), WorkCover agent, and sometimes an occupational rehabilitation provider.

296. Occupational rehabilitation providers approved by WorkSafe provide independent return to work services to injured workers, which focus on assisting them return to work with their original employer or, if necessary, a new employer.

297. Injured workers have 'return to work' obligations under the WIRC Act, which include that they must:

    - make reasonable efforts to actively participate and cooperate in planning for their return to work (section 111)
    - actively use an occupational rehabilitation service and cooperate with the service provider, to the extent that it is reasonable to do so (section 112)
    - actively participate and cooperate in any assessment of their work capacity, rehabilitation progress and future employment prospects, when requested and to the extent that it is reasonable to do so (section 113)
    - make reasonable efforts to return to work (section 114)
    - actively participate in an interview with their agent for the purpose of enhancing their opportunities to return to work, as required and to the extent that it is reasonable to do so (section 115).

298. If a worker does not reasonably comply with their obligations, an agent may issue a non-compliance notice, which can impact the worker's entitlements.

299. This investigation examined agents' issuing of non-compliance notices in complex claims when reviewing whether the quality of agent decision making has improved. Non-compliance notices were selected as a focus area for the investigation based on trends in complaints to the Ombudsman about these notices.

24 'Suitable employment' is defined in the WIRC Act, s. 3.

300. In the sample of complex claims reviewed, the investigation identified several return to work non-compliance notices which had been unreasonably or incorrectly issued. This included cases where:

- workers were required to participate in occupational rehabilitation at inappropriate stages of their recovery
- agents failed to genuinely consider workers' individual circumstances and the reasonableness of their non-participation
- agents incorrectly issued notices under the legislation.

301. The investigation also received evidence that agents sometimes issued non-compliance notices with a focus on liability management.

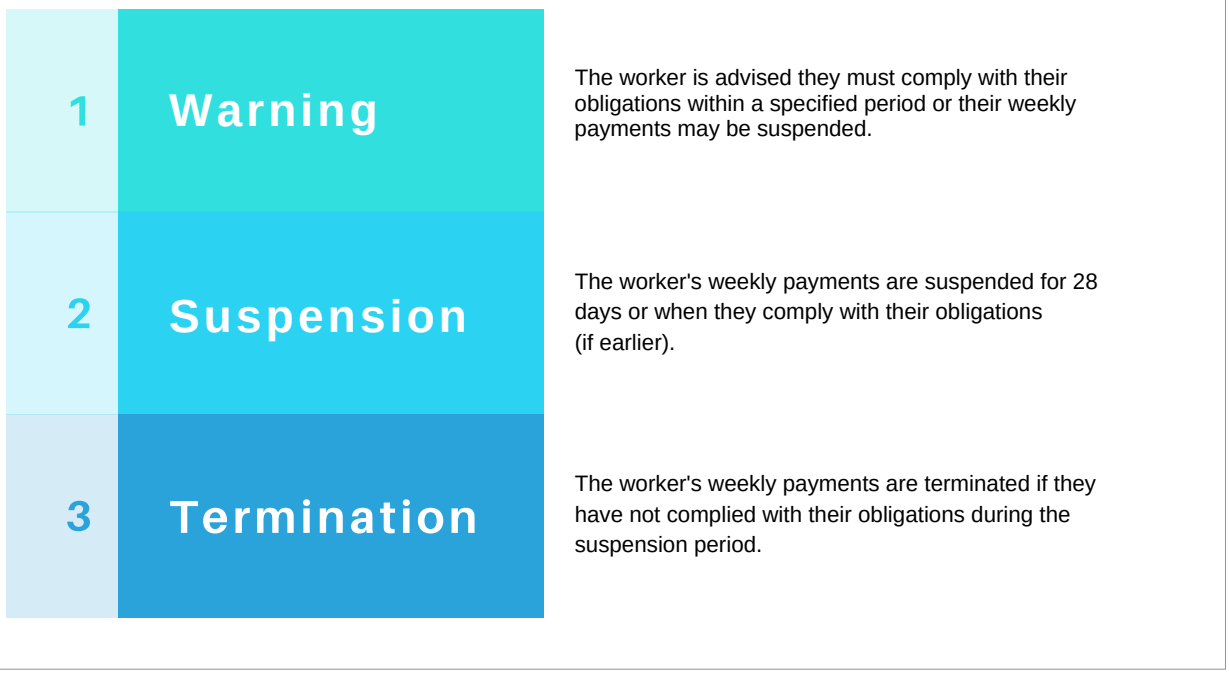
302. Additionally, the investigation identified issues regarding agents':

- consideration of 'suitable employment' options for workers
- termination of weekly payments of workers who had returned to work part-time, but due to their injury, were unable to make a full return to work.

Agents' issuing of return to work non-compliance notices

303. Agents may issue return to work non-compliance notices via a three-stage process, comprising a warning, suspension and then termination.

Process for issuing return to work non-compliance notices



304. Agents may also issue a 'cease and determine' notice where a worker has been repeatedly non-compliant over a 12-month period. This is a more severe sanction than a termination. The effect of these notices is that a worker's weekly payments are terminated and they cannot re-establish their entitlement, even if their circumstances change (as a result of a change to total incapacity or later compliance, for example), without the notice being overturned.

305. A cease and determine notice can only be issued where a worker does not comply with their obligations after being issued a suspension notice and has within the preceding 12 months been issued:

- two previous warning notices without a subsequent suspension; or
- a previous suspension notice, resulting in their weekly payments being suspended.

306. Agents are required to consider a worker's individual circumstances prior to issuing a return to work non-compliance notice. Sanctions should not be applied where a worker has made a reasonable effort to comply with their obligations or their non-participation was reasonable.

307. To assist agents' consideration of this, they are required to contact a worker to discuss their obligations and ask why they are not being compliant before deciding to issue a notice.

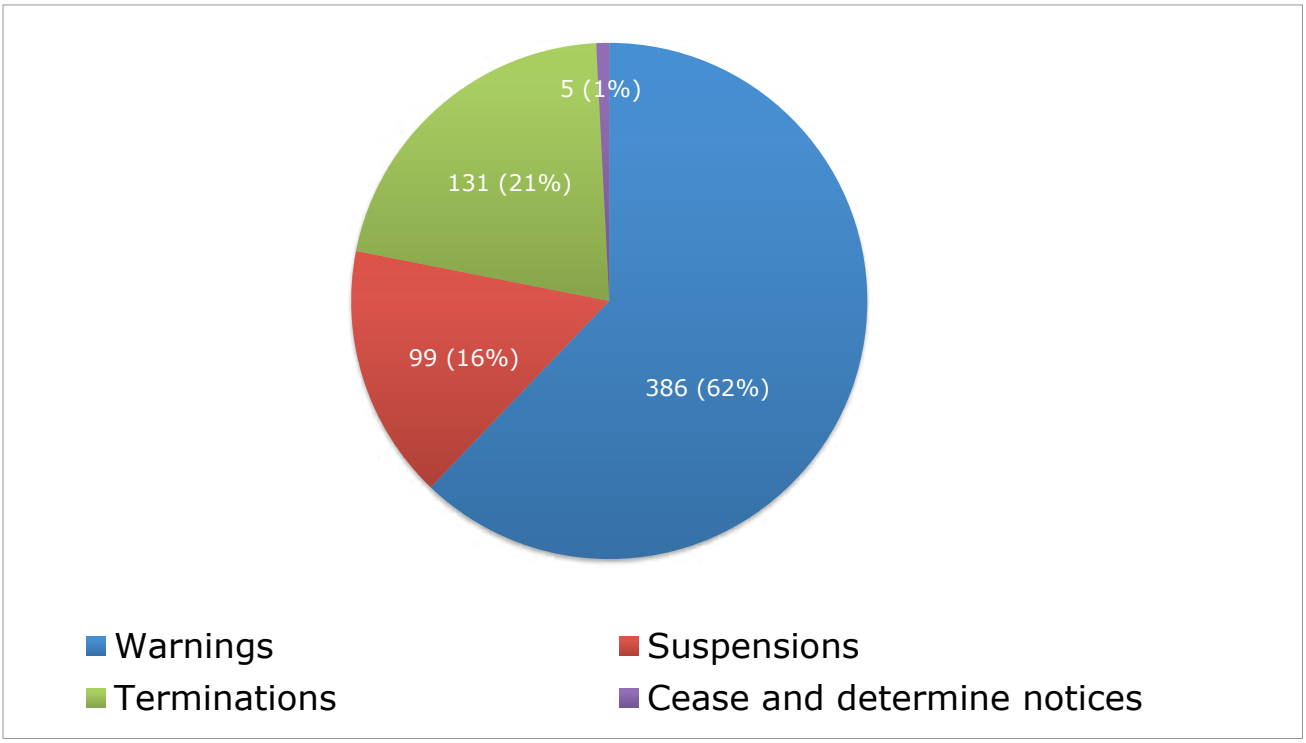
308. The WorkSafe Claims Manual outlines examples of 'common factors' that may influence the nature and extent of a worker's participation, which include:

- the worker's incapacity
- the seriousness of their injury, including psychological effects
- non-work-related injuries or illnesses
- language and literacy skills
- availability of and access to their treating doctor(s)
- the effect of medication or other treatments
- access to transport and residential location
- access to a phone
- family or carer responsibilities.

309. Training provided by WorkSafe to agent staff in April 2019 emphasised:

- The legislation requires a worker to make 'reasonable efforts' to meet their obligations.
- The onus of proof is on the agent to prove the worker acted unreasonably.
- Understanding the reasons why the worker did not comply is vital.

Non-compliance notices issued in 2017-18 by type



Source: WorkSafe Victoria

310. In 2017-18, 621 return to work non-compliance notices were issued across the scheme. Of the total notices issued, there were 386 warnings, 99 suspensions, 131 terminations and five cease and determine notices.

311. One hundred of the total notices were issued on complex claims where a worker had been receiving weekly payments for more than 130 weeks.

312. The investigation reviewed a sample of 25 return to work non-compliance notices issued on complex claims, three quarters of which related to workers' participation in occupational rehabilitation.

Workers required to participate in occupational rehabilitation at inappropriate stages of their recovery

313. While occupational rehabilitation can be an effective tool to assist injured workers to return to work, the investigation identified a number of complex cases where workers were required to participate in occupational rehabilitation at inappropriate stages of their recovery. This led to workers being deemed non-compliant with their obligations and subject to sanctions which affected their entitlements.

314. A review into occupational rehabilitation recently commissioned by WorkSafe[25] identified issues regarding the 'inappropriate timing' of occupational rehabilitation referrals by agents in some cases.

25 Institute for Safety, Compensation and Recovery Research (ISCRR), *Occupational Rehabilitation, Quality Improvement Review, Recovery and Return to Work after Injury: Review of Victorian Occupational Rehabilitation approaches*, Research Report 211 (December 2017).

315. Additionally, occupational rehabilitation consultants interviewed during the review reported that claims were sometimes referred to them after 'a number of other options had failed', which led to 'difficult and complex cases fraught with secondary complications'.

316. Occupational rehabilitation consultants variously reported that agent staff:

    - 'demanded' they complete tasks, enforce return to work obligations and/or 'push' injured workers, even when their judgement told them not to and the worker's treating doctor(s) had said they were not ready to go back to work
    - did not consider the impact of psychosocial issues on workers' return to work and 'placed unrealistic expectations on how long it took to support the injured worker back to work'.

317. One occupational rehabilitation consultant interviewed during the review said:

> We get a lot of referrals for people … [who have] got surgery in two months' time so obviously immediately [they think] 'why would I be engaged with you when I'm going to go into surgery?' Or people that are highly suicidal and psychologically unwell even if the claim may have been a back injury but psychologically they're not in a place to look at RTW [return to work]. Part of that claim tells the insurance companies they've got to refer them so they just do and that completely derails any chance of progression or I guess trust with us.

318. In the following case study, EML referred a worker to occupational rehabilitation despite medical evidence suggesting he could not return to work and could not participate in occupational rehabilitation as a result of 'psychotic hallucinations'. When the worker did not participate, EML terminated his weekly payments on the grounds of non-compliance.

Case study 18 – Worker required to participate in occupational rehabilitation despite psychotic hallucinations

Lee was working in a factory when in 2010 he injured his back. He ceased work and made a WorkCover claim, which was accepted by his employer's agent at the time, QBE. Lee also had an unrelated pre-existing psychiatric condition.

EML later took over Lee's claim and referred him to occupational rehabilitation services in early 2017. In mid-2017, EML arranged for Lee to be examined by two IMEs, an occupational physician and a psychiatrist. They both said Lee could not return to work but did not provide definitive opinions on the cause of Lee's symptoms. The occupational physician IME said Lee was unable to participate in occupational rehabilitation as a result of 'psychiatric issues of hallucinations' involving him 'speaking [to] and seeing dead relatives'.

EML asked the occupational physician IME to provide a supplementary report providing their opinion on Lee's capacity only based on his physical injury, as the psychiatric issues were outside their area of expertise. The IME responded:

> You will note that at the time that I saw this gentleman, he was having psychotic hallucinations. If you expect someone who is having psychotic hallucinations to give a rational medical history and provide a satisfactory clinical examination, then you've had little experience in dealing with psychiatrically disturbed people.
>
> I have reviewed the answers to my questions, which you have asked again. I am not able to untangle the physical from the psychiatric in the way that he presents. What you ask is unrealistic, as it is not possible to get satisfactory answers to your questions from a physical perspective when he is clearly so psychiatrically disturbed. Perhaps once he is adequately treated for his psychosis, it would be more realistic to look from the perspective of a physical presentation.

Three other medical reports obtained for Lee's common law claim[26] in mid-2017 also indicated he was unable to return to work. Despite having no clear medical opinions indicating Lee could return to work, EML continued to require him to participate in occupational rehabilitation.

EML had difficulties contacting Lee about his occupational rehabilitation and in mid-2017 he failed to attend a scheduled appointment. The provider told EML he had sworn at them when contacted about his non-attendance. EML issued Lee a warning notice for not attending the appointment and continued to unsuccessfully try to contact him. Lee attended a further scheduled appointment and so was deemed to be compliant at that time.

Continued on next page...

26 An injured worker is able to make a common law claim for pain and suffering and/or economic loss if they have sustained a serious injury and someone other than the worker was at fault.

Later in 2017 Lee advised his occupational rehabilitation provider he was unable to attend further appointments due to his back injury and psychological state. EML told the provider to continue to schedule appointments irrespective, as it was 'very keen' to 'keep momentum' on the claim. Lee did not attend a further scheduled appointment and both EML and the occupational rehabilitation provider were unable to contact him. EML issued Lee a second warning notice.

EML made several further unsuccessful attempts to contact Lee, before he contacted EML to advise his mobile phone number had changed, which is why EML had been unable to contact him. In late 2017, EML issued a third warning to Lee for further missed appointments and then in early 2018, issued a suspension and termination for his continued non-compliance. The termination was issued two days prior to the end of the suspension period. This made it technically invalid, as the Act states that the entire suspension period must have elapsed before a termination can be issued.

Lee's lawyer requested conciliation. EML's dispute resolution team reviewed the termination prior to conciliation and considered the termination should be withdrawn. However, EML maintained the termination at conciliation and the Conciliation Officer was unable to resolve the dispute. Lee did not dispute the decision further at court.

Following a request from the Ombudsman's investigation, WorkSafe reviewed the non-compliance notices issued to Lee and concluded they were 'not appropriate or sustainable decisions'. WorkSafe said EML's decision to refer and require Lee to participate in occupational rehabilitation services was not appropriate or in line with the Claims Manual, and did not take into account the available medical evidence. WorkSafe requested EML withdraw the notices and reinstate Lee's weekly payments from the effective date of the termination, which was about one year prior. As a result, Lee was back-paid close to $40,000 with entitlements ongoing.

You will note that at the time that I saw this gentleman, he was having psychotic hallucinations. If you expect someone who is having psychotic hallucinations to give a rational medical history and provide a satisfactory clinical examination, then you've had little experience in dealing with psychiatrically disturbed people.

– Occupational Physician

319. In another complex claim reviewed by the investigation, Gallagher Bassett required a worker to complete a computer course, despite the medical evidence suggesting he was indefinitely incapacitated for work and may never return. When the worker did not attend the course, Gallagher Bassett issued him a non-compliance warning notice.

Case study 19 – Worker with indefinite incapacity forced to attend computer course

David was working as a truck driver when in 2013 he injured his back. He ceased work and made a WorkCover claim, which was accepted by Gallagher Bassett.

After his weekly payments were terminated in late 2015, David was examined by a Medical Panel in early 2016, which found he was indefinitely incapacitated for all work as a result of his injury. The Panel considered David's potential employment options and opportunities for retraining were restricted by his age (he was in his late 50s), his low level of formal education, his limited transferrable skills, the nature and severity of his injury, the length of time he had been out of the workforce and his minimal computer skills. Gallagher Bassett reinstated David's weekly payments based on the Panel's opinion.

About a year later in early 2017, Gallagher Bassett arranged for an IME to examine David. The IME said David could not return to work as a truck driver, but other work and occupational rehabilitation 'could be considered' once he had completed a pain management program. However, the IME also concluded that there had been no material change in his situation since the 2016 Medical Panel examination. As there had been no material change, Gallagher Bassett was required to accept the Medical Panel opinion, that the worker was indefinitely incapacitated, as binding (see page 130 for further explanation of the binding nature of Medical Panel opinions). David's GP also continued to provide certificates indicating he could not return to work, and told Gallagher Bassett that in their opinion, David was 'unlikely to ever return to work again'.

Gallagher Bassett referred David to occupational rehabilitation based on the IME opinion and a vocational assessment was completed in mid-2017. The occupational rehabilitation provider suggested David would benefit from undertaking a computer course to increase his employability for potential suitable jobs, which Gallagher Bassett approved.

Gallagher Bassett instructed the occupational rehabilitation provider to continue providing services to David throughout the second half of 2017, despite there being no medical evidence he had a work capacity.

David did not attend the computer course he was enrolled in. When asked why, he said he did not want to participate as he had done a similar course a few years prior. Gallagher Bassett issued a non-compliance warning notice to him and told him he needed to attend the next available course, otherwise his payments may be suspended. Gallagher Bassett arranged for another IME to examine David in early 2018, who said David did not have a capacity to participate in occupational rehabilitation, but might be able to do so in the next six months upon improvement in his overall pain management. The IME said David had no current work capacity and there had been no change since the Medical Panel opinion. If not earlier, Gallagher Bassett should have told David he no longer needed to participate in occupational rehabilitation based on this opinion.

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David's wife contacted Gallagher Bassett to discuss the computer course and said David had 'declined lately' and was 'more depressed' than normal. Gallagher Bassett arranged for David to be seen by a psychiatrist IME, who said David's psychological state had 'only deteriorated in the setting of stress around the WorkCover process'.

David ended up going to the computer course as required by Gallagher Bassett, so his payments were not suspended. The course ran for nine weeks, which David completed in mid-2018. The occupational rehabilitation provider's retraining outcomes report noted that David reported sitting caused him pain, that trying to deal with the pain in addition to paying attention was 'not very easy' and that the course had caused him stress.

Gallagher Bassett later instructed the occupational rehabilitation provider to close David's file based on the most recent IME's opinion that he was not fit to participate in occupational rehabilitation until he got his pain levels under control. It is unclear why this did not occur earlier given the available medical opinions.

After a request from the Ombudsman's investigation, WorkSafe reviewed the non-compliance notice issued to David and concluded it had been appropriately issued. WorkSafe highlighted the first IME's opinion that David had a capacity for retraining and that David had failed to attend the computer course despite reminders and follow ups. WorkSafe did not comment on Gallagher Bassett's reliance on an IME opinion indicating there had been no material change since the Medical Panel.

320. The investigation also observed cases where there was sufficient medical evidence to support referring a worker to occupational rehabilitation initially, however, agents received subsequent information suggesting the worker's condition had deteriorated and occupational rehabilitation services should not continue. Notwithstanding this, agents continued to require workers to participate.

321. The following case study is an example of this. Allianz continued to require a worker with a mental injury to participate in occupational rehabilitation despite evidence her condition had deteriorated and she no longer had a work capacity. Under pressure, the worker attended these appointments but was sanctioned with non-compliance notices when she did not provide evidence to the occupational rehabilitation provider that she had applied for jobs.

Case study 20 – Worker required to apply for jobs, despite deterioration and incapacity for work

Audrey was working at a childcare centre when in late 2015 she sustained a mental injury from bullying and harassment.* She ceased work and made a WorkCover claim, which was accepted by Allianz. In mid-2016, she returned to work on modified duties and reduced hours.

Allianz arranged for an IME to examine Audrey in early 2017, who said she was not able to increase her working hours beyond what she was working at that time, due to her ongoing symptoms. Information from Audrey's treating doctors similarly indicated she was working as much as she could and was slowly working towards increased hours.

In mid-2017, Audrey's employer decided it was no longer able to provide suitable duties for her and terminated her employment. As a result, Allianz approved occupational rehabilitation to assist Audrey to find new suitable employment. In late 2017, Audrey did not attend a scheduled appointment with her occupational rehabilitation provider. Allianz attempted to contact her on the same day as the appointment to discuss her non-attendance, and then proceeded to issue her a non-compliance warning notice a couple of hours later.

Allianz began receiving ambiguous information about Audrey's capacity to work:

- A late 2017 IME report said Audrey's condition had worsened and she no longer had capacity for any work, but that it 'may' change in six to nine months.
- Audrey's treating psychiatrist told her occupational rehabilitation provider that Audrey's condition had deteriorated, and she had no capacity to work.
- Audrey's GP issued a certificate of capacity stating Audrey had capacity to work, but later changed it to say she was unfit for work.

Despite this, Allianz asked the occupational rehabilitation provider to continue providing services to Audrey and to inform Allianz 'as soon as possible' if she was non-compliant. Allianz issued Audrey a further non-compliance warning in early 2018 on the basis that she did not provide evidence of job applications, even though there was no clear evidence she had capacity for work at that point. Allianz did not contact Audrey before issuing the warning to discuss the reason for her non-compliance. It then issued:

- a non-compliance suspension notice after Audrey missed an occupational rehabilitation appointment
- a notice terminating her weekly payments at 130 weeks because she had a current work capacity, or alternatively, was incapacitated but this was not likely to continue indefinitely.

Audrey requested conciliation regarding the non-compliance notices and termination, but the dispute could not be resolved at conciliation. Audrey did not dispute the decisions further at court.

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Following a request from the Ombudsman's investigation WorkSafe reviewed the non-compliance notices and concluded it was not appropriate for Allianz to issue the notices before seeking to reconcile the conflicting opinions about work capacity between Audrey's treating doctors and the IME. It said Allianz's approach did not 'properly reflect or align with a holistic approach to a client's recovery' and so the notices would be withdrawn.

WorkSafe also reviewed the 130-week termination and concluded there was insufficient evidence to support the decision, so it would be withdrawn. This resulted in reinstatement of Audrey's ongoing weekly payments, and a back-payment of nearly $30,000.

* This case is also discussed on page 39.

322. The investigation also identified some examples of good practices by agents in relation to the use of occupational rehabilitation and return to work non-compliance notices. This included the following case study, where Gallagher Bassett decided not to suspend a worker's entitlements after it identified it was relying on outdated medical information about her capacity to return to work and participate in occupational rehabilitation.

Case study 21 – Suspension notice not issued due to outdated medical information

Emma was working as a police officer when in 2002, she sustained a mental injury from bullying and sexual harassment. She ceased work in 2006 and made a WorkCover claim, which was accepted by Gallagher Bassett.

In late 2017, an IME examined Emma and concluded that while she could not go back to work as a police officer, she had a capacity for work that was suitable for her. Gallagher Bassett subsequently referred Emma to occupational rehabilitation services to assist her finding a new job.

Emma missed a number of occupational rehabilitation appointments and so Gallagher Bassett issued two non-compliance warning notices to her. Gallagher Bassett prepared a non-compliance suspension notice on the basis that Emma did not attend a further appointment within the warning notice period; however, it did not proceed with the suspension as it identified that the IME opinion it had relied upon to indicate she had a capacity was over six months old. Instead, Gallagher Bassett arranged for a further examination with the IME to obtain an updated opinion on Emma's capacity.

Workers' individual circumstances and reasonableness of non-participation not considered

323. In a number of complex claims reviewed by the investigation, agents did not genuinely consider workers' individual circumstances or whether their non-participation was reasonable before proceeding to issue non-compliance notices. This included cases where agents did not contact a worker to seek their explanation prior to issuing a non-compliance notice, or allowed them less than 24 hours to provide an explanation.

324. Witnesses interviewed during the investigation also raised concerns about this, with Conciliation Officer A querying whether agents were 'really truly impartially looking at the full circumstances of the worker' before issuing a notice. Conciliation Officer A said agents tended to only get an opinion regarding return to work from an IME, but not the worker's treating doctor(s), which they said did 'fly in the face of the proper processes that they're meant to follow'.

I think that they're unfairly using that part of the legislation to bully somebody into going back to work when their own doctor is saying 'look, you can't'.

– Conciliation Officer

325. WorkSafe's recent training to agents emphasised they should not rely solely on an IME's opinion without consideration of the worker's treating doctors' opinions and that a worker was not necessarily being non-compliant where they were following the advice of their treating doctors.

326. Conciliation Officer B said:

> I think that they're unfairly using that part of the legislation to bully somebody into going back to work when their own doctor is saying 'look, you can't'. And so then the worker is in the position where they either go back to work in contravention of their treating doctor's opinion and potentially get worse. Or they have their payments stopped because they're refusing to participate. It's an awful situation.

327. In the following case, Gallagher Bassett issued a warning to a worker with a mental injury for failing to attend an occupational rehabilitation appointment, despite the worker having been admitted to hospital after engaging in self-harm behaviour five days prior. Gallagher Bassett was aware of the worker's hospital admission, but issued a warning on the basis that the worker was not physically in hospital on the day of his appointment. The worker had also become homeless around this time.

Case study 22 – Warning issued to homeless worker admitted to hospital after engaging in self-harm behaviour

Tyler was working in finance when in 2011, he sustained a mental injury after being harassed at work. He ceased work and made a WorkCover claim. His claim was accepted by Gallagher Bassett after receiving an IME opinion that his condition was caused by the incident at work and he was incapacitated as a result. Tyler was seen by another IME in 2013, who found he was likely to remain incapacitated for the foreseeable future.

A few years later in mid-2017, Gallagher Bassett referred Tyler for an occupational rehabilitation assessment. It had not obtained an updated IME opinion on the worker's condition at this time. An occupational rehabilitation provider made an appointment for Tyler to attend. However, the week before the appointment, Tyler was admitted to hospital after engaging in self-harm behaviour and being apprehended by police because he presented a risk to himself and/or others. Tyler did not attend the scheduled occupational rehabilitation appointment. The occupational rehabilitation provider told Gallagher Bassett it had spoken with Tyler and he said he had been in hospital. The provider gave Gallagher Bassett updated contact details for Tyler (phone and email) and said Tyler had become homeless (so was unable to receive mail).

Gallagher Bassett obtained a copy of Tyler's discharge report from the hospital, which referred to his increasing anxiety and suicidal ideation. Gallagher Bassett decided to issue Tyler a warning for his failure to attend the occupational rehabilitation appointment, because the discharge report did 'not advise he was in hospital on the day of the appointment or recently discharged'. He had, in fact, been admitted five days prior. The warning required Tyler to attend a further occupational rehabilitation appointment and said if he did not, his weekly payments would be suspended for 28 days. Gallagher Bassett sent the notice to Tyler's residential address, despite being advised he was homeless.

Tyler did not attend the further occupational rehabilitation appointment. Gallagher Bassett tried to contact him again on his mobile and home phone number, even though it knew he no longer resided there. Gallagher Bassett then sent him an email to his old email address, despite having an updated one, requesting he explain his non-attendance 'as a matter of urgency'. The following day, Gallagher Bassett issued a suspension notice.

Tyler requested conciliation regarding the warning and suspension, on the basis he 'just got out of hospital and still wasn't well and had no home to stay in'. Gallagher Bassett reviewed the notices prior to conciliation, noting that while Tyler had been given 'multiple' opportunities to attend appointments and his inpatient stays were prior to any of these, the 'issue' was that he had been 'in and out of hospital', had changed email addresses and become homeless. Gallagher Bassett reinstated Tyler's entitlements after he attended a further occupational rehabilitation appointment. At conciliation, Gallagher Bassett agreed under a recommendation by the Conciliation Officer to pay Tyler during the suspension period.

WorkSafe reviewed the notices issued to Tyler following a request from the Ombudsman's investigation. It said while this had been a 'very complex claim' to manage, Gallagher Bassett 'did not have a reasonable basis to support the non-compliance process'. WorkSafe noted the available evidence indicated Tyler's mental health condition was 'very unstable' and that there was no medical evidence supporting a work capacity. It said the notices would be withdrawn as they were 'issued without basis'.

328. In another case detailed below, EML persistently required a worker with a mental injury to participate in occupational rehabilitation, despite receiving evidence this was causing his mental health to deteriorate. EML issued the worker two non-compliance warning notices on the basis he was not 'actively participating' in the occupational rehabilitation appointments he attended.

Case study 23 – Worker required to apply for jobs, despite deterioration and incapacity for work

Stephan was working for a construction company when in 2011 he sustained a mental injury from work stress and bullying. He ceased work and made a WorkCover claim, which was accepted by his employer's agent at the time, QBE.

QBE terminated Stephan's payments in 2014, but they were reinstated when a Medical Panel concluded Stephan was unable to return to any work indefinitely. Stephan's claim was transferred to EML. In 2017, EML terminated Stephan's weekly payments based on an IME opinion that Stephan's condition was largely in remission and he could return to suitable employment. EML also referred Stephan to occupational rehabilitation.

Stephan and his wife, who accompanied him to the occupational rehabilitation appointments, expressed frustration to the occupational rehabilitation provider about having to attend when he and his GP believed he could not return to work. They raised concerns about the impact of this on Stephan's mental health. Stephan's GP also provided a report detailing the deterioration of Stephan's mental health as a result of EML's actions. The GP said:

> As a consequence of the insurance company creating turmoil … [Stephan] has become increasingly agitated and has increased his smoking to double and is extremely short of breath. He is not eating and has lost approximately 6kgs in weight. He is not sleeping, just sitting in the chair … he has now become very reclusive and withdrawn. The Insurance Company have re-opened up all of … [Stephan's] old psychological wounds and he [is] now deteriorating quite profoundly … His emotional state has declined …

Stephan requested conciliation regarding EML's termination and stopped attending occupational rehabilitation appointments as he felt it constituted 'bullying and harassment'. Stephan's GP again wrote to EML expressing concerns about the requirement for Stephan to attend occupational rehabilitation, stating he was 'not coping with the pressure' and said:

> For you to go on about warnings is extremely silly and can only provoke a significant decline in … [Stephan's] medical condition … [Stephan's wife] tells me that … [Stephan] is always a nervous wreck after these meetings … He shakes and he avoids any conflict or confrontations and he doesn't eat for days and he cries and by the time that they get him settled, it … [is] time for him to go back to another meeting … [Stephan's wife] also told me that you did not seem to be particularly interested in the psychological health of … [Stephan] and just kept going on about a warning letter.
>
> You really need to understand how significantly your comments and actions have aided the decline in … [Stephan's] condition. He previously did not need to see the psychiatrist for significant periods of time but now has to see him every fortnight … [Stephan] has a conciliation meeting coming soon and I have written voicing my considerable concerns regarding his treatment.

A few days later, EML issued a return to work non-compliance warning to Stephan for not actively participating at occupational rehabilitation appointments.

Continued on next page…

At conciliation, EML agreed to withdraw the termination and reinstate Stephan's weekly payments after the Conciliation Officer raised concerns. However, a week later, it told the occupational rehabilitation provider to continue providing job seeking services to Stephan as he was still considered to have a capacity for suitable employment. This was despite EML effectively conceding Stephan had no capacity to work at conciliation the previous week.

Stephan requested conciliation regarding the non-compliance warning too. EML reviewed the warning but concluded that the decision should 'be maintained for future claims management', noting that if Stephan proved to be non-compliant in the future, the warning could be used to issue a cease and determine notice. At conciliation, the dispute could not be resolved. Stephan did not further dispute the decision at court.

Although Stephan attended further occupational rehabilitation appointments and participated to the best of his ability, EML issued a second non-compliance warning to him in mid-2018 for not 'actively participating' and engaging in job seeking activities. Stephan requested conciliation about this warning too and again, the dispute could not be resolved. The occupational rehabilitation provider contacted EML expressing concern that its continued involvement with Stephan was 'now having unintended consequences' and stated:

> He always presents as a man who is unwell; however yesterday it was evident he is getting worse … [Stephan] looked sick. He was pale, and appears to have lost even more weight. As always … [Stephan] was anxious … [Stephan] explained that his psychiatrist has increased his medication, as he is not coping psychologically … [Stephan] explained that he is experiencing high levels of stress … [Stephan] explained that dealing with EML regarding claim-related matters, along with being requested to actively participate in … [occupational rehabilitation] and pursue new employment is detrimental to his health. What I observed yesterday appears to be consistent with … [Stephan's] explanation. He is not coping.

In response, EML said its requests that Stephan attend occupational rehabilitation 'would, in any normal case, be of minimal impact on a person's day to day functioning and not affect someone to this extent'. It requested the provider arrange a meeting with Stephan and his GP and agreed to suspend Stephan's occupational rehabilitation services for 90 days.

WorkSafe reviewed the non-compliance notices issued to Stephan following a request from the Ombudsman's investigation and concluded they were not appropriately issued, so would be withdrawn. WorkSafe noted that while Stephan's payments were not impacted by the notices, it recognised they may have 'negatively impacted our client's experience and we regret that'.

For you to go on about warnings is extremely silly and can only provoke a significant decline in … [Stephan's] medical condition … [Stephan's wife] tells me that … [Stephan] is always a nervous wreck after these meetings … He shakes and he avoids any conflict or confrontations and he doesn't eat for days and he cries and by the time that they get him settled, it … [is] time for him to go back to another meeting.

– General Practitioner

329. After reviewing the notices in the above case, WorkSafe also appropriately requested EML undertake a 'health check' of non-compliance notices issued over the last 12 months and report the findings to WorkSafe. EML reviewed 20 claims where non-compliance notices had been issued and found that three did not comply with the Claims Manual. The remaining 17 were considered to comply; however, in three of these, it was unclear whether the agent contacted the worker to clearly establish the worker's reason for non-compliance. The review did not specifically focus on notices issued on complex claims.

330. The investigation also identified cases where an agent issued a worker a non-compliance notice for non-attendance at an appointment, despite providing a reasonable excuse and demonstrating cooperation and participation prior to the missed appointment.

331. The following case study is an example where Allianz issued a warning notice to a worker for missing two occupational rehabilitation appointments, despite being unwell with the flu and having no history of non-compliance. Allianz concluded she had not made reasonable efforts to participate, without contacting the worker direct to discuss the reasons for her non-attendance.

Case study 24 – Worker penalised for missing two appointments despite being sick with the flu

Allison was working as a teacher when in 2011, she sustained a mental injury after being involved in a violent incident. She ceased work and made a WorkCover claim, which was accepted by Allianz.

After a few years off work, Allison was seen by an IME in 2016 and 2017 who said her condition had improved and she could return to suitable employment. Allianz engaged an occupational rehabilitation provider to assist Allison to find a suitable job and return to work.

In late 2017, Allison was unable to attend two scheduled occupational rehabilitation appointments due to being unwell with the flu and so asked her provider to reschedule them. The same day Allianz became aware of this, it issued a warning notice to her for failing to attend the appointments. It said she had not made 'reasonable efforts' to participate. As required by the Claims Manual, Allianz did not contact Allison to discuss her non-attendance before issuing the notice. One hour after receiving the warning, Allison contacted Allianz reiterating she had been 'very sick' and that she did not deliberately miss the appointments. Allison attended the next scheduled occupational rehabilitation appointment and so her payments were not suspended.

WorkSafe reviewed the notice during the Ombudsman's investigation and concluded it was not appropriately issued, so would be withdrawn. In response to the draft report, Allianz acknowledged that it 'did not follow the process in omitting to establish contact with the worker to further understand her reasons for not being able to attend the appointment'. Allianz also said its 'standards for this process have been improved'.

Non-compliance notices incorrectly issued under legislation

332. The investigation identified instances where notices did not comply with the requirements of the WIRC Act. This included cases where agents:

- did not provide the worker with the required notice period
- issued notices to workers for failing to contact their case manager, even though this is not a legislative obligation on workers
- issued notices under the incorrect section of the WIRC Act.

Non-compliance with notice period

333. After issuing a non-compliance notice, agents are required to provide a worker adequate opportunity to demonstrate compliance with their obligations.

334. To demonstrate compliance, a worker may have to attend an occupational rehabilitation appointment, participate in a retraining course or return to work, for example.

335. Under the WIRC Act, agents must provide a worker at least 14 days to demonstrate compliance. The Claims Manual states that if the notice is sent by mail, agents should also allow for two postal days.

336. The case study below is an example of a complex claim reviewed during the investigation, where an agent required a worker to demonstrate compliance only six days after issuing the warning. It then suspended the worker's weekly payments prior to the review date specified in the warning, and ultimately issued a termination.

Case study 25 – Worker required to attend computer course six days after warning notice

Nathan was working as a gardener when in 2007 he injured his leg at work. He made a WorkCover claim which was accepted by Allianz. He eventually returned to work and so his weekly payments were terminated. He later developed a secondary mental injury and ceased work. IMEs who examined him in mid-2017 indicated that while he could not return to work as a gardener, he probably had a capacity for suitable employment. His treating doctor believed he could not return to work.

Allianz referred Nathan to occupational rehabilitation services based on the IME opinions. In late 2017, Nathan did not attend a scheduled appointment. Allianz tried to contact him twice about his non-attendance before issuing him a warning notice for the missed appointment. Although Allianz was required to give Nathan 14 days to demonstrate compliance, the notice said he needed to attend a computer course six days after the date of the notice and an occupational rehabilitation appointment eight days after the date of the notice. Allianz said his claim would be reviewed again 21 days after the date of the notice to determine whether a suspension would be issued.

Nathan did not attend the computer course or the occupational rehabilitation appointment and after trying to contact him twice, Allianz issued him a suspension notice before the review date specified in the warning notice. This was not compliant with the Act. Nathan's non-attendance continued and so Allianz terminated his weekly payments in late 2017.

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In early 2018 Nathan requested conciliation. Allianz reviewed the notices, finding that the merits of the notices appeared to be 'sound', but that the 'technical aspects' would make the notices unsustainable. Allianz considered this would 'attract significant scrutiny' and so agreed to withdraw the notices.

In response to the draft report, Allianz said:

> We agree the timings of the warnings were incorrect in this instance and therefore rectified this prior to conciliation.
>
> The case manager and technical manager who made this decision have undergone a performance discussion in relation to this matter and the application of the non-compliance process.
>
> The identified actions were completed in October 2017. Subsequent to this, in 2018, Allianz implemented our Quality Decision feedback program which mitigated this issue.
>
> Furthermore, in August 2018 and July 2019, the correct application of the RTW Non-Compliance process has been discussed with technical managers (who have responsibility for endorsing these decisions). Technical managers also recently completed WorkSafe training with regard to RTW Non-Compliance.
>
> ... the compliance team monitors compliance through regular audits for this process.

Another example

In another complex claim reviewed, EML required a worker to attend an occupational rehabilitation appointment nine days after the date of a warning notice issued to him, which was not compliant with the WIRC Act.

Notices issued for failure to contact case manager

337. Workers are required by legislation to participate and cooperate with assessments or interviews when requested. It is also important that workers are contactable by their agent throughout the life of their claim. However, there is no express obligation for workers to respond to routine phone calls or emails from agent staff, and agents do not have the power to sanction them for failing to respond.

338. The investigation found examples of agents issuing return to work non-compliance warning notices in these circumstances. While these did not immediately affect workers' entitlements (as they were only warnings), they had no legislative basis and could have been used to issue further sanctions against them in the future.

339. The following case study is an example of this practice, where a worker was issued a warning notice after his agent could not get in contact with him over the course of a few months. The worker claimed he had provided CGU updated contact details, which were not properly recorded by CGU and so the worker was unaware of the attempted contact.

Case study 26 – Warning issued for failure to respond to 'courtesy calls'

Arthur was working as a labourer when he injured his neck and back at work in the late 1980s. He made a WorkCover claim, which was accepted by his employer's agent at the time.

CGU later managed his claim, however, was unable to get in contact with him for about four months in late 2017 despite numerous attempts. File notes about the attempted contact suggested they were just 'courtesy calls'. CGU also sent Arthur a 'courtesy' letter in late 2017 asking him to call them and said if it did not hear from him, it may not be able to ensure he received the support and assistance he was entitled to. The letter did not state his entitlements may be affected if he did not contact CGU.

After further unsuccessful attempted contact in early 2018, CGU issued a return to work non-compliance warning notice to Arthur. The notice stated that Arthur had an obligation to 'actively participate and co-operate on a regular basis in relation to your progress of your workcover [claim] in relation to capacity for work, treatment and future employment prospects'. It said Arthur needed to 'actively participate and co-operate in planning for return to work by maintaining ongoing contact with … [his] case manager' and that it was 'expected' he call his case manager within one week. CGU paraphrased and amended the wording of workers' legislative obligations to suit the purpose of its notice. CGU said Arthur's weekly payments would be suspended if he continued to be non-compliant.

Arthur subsequently contacted CGU stating he had been in contact and provided updated contact details previously. It appears these were not recorded by CGU and may have been the reason it was unable to get in contact with him. CGU advised Arthur it now considered he was being compliant and so would not suspend his payments.

WorkSafe reviewed the non-compliance notice issued to Arthur during the investigation and said, on balance, the notice was appropriately issued, noting that CGU made several attempts to contact Arthur by phone and letter. WorkSafe also said that after the notice was issued, CGU contacted Arthur's GP clinic which indicated his contact details had changed and then contacted Arthur to request he contact CGU, which he did. WorkSafe said:

> [I]t would have been preferable for improved quality decision-making if the agent had consulted with the THP [treating health practitioner] prior to issuing the notice in line with current expectations. Given WorkSafe's expectations it has raised this matter with senior management at the agent. An appropriate priority note has been recorded on the claim indicating that the warning notice … cannot be relied upon in any future non-compliance decision making.

WorkSafe did not comment on whether it considers agents can lawfully issue a non-compliance notice to a worker for failure to contact their agent.

In response to the draft report, CGU said:

> This case study implies CGU has issued a non-compliance notice where it had no authority to do so which appears unjust without broader context in relation to the claim. Whilst there may not be an express requirement for workers to communicate, CGU submits that communication is a form of participation required for recovery and return to work planning and enabling us to break the cycle of compensation whilst the Claims Consultant keeps regular contact as part of the worker's recovery.

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> A similar process is followed when a worker's employer is non-compliant with their obligations. CGU will refer an employer to WorkSafe and its Inspectorate team. Employers who continue to be non-compliant may incur financial penalties.
>
> In the context of this claim, the worker lodged a claim for a back injury which occurred … [in the late 1980s] and has been in receipt of compensation for … [over 30 years]. The worker unfortunately/sadly suffers from difficult personal circumstances which extend well beyond their injury compensation claim.
>
> The Claims Consultant attempted to contact the worker for several months … [over a four-month period]. A non-compliance warning letter was sent after numerous attempts were made to speak with him. Prior to the expiration of the warning letter the Claims Consultant contacted his GP and received updated contact details for the worker.
>
> CGU acknowledges that the use of the non-compliance warning letter in this instance was potentially inappropriate in that the worker may not have received previous communications, however we were continuing to contact … [Arthur] in good faith using the latest contact details on file (which upon further contact with his GP we discovered had changed).

The investigation maintains its view that under the WIRC Act, agents have no power to issue a non-compliance notice to a worker for failing to respond to 'courtesy' calls or letters from the agent.

Another example

In another complex claim reviewed by the investigation, EML issued a warning notice to a worker after unsuccessfully attempting to contact her on two occasions. The worker had no history of non-compliance and the warning notice was issued only two weeks after the initial attempted contact. Shortly after receiving the warning notice, the worker contacted EML advising she lived 'in the bush', so her phone 'cuts in and out of service'. She said that was probably why EML had been unable to get in contact with her.

WorkSafe reviewed the non-compliance notice issued to the worker during the investigation and concluded the notice was not sustainable. WorkSafe noted that EML's attempts to contact the worker occurred within a four-day period and were the first contacts recorded in about six months. WorkSafe said it had raised the matter with senior management at EML and confirmed the notice would be withdrawn.

Notices issued under incorrect section of legislation

340. The investigation identified three instances where agents incorrectly used the return to work non-compliance provisions to sanction other worker behaviour, particularly failure to attend independent medical examinations.

341. Under section 27 of the WIRC Act, injured workers have an obligation to attend independent medical examinations. Like return to work obligations, an agent may suspend a worker's entitlements if they unreasonably refuse to attend or obstruct an independent medical examination. However, the ability to suspend a worker's entitlements for non-attendance at an IME is contained in a separate section of the Act to return to work non-compliance notices. The Claims Manual confirms this distinction.

342. In light of the three instances identified by the investigation, WorkSafe said it would 'provide further clarification and guidance to all agents' regarding the use of these sanctions. It also confirmed that the notices incorrectly issued in the three cases identified by the investigation would be withdrawn.

343. In response to the draft report, Xchanging, the agent responsible for two of the notices, maintained it was 'satisfied' the notices were issued correctly and highlighted that in one of these instances:

> Reliance on s27 [relating to IME non-compliance] would have resulted in a harsher financial impact for the worker. Had the notice been issued under s27, all entitlements to compensation including all medical treatment, would have been immediately suspended.

344. The investigation remains of the view that the notices were issued under the incorrect section of the Act as they related to worker's non-compliance with their obligations to attend independent medical examinations.

Non-compliance notices issued with a focus on liability management

345. While it is appropriate for agents to issue return to work non-compliance notices where a worker is unreasonably refusing to comply with their obligations, the investigation received evidence that in some cases, agents have used them primarily as a mechanism to cease a worker's payments and reduce their liabilities. This is contrary to the objective of non-compliance activity, which WorkSafe said is to 'influence the worker to comply'.

346. Conciliation Officer B raised concerns at interview about this practice, stating:

> I do think they are being used a bit … by the agents when they can't find another way of terminating a claim. And especially when they've got an employer who is riding the worker quite a lot because they either don't like them, they're jacked off that they put in a claim in the first place, so the employer can often be the one who's driving it too. Not the agent.

347. Conciliation Officers also raised concerns about agents 'forcing' workers to attend occupational rehabilitation to facilitate the termination of their entitlements, instead of genuinely attempting to facilitate a return to work.

348. Conciliation Officer A said at interview that agents look at non-compliance as a 'tool' available to them, particularly for workers who are unable to return to their original employment. They said:

> [The agent is] attempting to get a person out into the workforce and the OR [occupational rehabilitation] service provider is attempting to engage them in that process and on some occasions a dispute arises because the agent is wanting more to get them off the books. In other words, they want to terminate their payments and the best way to do that, regardless of what their doctor's certificate is … but an independent doctor says that they can do X, Y and Z in terms of suitable jobs and so they … force a worker to attend OR service providers and when they don't they start the non-compliance process.

349. Conciliation Officer A described agents' use of the return to work process as a 'stick rather than a carrot', stating that return to work was meant to be about 'encouraging people back to work because it's good not only for them, for their injury but also for the mental wellbeing as well'. The Conciliation Officer said 'the converse applies' and '[t]hey end up with stress cases as a result of it'.

350. In response to the draft report, CGU said:

> Opinions in IME reports which identify a capacity for work may be used to consider a change in the direction of a claim, and to discuss a new strategy.
>
> Widely published statistics make it very clear that a return to health and a return to work are in the best interests of an injured worker, and in cases of the longer term injured, breaking the cycle of not being at work is often complex and difficult.
>
> The description of 'stick rather than carrot' is emotive, however the responsibility of an agent is to manage claims within the spirit of the legislation, which may mean using the opinion of a specialist to make decisions on claims that will interrupt the claims cycle but are ultimately in the best interests of an injured worker.

351. Conciliation Officer D described the use of return to work non-compliance notices as 'strategic', and said they should be used 'extremely sparingly' as it was '[m]uch better to get people back to work in suitable employment by a particular time without using the sledgehammer approach'.

352. Conciliation Officer G said:

> [N]othing has the flavour of being genuine. It's not about a genuine return to work. It's about looking at a capacity to do something and the reality of that translating into genuine suitable employment for a person to go back to work, I think, is fairly slim.

353. WorkSafe informed the investigation that it has, on numerous occasions, reminded agents and occupational rehabilitation providers that:

- occupational rehabilitation is an 'independent worker service'
- the occupational rehabilitation provider is 'not to be used as an agent RTW [return to work] compliance tool'.

354. A 2017 review into occupational rehabilitation commissioned by WorkSafe identified issues regarding occupational rehabilitation being used as a compliance tool. Occupational rehabilitation consultants told the review they perceived, in some cases, that referrals to occupational rehabilitation services were 'not in the interest of the injured worker and were being used as a tool to cut benefits'. One occupational rehabilitation consultant said:

> Sometimes they [case managers] can use job seeking services … as a compliance tool … so the worker may not be ready to go into job seeking services, but because the case manager wants to go down a compliance track and cut their payments, they put them into job seeking knowing that they won't attend and that they will hopefully be able to cut their payments and that can be frustrating because then we end up with a start and fail outcome … because we've been used as a compliance tool, rather than a … [job seeking service].

355. Another occupational rehabilitation consultant referred to the low return to work rate of workers involved in new employer occupational rehabilitation services, and said agents 'use up more [services] for compliance than actually thinking that we might actually get someone back to work' which they said is 'frustrating'.

356. The sample of agent staff emails also highlighted issues with agents' use of the non-compliance process.

Example 1

CGU emails showed staff had been reminded of their weekly 'entitlement review' targets, and provided tips on 'where to look' for claims where entitlements could be reviewed and potentially terminated. The suggestions included 'non-compliance' and said 'those who haven't been contactable are ones we want on the list'. One email from a Technical Advisor said:

> Remember the goal is RTW [return to work] and you should be focusing on that where possible [but] in the alternative where RTW is not an option- ask yourself 'How will I stop compensation' (of course if they are entitled they will continue to have the entitlement- but every claim still needs to be reviewed to determine are they in fact entitled).

Example 2

Another email from the CGU Technical Advisor said that return to work non-compliance notices were not being used enough and there were 'concerns from above' about this. They said that as a result 'the message is we need to be issuing more warnings', and that each week she would be asking staff to provide a list of workers whom they had not been able to contact. She said that if a 'non-contact letter' had been sent and the worker did not return the call within a week, a warning should be issued.

In response to the draft report, CGU said:

> This email reference should be read in context of its intent. An internal review found some claims where there were issues of non-compliance [which] were not being managed in accordance with the legislation, and that our responsibility is to ensure compliance with the legislation.
>
> For CGU, the rate of issuance of non-compliance has reduced 32% since the first … [Ombudsman] review which demonstrates CGU's acknowledgement of the first review and is an outcome of the training conducted with staff relating to correct procedure.

357. CGU also noted in its response to the draft report that the report cited 'several examples of inappropriate use of non-compliance letters'. It said that given the 'extremely small sample of claims' reviewed by the investigation, it was 'difficult to conclude that this is a systemic issue for the scheme'. Although the investigation's review was confined to 25 non-compliance notices issued on complex claims in 2017-18, 15 of these were randomly selected. Additionally, the sample reviewed made up about a quarter of the total notices issued on complex claims that year where a worker had been receiving weekly payments for more than 130 weeks.

358. CGU also said:

> Issuing a letter of non-compliance is not taken lightly and is sometimes used because we are unable to contact the injured worker to discuss their claim, or failure of the injured worker to participate in the process. It's important to note that CGU will issue a warning letter prior to consideration of a non-compliance notice. We strive for a cooperative relationship that doesn't require the use of non-compliance letters in these situations, however when an injured worker does not attend appointments, fails to participate in rehabilitation or job seeking/career re-training programs, or return phone calls, there are limited options to ensure a claim is kept on track to ultimately, help the injured worker recover as best as possible.

359. In one of the claims reviewed by the investigation, Xchanging and the worker's employer planned to pursue a 'cease and determine' notice in order to 'cease' the worker's claim. At the time this strategy was agreed upon, the worker had not demonstrated unreasonable non-compliance with her return to work obligations, nor repeated non-compliance over a 12-month period which is required to issue a 'cease and determine' notice.

Case study 27 – 'Cease and determine' notice a predetermined outcome

Melissa was working as a baggage handler when in late 2016, she injured her back.* She ceased work and made a WorkCover claim, which was accepted by Xchanging.

Xchanging arranged for an IME to examine Melissa in mid-2017 and again three months later. The IME concluded that 'for practical purposes', Melissa did not have 'any capacity for meaningful productive employment at that stage'. Xchanging requested a supplementary report from the IME, and they subsequently conceded that she could return to 'suitable duties' if these could be arranged.

Xchanging initiated discussions in late 2017 with Melissa, her treating doctor and her employer about possible return to work arrangements. A return to work meeting was arranged in early 2018, however, Melissa told Xchanging she was anxious and stressed about attending and could not return to work with her original employer. She expressed a desire to resign and said she was working with her occupational rehabilitation provider to try to secure new employment elsewhere. Despite this, Xchanging told her that she had an obligation to attend the meeting and that if she failed to do so, Xchanging would 'start the non compliance process' and 'issue her a warning letter'. Melissa recontacted Xchanging later that day to express how 'terrified' she was of attending the meeting and going back to work with the employer. She resigned from her employment on the same day.

Continued on next page...

The scheduled meeting went ahead between Xchanging and her employer, but Melissa did not attend. A file note regarding the meeting stated compliance issues were discussed and Xchanging confirmed it would start the 'cease and determine process'. Xchanging issued a warning notice to Melissa in early 2018 for her failure to attend the return to work meeting with her employer. It said she needed to return to work with her original employer and participate in an interview with Xchanging, otherwise her weekly payments would be suspended. Xchanging sent a copy of the warning to Melissa's employer via email and stated:

> In terms of a further warning we need to await the expiry of this warning period before we enter into another warning period … (As per our discussion on Thursday we were applying the longer strategy with an expected outcome of a cease and determine).

Two days after the warning notice was issued, Melissa's occupational rehabilitation provider informed Xchanging it had been in negotiations with a potential new employer for Melissa and would provide a further update in due course. Melissa attended the interview scheduled with Xchanging during which she confirmed she had resigned from her employer as 'physically and psychologically' she could not return. She also said she was in the process of obtaining a new job and her GP had sent through a certificate confirming she could not return to work with her original employer.

Xchanging then issued Melissa a second warning notice for her failure to return to work with her employer. It said her weekly payments would be suspended for 28 days if she had not returned to work with her original employer before her claim was reviewed again. Xchanging said, taking into consideration her feedback at the interview, it had decided not to proceed with a suspension, instead issuing a second warning. It was evident though from the contact between Xchanging and her employer that the second warning was issued (instead of a suspension) to achieve the 'end goal' of a cease and determine notice.

Shortly after the second warning, Melissa's occupational rehabilitation provider informed Xchanging that Melissa had reported a 'flare-up' in her injury and her GP was now certifying her unfit for any work. The provider also confirmed it was continuing negotiations regarding new employment for Melissa.

Ten days after being advised of the reported 'flare-up' in Melissa's injury, Xchanging issued Melissa a third warning notice for her failure to return to work with her original employer. Xchanging said her weekly payments would be suspended if she did not return to work with the employer within 18 days. At the expiration of this period, Xchanging then issued a suspension notice, and finally, a 'cease and determine' notice. All three warnings, the suspension and cease and determine notice were issued within the space of about three months.

Melissa requested conciliation regarding the five notices. Upon review, Xchanging noted Melissa had resigned from her original employer and had 'otherwise been compliant with all other OR [occupational rehabilitation] requirements'. Xchanging acknowledged all five notices were not appropriate and withdrew them prior to the scheduled conciliation conference. Xchanging reinstated Melissa's weekly payments.

WorkSafe reviewed the notices as part of a routine review of all 'cease and determine' notices, and concluded they were not appropriately issued. In response to the draft report, Xchanging said '[t]his example was used to improve training and claim management process'.

* This case is also discussed on page 139.

Consideration of 'suitable employment' options for workers

360. Witnesses interviewed during the investigation raised concerns about agents terminating workers' weekly payments because they can return to 'suitable employment', without properly considering what constitutes 'suitable employment' under the WIRC Act.

361. As outlined earlier, agents must take into account a range of factors when considering whether there is 'suitable employment' for a worker, including their age, education, work experience, place of residence and nature of their incapacity resulting from their work injury.

362. Various Conciliation Officers said job options agents used to suggest a worker could return to work and terminate their weekly payments were often 'offensive', 'disingenuous', and 'fanciful'. Conciliation Officer D said:

> My only wish is that when people get assessed vocationally, they get assessed genuinely. The jobs – and the Courts have criticised many of these – but jobs in the past, car park attendant, light process worker – what the hell does that even mean? There are probably about 2,000 jobs out there that are light process work. Some of them would be quite light and others would be quite complex. School crossing attendant – somebody with a back injury, you're saying they can stand all day, you know, stand for 2 hours in the morning and come back 2 hours in the afternoon – rain, hail or shine? So … they are fanciful jobs, they are not real jobs.

363. Conciliation Officer D further said:

> [T]his scheme is not about getting a doctor or a vocational assessor or an assessment generally to say the worker has an entitlement, it is designed in many cases to say they have no entitlement. Because they [the agent] want to get them off the scheme, because they want to make money, it comes back to what I said in the beginning – it's a private business. And the best way for a private business is get people who are on compensation, off compensation.

364. Injured workers surveyed as part of the 2017 review of occupational rehabilitation commissioned by WorkSafe provided feedback about their experience with these services.

365. In some cases, the surveyed workers reported that occupational rehabilitation services were not suitable for their needs and experiences. Examples included proposed jobs that were two hours away from where the worker lived, and inappropriate training courses. The review said that '[o]verall, there was a belief that OR [occupational rehabilitation] providers were more focused on finding the worker any work, rather than jobs that are commensurate with their skills and previous experience'. Examples of feedback provided during this review are outlined on the following page.

366. Stakeholders and long term injured workers surveyed as part of a separate review finalised in 2018[27] also said proposed job options were 'inappropriate or would not provide a living wage'. Examples provided included a school crossing attendant and pamphlet deliverer.

27 Dr Elizabeth Kilgour and Dr Agnieszka Kosny, Institute for Safety, Compensation and Recovery Research (ISCRR), *Victorian Injured Worker Outcomes Study, Study 1 – A qualitative enquiry into outcomes for injured workers in Victoria who have longer term claims*, Final Report, April 2018.

Comments from injured workers, in a 2017 review commissioned by WorkSafe

They don't find jobs that are suitable, just ones they think are alright.

The selection of jobs that they replied with was a waitress job and they based that on my experience of being a waitress when I was 15. They should apply an aptitude test and assist with the career paths; not look at out-dated résumé and go on them.

I've done kitchen and cleaning jobs throughout my life and they are sending me to bank jobs. So they don't live in the same world as I'm in.

I don't see the point – she's picking out the most ridiculous jobs I can't even do. My back is buggered and my neck is very sore, I'm always in pain. At the moment, there's none that I am capable of.

If I offered an employment service to people on WorkCover, I would be realistic as to what the person can and can't do. I would look at what they like to do. I'm 57 years old and I have numerous ailments and they suggested that I apply as a corporate secretary. They are not realistic in their expectations. It was 15 years ago since I was in the workforce.

367. Witnesses interviewed during the investigation raised concerns about agents' reliance on IME opinions about a worker's capacity to return to work, which they believed did not adequately address the suitable employment criteria. Conciliation Officer G stated at interview:

> [T]hey don't want to have their IMEs really looking at the definition of 'suitable employment', because everyone would stay on payments almost, if they're still on payments at 130 weeks. I mean that's a bit of a stretch but, it's a really important juncture, 130 weeks.
>
> ...
>
> No one wants to see someone still on comp[ensation], two and a half years after they've injured themselves. It's not good for anybody, but there are some people that should remain on payments for very good reason. And when you're having a lengthy discussion about that, but you have these particular doctors that are just too ready to say 'oh yeah, capacity to do that'. It's very frustrating because the reality is, the panel will overturn it anyway.

368. The then Convenor of Medical Panels said at interview that Panels 'pretty consistently' saw the suitable employment 'test' not being 'applied appropriately'. He said it was 'a very difficult test to apply' which IMEs did not understand 'very well'. He said WorkSafe told him IMEs were given training about interpreting questions about 'suitable employment', but that 'obviously the training is not working' as Panels saw IMEs consistently misapplying the test. The then Convenor also said:

> [I]t seems obvious that in many cases they [the agent] haven't gone back [to the IME] and clarified. So ... they [the IME] don't appear to have applied the test, or ... they haven't given enough information for someone reading the report to understand whether they've applied it. And ... the agent hasn't gone back and said 'Well, look, can you just clarify whether you've taken in to consideration these things?' and so that then I think reinforces sloppy behaviour.

369. When queried why agents do not seek clarification from IMEs regarding their consideration of the definition of 'suitable employment', the then Convenor said:

> [I]t could be that they themselves don't understand the test and that they therefore ... don't understand that what they're getting back isn't ... a rigorous analysis. It may be that they've got an answer. The fact that ... it hasn't been validated by adequate reasoning is something that they believe isn't something that they need to take up. So they have a definitive answer, the person has a work capacity or the person does not have a work capacity, and that's all that they were really interested in because it answers their question. And ... in a way that's a fundamental flaw in the process because the way we [Medical Panels] approach things is to say 'That's the question. That's our answer. And here is our reason for the answer'. But the way the IME process works leaves out really the third stage to some extent. So it asks the question, it asks for an answer, but ... it doesn't rigorously look at asking for the reasons. And so, how do you know whether the answer is an appropriate answer to a question if you don't really know what the reasons were ...

370. A WorkSafe Clinical Panel Advisor also raised concerns at interview about IMEs and agents failing to give realistic consideration to suitable employment for injured workers and said there needed to be greater 'push-back' by agents on IMEs to 'explain their opinions better'.

No one wants to see someone still on comp[ensation], two and a half years after they've injured themselves. It's not good for anybody, but there are some people that should remain on payments for very good reason.

– Conciliation Officer

Unreasonable termination of payments to workers who have returned to part-time work

371. The investigation identified issues regarding decision making on complex claims where workers had successfully returned to work part-time. These workers were unable to return to work full-time as a result of their injury and so were in receipt of 'top up' weekly payments to supplement their income. The evidence of this issue related to one of the five agents, Gallagher Bassett.

372. To be eligible to receive 'top up' weekly payments, a worker's entitlement to weekly compensation must have ceased at 130 weeks and they must:

    - have returned to work working at least 15 hours and earning at least $205 per week and
    - be indefinitely incapable of undertaking further additional employment or work which would increase their earnings, because of their injury.

373. In the complex claims reviewed, workers receiving 'top up' payments returned to work, but Gallagher Bassett terminated their payments by arguing that the workers:

    - could increase their hours or do more work than the worker claimed they could
    - could leave the job they had returned to and retrain or get a new job, which would enable them to increase their hours
    - no longer met the criteria to receive 'top up' payments.

374. The terminations were overturned or withdrawn through the dispute process because there was insufficient evidence to support them.

375. In one complex claim, Gallagher Bassett terminated a worker's payments twice and attempted a third termination. This was despite two separate Medical Panels finding he had 'severe spinal dysfunction' from a work injury and was indefinitely incapable of undertaking further work as a result. This case is outlined on the following page.

Case study 28 – Payments of worker with long-standing 'severe spinal dysfunction' terminated

Nicholas was working as a self-employed tradesman when in 2009 he injured his back at work. He ceased work and made a WorkCover claim, which was accepted by Gallagher Bassett. He made several attempts to return to full-time work over the coming years, which on occasion resulted in 'flare ups' of his injury.

Gallagher Bassett terminated his weekly payments in 2011 on the basis that he had received payments for 130 weeks and had a work capacity. While Nicholas could undertake some work, he could not return to full-time work as a result of his injury, so he applied to Gallagher Bassett for 'top up' payments. Gallagher Bassett rejected his application but in 2014 a Medical Panel found Nicholas was indefinitely incapable of undertaking further work as a result of 'severe spinal dysfunction', and Gallagher Bassett approved top up payments.

Gallagher Bassett terminated Nicholas' payments in mid-2015 on the basis that he was no longer meeting the criteria for these payments and that after six years, his injury was no longer work-related. Gallagher Bassett relied on an IME's opinion that '[t]here was nothing other than the fact he was overweight and deconditioned which was causing the symptoms in his back', despite there being no identifiable change since the Medical Panel opinion. Nicholas requested conciliation regarding the termination, stating:

> [The IME] makes the statement that there is nothing other than the fact that I am overweight and deconditioned which is causing the symptoms in my lower back. The truth is exactly the opposite where it is my injury that is causing me to be slightly overweight and deconditioned. I was not like this before my injury …
>
> I … stated at the … [IME] examination that the reason I can work the three hours per day is that I can break up the hours during the day depending on the job and do not always have to work three hours straight. I have fulfilled all of the criteria for the compensation that I am entitled to and despite my constant back pain I do everything in my power to maintain a level of fitness and mobility so I am able to carry out the work that I am doing within my capacity as stated by my medical doctor …
>
> Worksafe publicly praises their commitment to getting injured people back to work which I believe is fantastic, however in my particular case the reality for me is the insurer and their agents such as … Gallagher Bassett appear to intimidate me to try and force people to work when they are not ready or give up their claims as being just too hard, so that they don't have to pay them. I would prefer to not have an injury but the painful fact is I do have a serious injury and am a genuine case for compensation.

At conciliation in mid-2016, the matter was referred to a further Medical Panel which again concluded Nicholas was indefinitely incapable of undertaking further work as a result of severe spinal dysfunction from his injury. In forming its opinion, the Panel noted the flexible nature of Nicholas' self-employed working arrangements, which enabled him to work from a workshop attached to his home, take regular breaks and modify his hours as necessary, which at that time were three hours per day, five days per week. Gallagher Bassett reinstated Nicholas' weekly payments based on the Panel's opinion.

In mid-2017, Gallagher Bassett approved an occupational rehabilitation assessment for Nicholas to 'identify what services may assist his return to work'. The assessment identified five other potential suitable employment options for Nicholas.

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Gallagher Bassett approved further occupational rehabilitation services for Nicholas, despite him reporting that his goal was to maintain his employment as a self-employed tradesman and that he did not want to seek other employment, as it would not afford him the same flexibility to work within his restrictions.

Later in 2017, Gallagher Bassett arranged for Nicholas to be examined by another IME, who concluded that after over eight years, his impairment was no longer related to the incident at work. He concluded that, based on the physical impairment alone, Nicholas could return to work performing pre-injury duties and hours. The IME also said he believed there had been a 'significant alteration' in Nicholas' presentation since the Medical Panel's examination, but did not explain how he had recovered. Gallagher Bassett subsequently told Nicholas' occupational rehabilitation provider that it was a 'safe assumption that based on the evidence to hand, his claim will be wrapping up very soon'.

In late 2017, Gallagher Bassett terminated Nicholas' 'top up' payments a second time, on the basis of the recent IME opinion. Nicholas again requested conciliation and stated:

> My injury is real, I did sustain it from a working accident, I know and my treating doctor knows that I have tried everything in my power to even be able to work the hrs that I work now by total self discipline and constantly exercising to sustain strength in my body to be able to work these hrs …
>
> Recently I have tried to work an extra 3 hrs based on the recommendation of … [my occupational rehabilitation provider] and my treating doctor but have only been able to do this with an increase in pain killers and sleeping tablets. I know I cannot sustain these extra hrs and I have informed my treating doctor of this.
>
> GB [Gallagher Bassett] does not want to get people back to work, they just want to justify their work to worksafe and get people off workcover at any cost.

Gallagher Bassett reviewed the termination prior to conciliation and noted if the matter was referred to another Medical Panel it would likely 'go in the worker's favour'. In early 2018, the Conciliation Officer asked Gallagher Bassett to withdraw its decision. The Conciliation Officer highlighted that Nicholas' working hours and treatment had not altered in a number of years and said there was nothing that satisfied them there had been a material change since the last Medical Panel opinion. Gallagher Bassett subsequently withdrew the termination and reinstated Nicholas' payments.

After reviewing Nicholas' claim file, the Ombudsman's investigation asked Gallagher Bassett whether it intended to continue to require him to participate in occupational rehabilitation. It confirmed it would not given he continued working in his self-employed role part-time, but said it intended to issue a third termination of his 'top up' payments as he had increased his hours from 15 to 18 per week. Gallagher Bassett said this was 'above the approved hours' and so Nicholas would need re-apply for payments based on him working 18 hours per week.

There is no requirement in the WIRC Act that a worker re-apply for 'top up' payments if they are able to slightly increase their hours. Provided a worker is meeting the minimum working requirements and is indefinitely incapable of undertaking further work as a result of their injury, they remain entitled to 'top up' payments. The medical evidence supported this, so the investigation asked WorkSafe to review Gallagher Bassett's impending third termination of Nicholas' payments. WorkSafe subsequently said it had informed Gallagher Bassett of its view that the medical evidence did not support a termination and that it should not require Nicholas to re-apply for his payments based on a slight increase in his working hours.

376. In another complex claim, Gallagher Bassett terminated the 'top up' weekly payments of a worker with a mental injury, despite a Medical Panel opinion that she was indefinitely incapable of working more than 15 hours per week. The worker had returned to work part-time working for her family member's business and reported struggling with the hours she was working, despite the support of her family member to remain at work.

Case study 29 – Worker with mental injury employed by family member told she could work more

Gabrielle was working as a police officer when in 2007, she sustained a mental injury after being bullied and harassed at work.* She ceased work and made a WorkCover claim, which was accepted by Gallagher Bassett.

After several years, Gabrielle returned to part-time employment assisting a family member's business in 2015. She was unable to return to full-time work as a result of her mental injury, so applied to Gallagher Bassett to receive 'top up' weekly payments. Gallagher Bassett rejected her application. At conciliation, the matter was referred to a Medical Panel, which concluded Gabrielle was likely to continue indefinitely to be incapable of undertaking more work because of her mental injury. In forming its opinion, the Panel noted the flexible nature of the work she had returned to and her reliance on her family member who was providing her employment, stating:

> [T]he worker told the Panel … that her … [family member] picks her up in … [their] vehicle, and she accompanies … [them] and assists … [them] with … [work].
>
> The worker said that in order to ensure that the worker is ready to leave for work on time her … [family member] telephones her and prompts her to get out of bed, get dressed and have breakfast. The worker said she has found the return to work very difficult and tiring. She told the Panel that … after each shift (which is a maximum of 4 hours) she is exhausted and goes straight to bed. The worker said that due to anxiety, she initially found it very hard to interact with any of the … [clients] but now manages to have superficial conversations with some … [clients].

In regard to Gabrielle's mood, the Panel noted she said she often felt very depressed and 'deeply ashamed of how her life … [had] changed since the injury'. It further noted that Gabrielle described having little motivation, significant anxiety and rumination and said she 'would like to not be alive'. Gallagher Bassett approved Gabrielle's application based on the Panel's opinion and she started receiving ongoing 'top up' weekly payments.

About one year later, Gallagher Bassett arranged for an IME to examine Gabrielle, who concluded she was not working to her maximum and that she could 'progressively' and 'slowly' increase her hours. The IME said Gabrielle's reported symptoms were 'mild' and that she was 'not well motivated' and not a 'self-starter'. However, the IME said there had been minimal change in her condition since the Medical Panel's examination. The IME's report said:

> She told me she is 'stuffed doing the hours I'm doing now'. She told me that it is hard work. She told me she feels wrecked physically and mentally. She told me that, 'it's … [my family member] pushing me to make sure I get fifteen hours a week'. She told me it is degrading that she is working for her … [family member] and that … [they] must ring and get her out of bed. She told me … [they make] coffee and sandwiches for her. She told me she is supported by … [them]. She told me it is a flexible arrangement. She told me … [they are] not a tough boss.

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In a supplementary report, the IME also confirmed there were other jobs Gabrielle could undertake working more than 15 hours per week and said she could increase her hours progressively over six months to full-time hours. Gallagher Bassett terminated Gabrielle's payments based on the IME's opinion.

Gabrielle disputed the termination at conciliation and the matter was referred to a further Medical Panel. The Panel, like the previous Panel, found Gabrielle was indefinitely incapable of working more than 15 hours per week as a result of her mental injury. The Panel noted Gabrielle reported she would 'struggle to do any other work or work for longer', that her family member was 'highly flexible and accommodate[d] her psychiatric condition' and that she was 'exhausted with the amount of work that she … already [did] and … [did] not feel she could work any more'. In forming its opinion, the Panel said:

> [T]he worker's current employment is very protective of her by virtue of her … [family member] being her employer and the nature of the work. The current employment situation is extraordinarily flexible and accommodating of the worker's fluctuating condition. The Panel thus concluded that the worker is currently working at her capacity and cannot increase her working hours under the current arrangement. The Medical Panel is also of the opinion that the present employer is more supportive and protective of the worker than other employers are likely to be in open employment and that she would not be capable of working more hours with another employer.
>
> The Medical Panel considered whether this situation was likely to continue indefinitely. The Medical Panel noted that the worker had been working at her current hours from … 2015 … [with] little change. The Panel could not predict when and if the worker might improve.

The Panel also said it disagreed with the IME's opinion that her condition was mild. Gallagher Bassett reinstated Gabrielle's payments based on the Medical Panel opinion.

* This case is also discussed on pages 132 and 175.

377. The following case study is another example of an unreasonable termination of a worker's 'top up' weekly payments by Gallagher Bassett, this time relying on a technical argument that the worker was no longer meeting the criteria to receive payments under the Act.

Case study 30 – Agent behaviour 'entirely focussed on minimising their costs' rather than helping worker remain at work

Brian was working as a tradesman when in 2011 he injured his back. He made a WorkCover claim which was accepted by Gallagher Bassett. His weekly payments were later terminated by Gallagher Bassett in mid-2014 on the basis that he had received 130 weeks of payments and had a work capacity.

While Brian could undertake some work, he could not return to full-time work as a result of his injury, so made an application to Gallagher Bassett for 'top up' payments in mid-2016. Gallagher Bassett rejected his application based on an IME opinion that his injury was no longer work-related and degenerative changes were the cause of his persisting symptoms. The IME also said Brian could increase the hours he was working.

Brian disputed the rejection at conciliation and the matter was referred to a Medical Panel. The Panel concluded Brian's back injury remained related to the work incident and that as a result of the injury, he was indefinitely incapable of working more than the 22 hours he was working per week as a self-employed tradesman. Gallagher Bassett approved Brian's payments as a result of the Panel's opinion.

In early 2018, Gallagher Bassett arranged for a further IME to examine Brian, who also said he was indefinitely incapable of working more than 22 hours 'unless he changes his occupation and attempts some other non-physical occupation'.

In mid-2018, Gallagher Bassett terminated Brian's 'top up' weekly payments on the basis that he was not consistently working 22 hours per week and working to his maximum capacity. Gallagher Bassett noted Brian's total hours worked each week included 'non-remunerated activities' in the form of administration for his business and said when his 'actual paid work' was considered in isolation, he had not consistently worked 22 hours per week.

Brian requested conciliation. Upon reviewing the decision, Gallagher Bassett's Dispute Resolution Officer recommended it be withdrawn, noting:

> The premise of our argument seems to be that the worker [is] self employed and not working up to the maximum of 22 hours per week as determined by the Panel in 2017 because his current time sheets include hours for administration work and as this is not paid work therefore should not be included. I don't agree with this and I'm not really sure we can run this argument because tradesman [sic] generally allow for all of this kind of stuff when they quote their clients.
>
> I also noted that the time sheets with the worker's original … application [for top up payments] included his time for admin work so we were happy to accept it and pay then but decide differently now …
>
> On review the time allotted for admin work is minimal compared to the … [labouring] work he is doing and in some weeks … [his] 22 hours are comprised of labouring work only.

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One of Brian's treating doctors provided a report for conciliation in which he said he was 'bemused' by Gallagher Bassett's inference that the administrative work Brian undertook was 'not work or even part of the remunerated work'. He further said:

> The behaviour of the insurer has been entirely focussed on minimising their costs rather than assisting … [Brian] back to as much health and activity as possible and this decision by Gallagher Bassett will make his ongoing small business impossible.
> …
> Over the course of the time I have known him … [Brian] has done all he can to progress with respect to his physical health and return to work. He has maintained a self managed exercise programme and relied on professional treatment as little as possible. In the context of a person that continues to experience a significant level of constant pain … [Brian] has remained focussed [on] returning to as much of his previous lifestyle as possible.

Gallagher Bassett agreed to withdraw the termination prior to conciliation.

The behaviour of the insurer has been entirely focussed on minimising their costs rather than assisting … [Brian] back to as much health and activity as possible …

– Treating doctor

Agents acting unreasonably during conciliation

378. The investigation examined agents' actions with respect to claim decisions disputed at conciliation. The purpose was to establish whether, since the Ombudsman's 2016 investigation, cases of agents maintaining unreasonable decisions during conciliation, that they knew would not hold up in court, had continued to arise.

379. When a worker requests conciliation, agents are required to:

    - review the decision to ensure it is 'technically sound', 'based on reasonable evidence' and appropriate in light of any new evidence received after the decision was made
    - withdraw the decision before conciliation if it would not have a reasonable prospect of success at court (ie not be 'sustainable') or was not made in accordance with the WIRC Act
    - take all reasonable steps to resolve the dispute.[28]

380. Agents have dedicated dispute resolution staff who are responsible for reviewing decisions and attending conciliation. WorkSafe requires these staff to have:

    - the 'appropriate experience and knowledge' and be 'fully equipped' to deal with the conciliation process
    - the 'authority to resolve the dispute' and the 'willingness to do so'
    - a 'thorough knowledge of the file' and be 'willing and able to discuss issues in dispute in a meaningful and constructive way'.[29]

381. While overall the number of disputes at conciliation has reduced since the Ombudsman's 2016 investigation, the rate at which decisions are withdrawn or changed through the dispute process remains high.

382. Witnesses interviewed during the current investigation said some changes were initially observed after the Ombudsman's 2016 report, including a reduction in disputes and agents being 'more readily prepared to try and resolve matters at conciliation'. However, they said as time went on 'old habits came back'.

383. The evidence obtained by this investigation showed that in some complex claims, agents:

    - maintained unreasonable decisions during conciliation
    - were unwilling to resolve disputes at conciliation.

384. These claims highlighted the impact of these practices on already vulnerable injured workers, in addition to the financial implications to the scheme. In 2017-18, the average cost to the scheme per conciliation was over $2,000; a Medical Panel referral cost nearly $4,000; and the average court case amounted to nearly $35,000.

28 *Ministerial Guidelines as to authorised agent, self-insurer, employer and workers' assistant conduct at conciliation conference* (April 2011); WorkSafe Victoria, Claims Manual (2019) s 7.2.4 and 7.2.6.

29 WorkSafe Victoria, *Claims Manual* (2019) s 7.3.

Unreasonable decisions maintained during conciliation

385. Under the Ministerial Guidelines[30] and WorkSafe Claims Manual, agents are required to only maintain 'sustainable' decisions during conciliation. However, a Conciliation Officer is only able to direct an agent to overturn their decision where there is 'no arguable case', which is a lower threshold. The WIRC Act does not define what constitutes an 'arguable case'; however, WorkSafe said it considers this to mean:

> [T]hat there is either a legitimate legal dispute between the parties and/or evidence supporting the decision in dispute. The courts have held that there is an 'arguable case' as long as the denial of liability is not frivolous or without adequate enquiry and consideration.[31]

386. The effect of this is that an agent only needs to have an 'arguable case' to successfully maintain a decision at conciliation and avoid being directed to overturn their decision, even if the decision would not hold up in court.

387. The Ombudsman's 2016 investigation identified cases where agents maintained decisions during conciliation which were 'arguable', but not necessarily sustainable. As a result, the Ombudsman recommended that the State Government amend the WIRC Act to empower Conciliation Officers to issue a direction to an agent where a decision is 'unsustainable' – ie it has no reasonable prospect of success were it to proceed to court.

388. WorkSafe said it did not support this recommendation because:

> The aim of conciliation is for the parties to negotiate an agreed outcome. The role of the conciliator is to facilitate frank and open discussion, not evaluate the strengths and weaknesses of each parties' position and make a decision on the merits. The only qualification under the current system is that a conciliator may issue a direction if the conciliator forms the view that that the arguments advanced by the agent are essentially hopeless. It would fundamentally and detrimentally affect the conciliator's capacity to mediate negotiated outcomes if the conciliator's role included assessing whether a position was 'sustainable' as opposed to 'arguable'.
>
> Conciliation is a non-adversarial process, in respect of which the parties are not legally represented. It would become considerably more adversarial if, at the end of a conciliation which did not reach a compromise, the conciliator then abruptly changed roles and became the judge of which party's arguments were preferred.

389. WorkSafe's position is acknowledged; however, this investigation identified continuing issues regarding agents maintaining decisions during conciliation which were 'arguable', but not 'sustainable'.

30 *Ministerial Guidelines as to Authorised Agent, Self-insurer, Employer and Workers' Assistant Conduct at Conciliation Conference*, issued by The Hon Gordon Rich-Phillips MLC, Assistant Treasurer (April 2011).

31 Letter from WorkSafe Victoria to Victorian Ombudsman, 13 July 2016.

390. Conciliation Officers interviewed during the investigation said it was still 'very common' for agents to maintain decisions on 'one word' to build an argument, or to gather whatever 'pieces' of information they could to support a rejection or termination. Conciliation Officer E said agents would do everything they could to ensure a decision was maintained, and that their approach in some cases was:

> '[L]et's get it over the line, let's put something in there, let's cover all bases, so that we can hold our line and deny a claim' … put in a technical ground or something like that, that's not … in [a] common sense world, and even in terms of a sustainable world, that wouldn't count, but they chuck everything in, to cover all bases.

391. Conciliation Officer E also said:

> [T]he genuine dispute, is such a low bar … It's so rare that you [as a Conciliation Officer] can actually use your powers of direction, because you can only direct if there's no arguable case. So I probably do one direction a year, and I probably tell them I'm going to do about ten, and then they cave, but that's not a lot … out of all of the ones [disputes] I do a year that's not many … [agents could have] one flimsy piece of information, I wouldn't even call it evidence, or it's not even information, sometimes it's an argument, or a view, or an opinion from somebody, somewhere.

392. Conciliation Officer C said agents were 'very keen to get over the arguable case line' because they think 'that's all … [they] really need[ed] to do'.

393. Conciliation Officer A said disputes were sometimes difficult to resolve because agents were 'clinging on to the barest of arguments' despite only having 'a slither of an argument'. They said for these matters, Conciliation Officers had no option but to issue a genuine dispute certificate because an 'argument' existed; and if a worker wanted to dispute the decision further, they had to take it to court.

394. A worker representative said this was unfair to workers because:

> In effect agents know they can make a very poor decision, it doesn't get scrutinised because a conciliation officer can't say who's right or wrong … they merely try and get the parties to an agreement. It's not [un]til it gets to court that the facts are determined and there's a decision based on the merits of the argument … I think agents can make any decision they like.

395. The Police Association Victoria also raised concerns about the number of disputes that cannot be resolved at conciliation due to Conciliation Officers' limited powers to direct agents. It stated:

> A high proportion of our members' claims that reach conciliation are not resolved … There is a perceived reluctance of the ACCS to issue a direction at conciliation, despite the insurer rarely presenting an 'arguable' case. The threshold for an 'arguable case,' as evaluated by the ACCS, is seemingly very low. This lack of direction on the part of the ACCS leads to lengthy and ultimately futile delays for our members, as claims inevitably resolve prior to a court hearing. Our injured members are therefore spending an increased length of time in the system, without access to treatment.

396. The Police Association suggested agents maintained unsustainable decisions at conciliation knowing few workers, particularly those with mental injuries, would take the matter further to court. It said:

> The litigation process related to psychological injury claims has been suggested by our members to be equally or more stressful than the injury itself. Many claimants outside of the force who are involved in psychological injury claims will accept less compensation or abandon their claim to avoid these stressors. The Association believes that the process of rejecting these cases is in the hope that members run out of leave, benefits, or money, so that they give-up, resign, or return to work and forget about the claim.

397. In the following case study, Allianz rejected a worker's claim on the basis that it was not work-related, despite contrary evidence and 'risks' identified regarding the decision. It took Allianz six weeks after the worker requested conciliation and five months after the worker submitted their claim to withdraw the decision and accept the claim.

Case study 31 – Agent delays withdrawal of rejection prior to conciliation, despite acknowledging it was 'likely to be criticised'

Leo was working as a tram driver when in 2017, he injured his hip. On the date of the injury, Leo told his employer that the tram pedal was stiff and the tram was later sent to be repaired when it returned to the depot. Leo ceased work two months later due to pain and made a WorkCover claim. To assess his claim, Allianz conducted a circumstance investigation, arranged for an IME to examine Leo and sought information from his treating doctors.

A report provided by Leo's doctor detailed his chronic back and hip pain, his treatment following the injury and the results of an MRI scan. Leo's specialist also provided a report to Allianz describing Leo's 'insidious onset of right lateral hip pain nine months ago while working as a tram driver'. After examining Leo, an IME agreed with the diagnosis provided by Leo's treating doctors and said the cause of the injury 'could have been' work-related, though an MRI scan would clarify if the condition was as a result of 'pre-existing degenerative change'. The IME noted they were aware an MRI scan had been performed but had not been provided the results.

Allianz requested the IME provide a supplementary report clarifying the cause of the injury, however, rejected Leo's claim before it was received. In its rejection notice, Allianz said:

> Based on the available medical information, the cause of your claimed injury is not yet known. As such, Allianz is not satisfied that your claimed condition has arisen out of or in the course of your employment.

The following day, Allianz received a supplementary report from the IME who said that after reviewing the MRI report, there was no evidence of a pre-existing condition and Leo's employment contributed to his claimed injury. Despite this new evidence, Allianz did not alter its decision at that time and Leo requested conciliation.

Upon reviewing the decision, Allianz identified 'risks':

> RISKS - Have we obtained the sup report from [IME]
>
> The Notice seems to read that the cause of the injury is unknown. Whilst we are not required to state the origin of the injury if not work related, we are NOT saying the accelerator pedal was not stiff. There is no alternate cause postulated. At ACCS, we are likely to be criticised for this course of action.
>
> … if a resolution cannot be achieved at or before formal conference, the matter Is almost certain to be referred to the Medical Panel. Of course, a resolution at / prior to Conference is a desirable outcome and may well obviate the need for a Medical Panel referral.
>
> At this stage, there is no rebutting medical material, however this may well change prior to Conference. At this point the decision appears technically sound and is based on reasonable evidence.

Continued on next page...

Allianz then obtained a second supplementary report from the IME, who reiterated their opinion that Leo's pain was caused by operating trams and was therefore work-related. Allianz eventually accepted Leo's claim prior to the scheduled conciliation conference, which occurred six weeks after Leo requested conciliation and five months after he submitted his claim. The decision failed a WorkSafe audit,* noting that the claim should have been accepted as soon as the IME's first supplementary report was received.

In response to the draft report, Allianz acknowledged that the delay between receiving the supplementary report and accepting the claim was 'unacceptable'. It said:

> As in the case of this claim, in some instances, due to legislative timeframes, liability decisions need to be made using the information available by the 28th day post receipt of the worker's claim. These claims should be reviewed when further information is received which occurred in this instance. Nonetheless, we acknowledge there was a delay on Allianz's part.

Allianz said that it implemented a new follow-up process in early 2019 to ensure claims requiring follow-up are monitored by a senior employee and any variation to the original decision is timely.

* WorkSafe's Quality Decision Audits are further discussed on page 156.

398. The following case study is another example. Gallagher Basset maintained its termination of a worker's weekly payments at conciliation despite identifying multiple deficiencies in the decision and concluding it did not have a 'strong case'.

Case study 32 – Agent maintained termination despite acknowledging it did not 'have a strong case presently'

Caroline was working as a customer service officer when in 2011, she injured her shoulder at work. She made a WorkCover claim which was accepted by her employer's agent, Gallagher Bassett. Caroline was subsequently examined by a range of IMEs and two Medical Panels, after Gallagher Bassett attempted to terminate her entitlements on two separate occasions. In 2016, a Medical Panel concluded she had an indefinite incapacity for work as a result of her shoulder injury, in addition to a secondary mental injury and pain disorder.

In 2017, Gallagher Bassett terminated Caroline's weekly payments again, relying on two IME opinions indicating she was no longer incapacitated for work. Caroline requested conciliation. Upon reviewing the termination, Gallagher Bassett's Dispute Resolution Officer said they did not believe Gallagher Bassett had 'a strong case presently' and identified multiple issues with the termination, which included that:

- Two previous Medical Panels had concluded that Caroline was indefinitely incapacitated.
- It was 'hard to consider' the IME opinions which said Caroline had capacity, when the Medical Panel had determined indefinite incapacity only 12 months prior.
- The suitable employment options Gallagher Bassett identified in its termination were the same as those a previous Medical Panel found were unsuitable.
- The 'only justification' from the psychiatrist IME supporting an improvement in Caroline's mental injury since the Medical Panel in 2016 was that she 'wasn't teary' during the examination.

Continued on next page...

Despite this, Gallagher Bassett did not withdraw the decision prior to conciliation. At the conciliation conference, Gallagher Bassett offered Caroline limited weekly payments to try to avoid another Medical Panel referral, however, Caroline rejected the officer. Gallagher Bassett noted in a further file note that the IME opinions upon which the termination relied were 'not the strongest'.

The matter was ultimately referred to a third Medical Panel which concluded Caroline was indefinitely incapacitated for all work. As a result, Gallagher Bassett reinstated her payments, four months after they were terminated.

399. The sample of agent staff emails obtained by the investigation also highlighted examples of agents maintaining decisions they apparently knew were unsustainable.

Example 1

In one email exchange between Xchanging staff, a Dispute Resolution Officer recommended a termination be withdrawn at conciliation because they believed it was not arguable. However, claims staff said they were 'going to try and whip up a sup[plementary report] request' to the IME and said they could achieve the relevant financial reward measure* if they 'attend[ed] to this asap' (financial reward measures are discussed further on page 142).

In response to the draft report, Xchanging said:

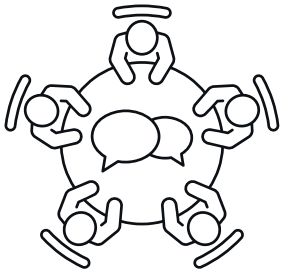
> The Xchanging DRM [Dispute Resolution Manager] challenged the basis for the decision with the Technical Manager. The full email trail clearly shows the Technical Manager deferred to the DRM to go ahead with whatever actions they deemed appropriate.
>
> The reference to the financial measure, while inappropriate, had no impact on the decision-making process or outcome.
>
> Before any action could be undertaken the worker's solicitor requested a Genuine Dispute outcome be issued. This certificate of outcome was issued by the Conciliator without the need for a conference.

Example 2

Emails between CGU staff highlighted a claim* which was rejected, despite acknowledgement that the sustainability of the decision was 'pretty slim'. CGU staff said it would be 'ideal' to 'let it go to Concil[iation]', but told the employer they needed 'to be willing to look at a resolution' if the worker appealed the decision, as it was not 'a strong decision at all'.

* This case is also discussed on page 75.

Rate at which decisions were changed or overturned in 2017-18



52% of decisions changed or overturned at conciliation

70% of decisions changed or overturned at court

68% of decisions changed or overturned at Medical Panels

400. While the number of requests for conciliation fell by 28 per cent from 2014-15 to 2017-18,[32] the rate at which decisions are withdrawn or changed through the dispute process has remained high, with about half of the decisions disputed at conciliation in 2017-18 changed.

401. Decisions disputed in court[33] were varied or overturned at an even higher rate, with 70 per cent of decisions that proceeded to court in 2017-18 (and resolved by 31 August 2019)[34] being varied or overturned.

402. Decisions referred to a Medical Panel for a binding opinion had a similarly high overturn rate in 2017-18, with:

- 66 per cent of decisions referred to a panel at conciliation varied or overturned[35]
- 70 per cent of decisions referred to a panel by a court varied or overturned.[36]

403. At interview, Conciliation Officer F said the high number of agent decisions overturned by Medical Panels 'underline[d] the poor decision making of the agent' and that agents 'hated' Medical Panel referrals 'because they usually lose'. Several Conciliation Officers also said they knew when they referred a dispute to a Medical Panel that it was likely to come back in favour of the worker.

404. In some complex claims reviewed by the investigation, such as case studies 13 and 32, there was evidence agents attempted to avoid a Medical Panel referral, because they knew their decision was based on insufficient evidence and would likely be overturned.

405. The sample of agent staff emails obtained by the investigation also showed examples of agents attempting to avoid a Medical Panel referral, including cases where:

- Xchanging attempted to establish a 'factual dispute to keep us out of the med panel'
- Gallagher Bassett proposed to offer a worker one month of payments at conciliation 'to avoid med panel'.

32 Excluding requests for conciliation regarding impairment benefits and maims.

33 Relating to statutory benefits decisions.

34 About 13 per cent of decisions disputed at court in 2017-18 remained unresolved at 31 August 2019.

35 This figure relates to the 98 per cent of decisions referred to a Medical Panel at conciliation in 2017-18 which were resolved by 31 August 2019.

36 This figure relates to the 98 per cent of decisions referred by a court to a Medical Panel in 2017-18 which were resolved by 31 August 2019.

406. Conciliation Officer C said at interview that agents sometimes maintained unreasonable decisions at conciliation even under threat of a Medical Panel referral because they were willing to 'take a punt' - knowing that 'maybe one in five comes back from the Panel and actually supports them [the agent] and the person's gone and off [compensation]'.

407. In response to the draft report, Gallagher Bassett said:

> The analysis in the draft report … and the inference that changes to decisions through the dispute resolution process means that the original decision was flawed:
>
> - Fails to acknowledge that the reduction in disputes is directly attributable to improved decision making, and that this reduction is sustained;
> - Ignores that a change in decision at conciliation, is most often the result of a genuine attempt to resolve matters, which is the purpose of conciliation;
> - Fails to acknowledge that a decision taken to court is accompanied by significant further information such that the parties are in the best position to assess the merits of the decision;
> - Fails to acknowledge that a decision to settle prior to a Court case, a matter where a genuine dispute was found at Conciliation, does not necessarily confirm the original decision was unsound, but instead reflect other factors such as the cost of continuing to Court even when a decision may be felt to be appropriate.
> - Fails to acknowledge that Medical Panels make independent assessments and changes to decisions arise from a difference of medical opinion, not adequacy of decision making.

Agents' unwillingness to resolve disputes at conciliation

408. Conciliation Officers interviewed during the investigation raised concerns about the willingness and authority of agent dispute resolution staff to resolve disputes at conciliation. Conciliation Officer A said that they were not 'truly coming with the true authority to make a decision without fear or favour'. Conciliation Officer A said:

> One of the big issues that is always [a] frustration for conciliation is that although agents are required to come to a conciliation to meaningfully conciliate and come to an agreement … the individual reps [of the agents] often do not have the authority to make decisions. They have to defer back to the claims management teams to run it by them … which is very frustrating because … one it goes against … what conciliation is about. And two, it stymies the process quite considerably.

409. Conciliation Officer A said that in some cases, agent representatives had told them that they needed to 'ring up work and just run it by them before … [making] a decision'. The Conciliation Officer said that this was 'absolutely inappropriate':

> [T]he people back there that are making the decision haven't seen the new information and haven't heard the discussions that have been around the table and so, that's one of the difficulties … the other issue is that the person from the agent has to be mindful of their own job. So if they're offering things that [they] think … the claims teams don't agree with, well they can only do that so many times before they end up having their own job at risk.

410. Conciliation Officer H said:

> Just last week I had quite a battle with a DRO [Dispute Resolution Officer] who took a decision 'back to the team' resulting in a firming-up of a barely arguable and certainly unsustainable decision. I get the impression that a number of DROs are equally frustrated with their lack of authority to make decisions on these matters.

411. Conciliation Officer C said that the 'inability of DRO[s] to make fair and proper decisions at conciliation' sometimes led to matters being referred to a Medical Panel because the Conciliation Officer thought the worker had an entitlement, but the 'DRO won't move'. They further said:

> If people came in good faith to conciliate on both sides of the table, we wouldn't need to worry about arguable case. We would be able to deal with the material in front of us and the parties could consider the merits of the argument. And if DROs had more flexibility to resolve disputes, I think we could do our job better.

412. In the below case study, a Gallagher Bassett Dispute Resolution Officer reviewed a termination for conciliation and concluded it was 'not arguable' and based on a 'confusing' IME opinion. The officer recommended the termination be withdrawn, but it was ultimately maintained at conciliation.

Case study 33 – Termination maintained at conciliation despite acknowledging it was 'not arguable'

Margaret was working at a university when in 2017, she fell over at work, injuring her neck, shoulder and back.* Margaret made a WorkCover claim which was accepted by her employer's agent, Gallagher Bassett.

Gallagher Bassett later arranged for Margaret to be examined by an IME, who concluded she had aggravated a previous back injury in the fall at work and was suffering from chronic neck and back pain. The IME also said Margaret appeared to have clinical depression; however, this was outside their area of expertise. The IME said from a physical perspective, Margaret's injuries had resolved and she was able to return to her pre-injury duties. However, the IME also said Margaret had an incapacity for pre-injury duties and this was indefinite. Gallagher Bassett requested a supplementary report from the IME to clarify their opinion. The IME confirmed Margaret's injuries had resolved and she had a physical capacity to work, but there was a 'psychological as well as physical element in all injuries'.

Gallagher Bassett then arranged for Margaret to be examined by a psychiatrist IME, who concluded she was not suffering from any mental injury. The IME said she could return to work, but said she would benefit from participating in a pain management program, as there was 'some risk' she could 'slip into psychological disorder'. Based on the two IME reports, Gallagher Bassett terminated Margaret's entitlements on the basis that her injuries had resolved and she was no longer incapacitated for work. Margaret requested conciliation. Upon reviewing the decision, Gallagher Bassett's Dispute Resolution Officer concluded it was 'not arguable' as the IME's opinion was 'confusing', noting they said Margaret was suffering chronic neck and back pain and that her back condition was aggravated by the work incident, but the aggravation had not resolved. The Dispute Resolution Officer recommended the termination be withdrawn.

At conciliation, Gallagher Bassett maintained its decision despite the Dispute Resolution Officer's view that it was 'not arguable' and the matter was referred to a Medical Panel. The Panel concluded Margaret had a current work-related injury which rendered her incapacitated for work. As a result, Gallagher Bassett reinstated her entitlements almost six months after they were terminated.

* This case is also discussed on page 183.

413. Witnesses interviewed also raised concerns about agent dispute resolution officers at times presenting 'offensive' offers to a worker in an attempt to resolve matters they knew would likely be overturned should they proceed further. A worker representative said sometimes agents made 'disingenuous' offers so that it looked like they had made 'reasonable efforts to resolve the dispute'. They said:

> What I found in recent times, is they'll make an offer they know is not going to be accepted, to be able to say 'we made reasonable efforts to resolve the dispute and we actually made an offer that was rejected by the worker and the worker's assistant'. I've had one where they offered two weeks, and I said 'well that's not a real offer, at all'. And the Conciliation Officer said 'well I've got to put it [to you], because they've put it to me'. I said 'well you need to go back to them because … that's disingenuous' … Now, if you've been off work with a mental injury for three or four months, then that two weeks' pay … it's just not genuine. It's absolutely an insult to the worker.

414. Conciliation Officer F also said:

> For the injured worker, it's like a court. They're traumatised, they're stressed, they don't know how it's going to work, they're the only person in the room not paid to be there, everyone else is a paid professional. And, so they often come away saying 'I still didn't feel heard' or 'they didn't listen' because they already had made up their mind' and that comes across and so that defeats the purpose of conciliation … I think a large part of the role of myself as a Conciliation Officer is to manage those human elements in the room – to make sure the injured worker has a say, gets across their emotion and the impact. But when you've got someone sitting there [an agent representative] saying 'no, no offers', they say 'well what was the point of coming', which is fair enough.

Difficulties resolving factual disputes at conciliation

415. When a matter proceeds to conciliation, there may be a range of issues in dispute, including:

- factual issues, such as the circumstances in which a worker injured themselves or whether a worker has made reasonable attempts to return to work
- medical issues, such as the diagnosis of a worker's injury, whether they have a work capacity or whether certain treatment is appropriate for their injury.

416. Where the dispute centres on medical questions, a Conciliation Officer may refer the questions to a Medical Panel for a binding opinion. However, this cannot occur where there are factual issues in dispute. Often these matters need to go to court as a Conciliation Officer cannot make a binding determination on factual issues like a court can.

417. Conciliation Officers interviewed during the investigation raised concerns about the difficulties they face resolving disputes about agent decisions which rely on factual grounds. Particular concerns were raised in relation to disputes about:

- return to work non-compliance notices[37]
- mental injury claims rejected on the ground they were caused 'wholly or predominantly' by reasonable management action.[38]

37 Agents may issue a 'return to work non-compliance notice' to a worker where they have failed to reasonably comply with their return to work obligations. Agents' issuing of these notices is further discussed on page 84.

38 Agents' rejection of claims on this ground is further discussed on page 71.

Disputes about return to work non-compliance notices

418. Conciliation Officers interviewed during the investigation said that due to difficulties resolving disputes about return to work non-compliance notices, workers often have to go to court if they wish to have them overturned. While many workers may not be in a position to take legal action, Conciliation Officers said that when these notices did proceed to court, it was difficult for agents to defend them and they would likely be overturned.

419. Conciliation Officer F said trying to resolve disputes at conciliation about these notices was 'particularly ineffective', and stated:

> The agent issues the notice to the worker saying you're not making reasonable efforts to return to work. There's a warning, a suspension and a termination, so there's the trifecta of decisions. They're all based around, 'we've sent you to an IME that says you've got a capacity'. The worker's doctor invariably is certifying them unfit, so the worker is following their doctor's medical advice. They come to conciliation; and because they've used the ground you haven't made reasonable efforts, it's not actually a medical dispute, it's a factual dispute. So as soon as we get the trifecta of return to work notices, three genuine disputes. Zero potential to resolve. Because it's not medical, can't refer it to the Panel. The worker's saying 'I'm sticking by my doctor's advice'. If it goes to court, clearly a Magistrate will say 'of course you're being reasonable, you're following your doctor's advice'.

420. Conciliation Officer B similarly said disputes of these notices were 'very difficult' to resolve at conciliation:

> [W]here a worker says 'well my doctor says I shouldn't be going back to work because I'm still too ill', the agents are ignoring the doctor's opinion and saying 'well, you're not participating'. So even though the worker is complying with what their treating health practitioner is saying, the agent's ignoring that and saying 'well, you're not participating in your own return to work'. And those ones we're not able to send to a Medical Panel, because they're about behaviour not a medical dispute.

421. Conciliation Officer B further said:

> [T]he Act is written in such a way that it's about the worker's participation. So it's not about the medical opinion. So what the agents get the worker on is, even though the worker is saying 'I'm just doing what my doctor says', the agents say 'well, bad luck, we don't care what your doctor says, you didn't come back to work'
> ...
>
> And it's awful. It's an appalling abuse, I think, of the system, in the sense that it's ... punishing the worker for taking the advice from their treating health practitioner.

422. Conciliation Officer D highlighted the difficulties agents have maintaining these decisions if they go to court, stating:

> They are very hard for the agents to win ... because ... the burden of proof is the opposite, they must prove that the worker unreasonably refused to comply. And that's not easy, and they have never been easy to win, because if you've got a doctor who says 'I am issuing you certificates that say you cannot do any work, I see you on a regular basis, and you are not to go back to work', how can a worker then be said to unreasonably refuse to comply to the return to work plan if his or her doctor is saying 'you can't work'. So they are notoriously difficult to win ... very rarely I suspect they ever would [go to court], because they would be negotiated.

423. The disputed return to work non-compliance notices reviewed by the investigation confirmed the Conciliation Officers' views, as a number of the notices resulted in a genuine dispute certificate at conciliation. Yet, upon reviewing these notices during the investigation, for example the notices issued in case studies 18, 20, 23 and 38 in this report, WorkSafe concluded that the notices should be withdrawn.

424. The investigation's review of non-compliance notices also showed that many warning notices were not disputed by injured workers, presumably because they have no immediate impact on their entitlements.

Disputes about claims rejected on reasonable management action ground

425. Conciliation Officers also raised concerns about their inability to resolve disputes at conciliation about mental injury claims rejected by agents on the 'reasonable management' ground because they involve questions of fact. Under the WIRC Act, a worker is not entitled to compensation if their mental injury was caused 'wholly or predominantly' by 'reasonable management action' by the worker's employer. Such action includes performance management, disciplinary action, dismissal and position reclassification.[39]

426. Conciliation Officer B said agents rarely made an offer to resolve disputes about claims rejected on this basis:

> [Y]ou talk to the employer and the agent and you say 'you guys rarely win them, so you're better off trying to resolve them here, managing them at this level rather than having them go to court where you're going to lose'. And the employers, because they see it as a personal affront to them … they tend to just say, no, not making any offers. Or they might make what I would consider as a really offensive offer. So they'll offer no weekly payments. They'll offer a little bit of medical and like treatment, as though that's going to make them go away. And it doesn't obviously. So, a lot of the time those matters end up in court because we can't refer them off into a Medical Panel.

427. Conciliation Officer B said of those that proceed to court, most of them are settled at the 'doorsteps of the court' or if they end up in court 'the worker gets up' and the decision is overturned.

428. Conciliation Officer D said:

> There are plenty of matters that come to conciliation [where] you know they're going to go nowhere … matters where there's factual disputes … [claims rejected because the injury was caused by] management action taken in a reasonable manner. That's a legal determination. So many … [of these] matters we can't resolve because it's a) a factual dispute and b) on the merits of what the management did was it reasonable action, now that is almost always evidentiary.

429. Conciliation Officer G similarly said they were generally not able to resolve disputes about claims rejected on this ground and that it was 'almost impossible to issue a direction' on them.

39 Refer to page 71 for further details.

Decisions contrary to binding Medical Panel opinions

430. Medical Panels are a key part of the dispute process and can be used by the ACCS or a court to resolve a dispute where there is a medical question regarding a worker's work-related injuries. Under section 313 of the WIRC Act, the opinion of a Medical Panel on a medical question referred to it must be adopted, applied and accepted as 'final and conclusive' by all parties.

431. WorkSafe informed the investigation that the impact of a previous Medical Panel opinion on a claim decision differs depending on whether the Panel previously provided an opinion on the same issue.

432. WorkSafe stated that where an agent seeks to revisit the same issue considered by a Panel (for example, whether a worker has an indefinite incapacity for all work), it expects the agent to demonstrate there has been a 'material change' in the worker's situation since the Panel's opinion. WorkSafe said examples of a material change included improvement in symptoms as a result of further treatment or an increase in the worker's skills as a result of retraining.

433. However, there is no guidance for agents in the WorkSafe Claims Manual about this. A WorkSafe Clinical Panel Advisor interviewed during the investigation suggested greater guidance to IMEs was needed about what constitutes 'material change' and the evidence needed to support this.

434. The Ombudsman's 2016 investigation identified that in some complex claims, agents unreasonably terminated workers' entitlements contrary to a binding Medical Panel opinion, including in cases where there was insufficient evidence of a 'material change' in the worker's circumstances. In some instances, such terminations were issued only a few months after the Panel provided the opinion.

435. Witnesses interviewed during the current investigation variously said it is 'not as common as it used to be' for agents to terminate entitlements contrary to recent Panel opinions, and that 'as a general rule' agents were 'pretty good' at complying with Medical Panel opinions.

436. Conciliation Officer A said at interview:

> [W]hen it comes to issues post [Medical Panel] opinion, how long do agents wait until they have another crack? Because that's often a vexed issue. I haven't seen as many attempts over the last few years as what there used to be … they don't rush to try and terminate like they used to.

437. In the complex claims involving a Medical Panel opinion reviewed during this investigation, it was rare for agents to terminate entitlements soon after a Medical Panel opinion. Generally, agents waited at least 12 months before re-assessing a worker's capacity.

438. While this is positive, the investigation identified several complex claims where agents terminated workers' entitlements without sufficient evidence of a 'material change' in the worker's condition since a Medical Panel opinion. All of these claims involved workers who had been receiving weekly payments for more than 130 weeks and had been found by a Medical Panel to have indefinite incapacity for work.

439. The following case study is one example. EML terminated a worker's weekly payments without evidence that there had been a material change in his condition since a Medical Panel opinion. It relied on an IME opinion that the worker could return to work, but did not provide the IME a copy of the previous Panel opinion.

Case study 34 – Worker's entitlements terminated twice, contrary to Medical Panel opinion

Allan was working as a machine operator when he injured his back at work in 2011. He made a WorkCover claim, which was accepted by his employer's agent at the time, QBE. Allan made several unsuccessful attempts to return to work, finally ceasing in 2013 due to his injury.

Allan was examined by a Medical Panel in 2015 after QBE terminated his weekly payments. The Panel's opinion was that Allan had no current work capacity and this was likely to continue indefinitely. QBE reinstated his payments. The Panel noted various factors that restricted Allan's employment options – his age, rural place of residence, limited literacy and numeracy skills, limited manual work experience, inability to drive a car very long and absence from the workforce since 2013. QBE reinstated his payments.

EML took over the management of Allan's claim in 2016. In 2017, EML approved an occupational rehabilitation assessment for Allan to identify what services would assist his return to work. It also arranged for an IME to examine Allan, who concluded he had a current work capacity. EML did not provide the IME a copy of the Medical Panel opinion.

EML later asked the IME to review other material and provide a supplementary report, however, still did not provide a copy of the Medical Panel opinion. Before receiving the report, EML terminated Allan's weekly payments in late 2017 on the basis that he had a current work capacity. Allan's treating doctor continued to certify him as unfit for employment.

Allan requested conciliation. EML reviewed its decision and concluded it should be maintained, however, acknowledged that its position 'may not be strong' and that there needed to be 'a material change and medical evidence to support a deviation from the … [Medical Panel opinion]'.

In early 2018, EML provided the IME a copy of the Medical Panel opinion and asked him to provide another supplementary report commenting on whether there had been a material change. This occurred about five months after the termination and six months after the IME first examined Allan. The IME said they were 'not able to identify any specific objective change' in Allan's condition. EML subsequently agreed at conciliation to withdraw the termination and reinstate Allan's payments.

EML again terminated Allan's weekly payments in mid-2018. The termination notice did not refer to the IME's opinion that there had been no material change since the Medical Panel opinion, nor did EML have new evidence confirming this. The effective date of the termination was about four months prior to Allan's retirement age.

Allan requested conciliation and EML agreed to resolve the dispute by providing him weekly payments to retirement age.

440. Conciliation Officer A said at interview that they had seen instances where agents had attempted to obtain further information to support a material change, even where an IME had already concluded there had been no change. They stated:

> [S]ometimes they will push IMEs to – to make that statement. You know, they'll get an IME opinion which doesn't suggest anything has changed. So they'll seek a supplementary report asking again can you give us further information of whether anything's changed. If the IME doesn't give enough information they might have another go at it again. That still does happen … I can't say that it happens frequently. But it still does happen.

441. The following case study is an example of this practice. Gallagher Bassett terminated a worker's entitlements contrary to a Medical Panel opinion, without sufficient evidence of a material change. Gallagher Bassett relied on an IME opinion, which initially said there had been 'little change' in the worker's condition since the Medical Panel.

Case study 35 – Termination based on 'little, i.e. minimal' material change

Gabrielle, a former police officer with a mental injury, returned to work part-time working for her family member's business and was receiving 'top up' weekly payments because she could not return to full-time work.* In late 2017, Gallagher Bassett terminated her payments based on an IME opinion that she was not working to her maximum capacity. A previous Medical Panel in 2016 had found that she was indefinitely incapable of working more than 15 hours as a result of her mental injury. While the IME said she could progressively increase to working full-time hours, he said there had been 'little change' in her presentation since the Medical Panel.

Gallagher Bassett wrote to the IME requesting a supplementary report, saying:

> [Y]ou stated, 'there has been little change in the presentation from the time the Panel assessed the worker'. Can we please confirm that this indicates a material change in her current presentation from that of the Medical Panel?

The IME provided a further report in which they stated the change in Gabrielle's presentation, 'though little, i.e. minimal', was 'material'.

When Gabrielle requested conciliation, a Medical Panel agreed with the previous Panel and overturned the termination. The Panel noted Gabrielle had been working the same hours for over three years with little change and remained on a high dose of antidepressants with little change. The Panel said it could not predict if and when Gabrielle's condition might improve. Gallagher Bassett agreed to reinstate Gabrielle's 'top up' weekly payments based on the Panel's opinion. By that time she had been without the payments for nearly six months.

* This case is also discussed on pages 114 and 175.

442. The then Convenor of Medical Panels said at interview that, due to the inherent complexity of some claims, they are likely to involve a medical dispute at some stage and end up being referred to a Medical Panel for a binding opinion. The investigation observed that this particularly occurred in cases where a worker had a primary physical injury and secondary mental injury, as well as sometimes a chronic pain syndrome.[40]

443. The then Convenor highlighted the benefits of a Medical Panel assessing such cases, as they comprise 'a group of doctors hopefully with all of the skills necessary to answer all of the questions together' and reach 'a unified … consensus view on all of those answers'. He described the 'luxury' of being able to put together a Panel containing practitioners of different specialties, which together will probably come up with a much better approach than the IME process. He said this is a 'very powerful part of the [Medical Panel] process'.

444. Where a worker has more than one injury, they are sent to IMEs of different specialities who are only able to provide their opinion on the worker's capacity based on the injury that falls within their area of expertise. The investigation observed that in some cases, the assessment of a worker's capacity by IMEs who were each only considering part of the worker's injuries in isolation produced a very different outcome to a Medical Panel considering a worker's capacity holistically, based on all of their injuries. This sometimes led to Medical Panels overturning the unreasonable termination of a worker's entitlements.

40 Refer to page 66 for further information on chronic pain syndrome.

445. In the following case study, Xchanging terminated the weekly payments of a worker with a primary physical injury and secondary mental injury despite a previous Medical Panel concluding that collectively, his injuries rendered him indefinitely incapacitated for work.

Case study 36 – Worker's payments terminated despite no change since Medical Panel examination from psychiatric perspective

Hamish was working as a tradesman when in 2013 he sustained an injury to his neck.* He ceased work and made a WorkCover claim which was accepted by his employer's agent at the time, QBE. His claim was later managed by Xchanging.

A Medical Panel examined Hamish in early 2016 after his weekly payments were terminated at 130 weeks. It concluded he had a persisting neck injury and secondary mental injury, which rendered him indefinitely incapacitated for all work. In forming its opinion, the Panel noted the 'severity of the physical and psychiatric disorders which affected his concentration, judgement, safety and reliability', his age (early 50s), his limited work experience providing few transferrable skills, his low formal education level, his lack of any effective computer skills and his absence from the workforce since 2013.

About a year later, Xchanging arranged for an occupational physician IME to examine Hamish's physical neck injury and a psychiatrist IME to assess his mental injury. In its requests to the IMEs, Xchanging highlighted that Hamish:

- participated in an ongoing gym/swim program at a facility which was 'an 80 KM return trip'
- picked up and dropped off his children at school
- did his own shopping.

In the request to the occupational physician IME, Xchanging specifically asked the IME to '[p]lease consider the physical capabilities required to complete these tasks and comment on whether … [Hamish] has a capacity for suitable employment'.

The IME concluded Hamish could return to suitable work with restrictions and that there had been a material change since the Medical Panel's examination. The psychiatrist IME said that while Hamish could not return to his original duties, he had a capacity for suitable employment from a 'solely psychiatric viewpoint without considering the physical injury'. The IME, however, said there had been no material change in Hamish's psychiatric presentation since the Medical Panel opinion.

Xchanging asked the psychiatrist IME for a supplementary report explaining why there had been no change, when the IME had concluded Hamish could return to work. In response, the IME did not confirm that anything had changed, but rather just appeared to hold a different opinion to the Panel about Hamish's work capacity. On this basis, Xchanging was required to accept that the Medical Panel's opinion that Hamish was indefinitely incapacitated remained binding, as nothing had changed, at least from a psychiatric perspective. Instead, Xchanging terminated Hamish's weekly payments based on the IMEs' opinions, selectively referring to extracts from the IMEs' reports, while omitting the psychiatrist IME's comment that there had been no material change. Hamish continued to be certified unfit for work by his GP.

Continued on next page...

Hamish requested conciliation and his treating psychologist provided a report stating '[m]ost, if not all, of the behaviours outlined to the Medical Panel were continuing' and said:

> In the time I have been seeing … [Hamish] … it has become very clear to me that his workplace injuries are highly unlikely to significantly improve and that he will continue [to] suffer from the psychological effects of the workplace injuries for many years to come and may never fully recover.

Xchanging reviewed the termination and noted the psychiatrist IME disagreed with the Panel's conclusions regarding the worker's capacity. Xchanging told Hamish's employer that concerns had been identified regarding the decision and it may need to be withdrawn. At conciliation, the matter was referred to a further Medical Panel which concluded that, based on Hamish's physical and mental injuries, he was indefinitely incapacitated for all work. In forming its opinion, the Panel noted various factors relevant to its assessment of Hamish's capacity for suitable employment which were similar to those highlighted by the first Panel, and included:

- the nature and severity of Hamish's physical injury 'which restricted functional capacity in lifting and neck movements'
- the nature and extent of Hamish's mental injury which it considered would limit his ability to 'engage reliably and consistently in employment due to the impact of chronic pain, depression and anxiety, and reduced memory and concentration'
- Hamish's limited level of education and work experience, which provided few transferrable skills.

Xchanging reinstated Hamish's payments based on the Panel's opinion.

In response to the draft report, Xchanging said the termination 'relied on an IME's erroneous interpretation of the Medical Panel's opinion'.

* This case is also discussed on page 196.

Agents allowing employers to influence claims management

446. Employers play an important role in the return to work process, but their role in decision making on claims is limited. They are not able to object to a decision, except at the initial stage of claim acceptance or rejection in very limited circumstances set out in the Act.[41]

447. Evidence provided to the investigation suggested some agent staff effectively see employers as their 'clients', as employers choose which agent they want to manage their premium and claims when registering for WorkCover insurance. An employer may also choose a different agent once every 12 months if dissatisfied with an agent's service.

448. The Ombudsman's 2016 investigation found that this sometimes created a tension between an agent's obligations to manage injured workers' claims and their desire to 'keep an employer happy' to prevent them taking their business elsewhere. This was particularly so for large employers who paid significant premiums.

449. As the relationship between an agent and employer remains unchanged, this investigation found that this tension continues and identified instances where employers had attempted to influence agents' management of claims. In some of these cases, agents accommodated employer's requests and sought their opinion regarding the management of a claim.

450. The sample of agent staff emails obtained by the investigation provided examples of this, three of which are outlined on the following pages.

41 An employer may object to the acceptance of a claim if a) the alleged worker was not a worker within the meaning of the Act, or b) the employer was not the correct employer of the worker at the time of the injury.

Example 1

An email from an Allianz manager referred to a meeting with an employer, during which the employer provided feedback on Allianz's management of their employees' claims. The employer also expressed preferences regarding the management of claims moving forward. The manager said positive feedback from the employer included the '[h]igh rejection rate' in a particular team. The manager also noted that a particular private investigation company was the employer's 'preferred provider for investigation[s]' (presumably surveillance and/or circumstance investigations). The manager asked that staff be made aware of this preference (among other things) and said:

> [The employer] is a great client for us and what they are looking for isn't out of our scope to deliver, hence please invest in our staff to deliver these actions please.

In response to the draft report, Allianz said:

- The employer preference of provider selected from the **WorkSafe investigation provider panel** to conduct factual circumstance investigations is not unreasonable. This type of investigation involves the presence of the investigator on the employer's premises and the investigator's role is to gather facts, not to provide any opinion on the matter. We do not believe that this provides any evidence of "agents allowing employers to influence claims management".
- The comment of a "high rejection rate" was an employer's perception. We note in the 6 months to April 2018 (the meeting with the employer occurred in May 2018) the rate of rejections for this employer was approximately 6.5% of claims received, in comparison with approximately 10% for all employers. [emphasis in original]

The investigation notes that regarding the use of private investigators, the WorkSafe Claims Manual states:

> **Agent selects investigation firm from WorkSafe registered firms**
>
> WorkSafe authorises a number of investigator providers as the only firms who can carry out WorkCover investigations. Agents may allocate an investigation to any of these registered providers.
>
> The agent determines which firm will carry out the investigation, employers must not exert influence in the claims investigation process.

Based on the above, and to ensure the circumstance investigation process is perceived as fair and independent, the investigation maintains the view that agents should not allow employers to select the investigation firm.

Allianz also said in response to the draft report:

> Any efforts of undue employer influence are not acceptable at Allianz. Ethics and Integrity training has been conducted in face to face sessions in 2017 and again in 2018, and the content is currently being transferred to an eLearning module which will be required to be completed as an annual refresher. This training provides the message that while the voice of the employer can be key to understanding and supporting return to health and work of workers who are injured, they do not have a role in influencing claims management activities/outcomes. This is also reinforced via our email communication schedule which provides a quarterly reminder of appropriate ethics and integrity in our working environment.

Example 2

A CGU email referred to a mental injury claim, which the CGU Eligibility Officer intended to reject on the ground that reasonable management action was the whole or predominant cause of the injury. The claim was reviewed by an Eligibility Technical Specialist who said 'on face value' they believed they were 'possibly looking at an acceptance', however, they assumed the employer would not be happy with this. The Eligibility Officer responded that they were happy to try to discuss the matter with the employer if it was 'felt it should be an accept', noting they had 'had some good results for them recently so they may be ok to accept this one'. The Eligibility Officer further said they 'couldn't really see a strong rejection on … [the worker's] claim'. The Technical Specialist sent a further response reiterating that they couldn't 'see a viable argument', but suggested the Eligibility Officer explore with the employer whether there was 'something else' they could provide which 'pushes it more towards [an injury caused wholly or predominantly by] management action'.

In response to the draft report, CGU said:

> The draft report infers that CGU makes decisions to appease clients rather than making a decision based on the legislation and taking into consideration available evidence. CGU refutes this finding and submits that the emails have been taken out of context.
>
> … [The worker] lodged her claim for mental injury … [in early 2018] having ceased work … [two weeks prior]. In her claim form … [the worker] stated her injuries were stress and anxiety from workplace bullying. Given the alleged circumstances of the injury, CGU's ability to properly assess what level of compensation (if any) may apply, it was necessary to discuss the claim circumstances and allegations of bullying with the employer.
>
> Employers play an important role in providing agents with information about factual circumstances surrounding the claim. CGU further submits that not all claims that are received concern injuries that arise out of or in the course of employment. A decision to accept a claim can often be very complex and far from straight forward. In the interests of operating a viable scheme for all parties, CGU recognises the importance of reviewing claims to make an objective determination on liability to ensure only entitled workers receive compensation.
> …
>
> Upon initial review of … [the worker's] claim, the allegations of bullying appeared unsubstantiated by witness statements. From discussions with … [the worker's] employer, there was little evidence of management action to address … [the worker's] allegations of bullying, however there was acknowledgement that there were issues to address. Upon review of clinical notes requested from … [the worker's] treating practitioner there was little information relating to any pre-existing mental illness. While CGU believes the right decision was made to accept … [the worker's] claim, there was enough ambiguity to make the decision difficult.
>
> The emails referred to in the draft report, did not necessarily relate to achieving outcomes the employer perceived as favourable, but rather outcomes which were correct based on the legislation and scope of evidence available. It is for that reason, that the Technical Specialist felt the employer would accept our determination in this instance.

Example 3

The investigation identified one case where Xchanging and an employer strategised to terminate a worker's claim in such a way that the worker would never be able to regain her entitlements. Email communication in this case* showed Xchanging and the employer formulating a claim strategy driven by the employer's desire to 'try to do everything … [they could] to minimise the impact of the claim on … [their] premium and obtain an outcome'. The employer told Xchanging which claim strategy 'option' they wanted Xchanging to pursue, stating it would be 'greatly appreciated' if they could pursue the option that would enable them to 'Cease Payments/Cancel Claim'. Xchanging later withdrew the notices issued to the worker prior to conciliation after acknowledging they were not appropriate.

In response to the draft report, Xchanging said it acknowledged there were 'errors of judgement in this case'. It said:

> The decisions were withdrawn prior to conciliation, demonstrating that if errors are made, Xchanging has mechanisms in place to rectify them.
>
> The actions of Xchanging were cause for regret and provided opportunities to improve training and decision-making processes.

* Further details about this case can be found on page 106.

451. Witnesses interviewed during the investigation also discussed the relationship between agents and employers, describing the employer as an agent's 'client' and outlined the influence they sometimes have over a claim.

452. A former agent employee interviewed during the investigation said she was aware of instances where an employer had attempted to influence the agent's selection of an IME to examine a worker. The former employee said:

> I haven't observed a lot of positive change in that area, unfortunately. There's still a lot of influence placed by employers on to case managers to select a doctor where they think they're going to get an outcome that they're looking for to terminate a claim or to influence an outcome.

453. The former employee said together agents and employers were 'absolutely always looking for different ways to terminate a claim' and that poor work practices occurred at the agent to 'keep the client happy so they don't move somewhere else'.

454. A worker representative interviewed by the investigation also said they were aware that some employers requested that agents send workers to certain IMEs. When asked whether agents have accommodated such requests, they said the agent 'certainly wouldn't say no'.

455. Conciliation Officer B also told the investigation that:

> [I]f they [an agent] have got an employer involved, and the employer's got their back up about accepting a claim, they won't accept it. It's supposed to be their decision. But they're so highly influenced by the employers because, particularly big ones, they're getting a lot of money out of big employers.

456. Conciliation Officer B highlighted the particular influence of employers in disputes about mental injury claims rejected on the grounds of reasonable management action.[42] They stated:

> [The agent representative] just won't make any offers. You try and get them and you talk to the employer and the agent and you say, look, these matters when they go to court, you guys rarely win them. So you're better off trying to resolve them here; managing them at this level rather than having them go to court where you're going to lose. And the employers, because they see it as, like, a personal affront to them … they tend to just say, 'no, not making any offers'. Or they might make what I would consider as a really offensive offer.

457. By contrast, an example was identified in an Xchanging email where it resisted an employer's attempts to influence the management of a claim, despite attempts and strong dissatisfaction expressed by the employer. The employer sent Xchanging copies of social media posts by the worker which they believed showed she was 'clearly manipulating' the situation and 'treating it as a holiday'. Xchanging provided the employer updates on the activities it was undertaking, to which the employer responded with dissatisfaction and said they were 'amazed' Xchanging was comfortable with the evidence it had presented, which it believed showed the worker was engaging in insurance fraud. Xchanging responded:

> We are not 'comfortable' with this, but social media posts and travels overseas don't always mean the person is without a mental injury, or the mental injury has resolved. Lots of injured workers with depression or anxiety can and do go overseas, we can't assume anything and must leave this to an independent medical examiner to comment on. Social media info can't be used by us to cease someone's claim, what we can do is present this information to an independent Dr, and we can base our decisions on the medical opinions.

42 The rejection of claims on this ground is further discussed on page 71.

Part Two:

The effect of financial rewards and penalties on agent decisions

458. In addition to looking at whether agents have continued to make unreasonable decisions on complex claims, this investigation revisited the way WorkSafe pays agents and the effect this has on agent decisions.

459. Although the investigation identified less documentary evidence that the financial rewards and penalties continue to influence agent decisions, when compared with the 2016 investigation, it still found some evidence showing:

- agents' continued focus on terminating claims and maximising profit
- the influence of the rewards and penalties on agents' offers at conciliation
- potential claims manipulation by one agent, which appeared to delay weekly payments to maximise its rewards.

The financial rewards and penalties

460. WorkSafe pays agents for acting on its behalf in issuing WorkCover insurance, collecting employer premiums and managing claims. This includes an annual fee which covers the costs of agents' core functions, as well as financial rewards and penalties[43] tied to agents' performance against key measures.

461. WorkSafe states these measures aim to:

> Align agent performance with WorkSafe's goals of delivering improvements in return to work and service, while driving quality case management and ensuring the overall sustainability of the Scheme.

462. WorkSafe adjusts the measures each year, but they broadly fall within the categories of:

- return to work
- sustainability (ie the financial sustainability of the scheme)
- service/quality (ie the service provided to injured workers and the quality of agent decision making).[44]

463. Each measure includes a target base performance level the agents are required to meet. If an agent does not meet the target, WorkSafe may financially penalise them. Conversely, where an agent exceeds the target, WorkSafe may financially reward them. Some measures carry greater rewards and penalties than others.

Changes since the Ombudsman's 2016 investigation

464. The Ombudsman's 2016 investigation found the measures in place at the time rewarded agents for terminating workers' entitlements, without adequate incentives to encourage:

- good quality decision making
- long term sustainable return to work.

43 WorkSafe refers to these as the 'Annual Performance Adjustment' (APA) measures, but for the purposes of this report we have called them 'financial rewards and penalties'.

44 There are also 'variable' measures which WorkSafe may change from year to year.

465. The investigation found, for complex claims, the measures encouraged agents to focus on terminations to achieve the financial rewards and maximise their profit. This was evidenced by a strong emphasis on terminations in claim files and agent staff emails, examples of which included agent staff:

    - documenting 'termination strategies' in internal file notes on claims
    - referring to terminated claims that achieved a financial reward as 'winners' or 'wins'
    - referring to the importance of achieving the financial rewards and the amount of money the agent could make for terminating claims.

466. The investigation identified that in some cases, agents made unreasonable decisions to achieve financial rewards. There was also evidence that agent staff manipulated, or considered manipulating, claims to achieve a financial reward or avoid a penalty.

467. Since 2016, WorkSafe has made a number of changes to the measures, including:

    - reducing the rewards and penalties for terminating claims
    - increasing the rewards and penalties for quality decisions
    - introducing a long term return to work measure, which rewards agents for getting workers back to work after being incapacitated for more than six months but less than two years
    - changing the scope of the existing return to work measure[45] so agents are only rewarded for claims where the worker returned to work and stayed at work for a minimum amount of time.

468. WorkSafe now publishes information about the financial reward and penalty measures in its Annual Report each year.

469. WorkSafe also developed training for agent staff which is updated and delivered annually. The training covers the intent behind the measures, their relationship to good administrative decision making and 'how this translates into daily decision making on workers' entitlements'.

45 This measure rewards agents for getting workers back to work within six months.

2017-18 financial reward and penalty measures

470. The financial reward and penalty measures for 2017-18 relevant to this investigation are outlined below.[46]

Table 1: 2017-18 financial reward and penalty measures

Measure	What does it assess?	Base performance level
Return to work measures		
26-week return to work measure	The proportion of claims where the worker returned to work* within six months and stayed at work for at least three weeks.	Mental injury claims: 53% Physical injury claims: 80%
104-week return to work measure	The proportion of claims where the worker returned to work** within two years (where they had not returned within six months).	35%
52-week weekly payments measure	The proportion of claims where the worker's weekly payments exceeded 52 weeks (one year).	10%
Mobile case management measure	The number of cases where an agent used 'mobile case management', which involves face-to-face engagement with any of the relevant parties involved in the claim (eg the worker or their treating doctor).	Different performance targets based on each agent's market share.
Sustainability measures		
134-week weekly payments measure	The proportion of claims where the worker's weekly payments exceeded 134 weeks (two and a half years).	2%
'Long tail' claims management measure	Agents' reduction of the number of claims where the worker was injured between 1985 and 2012 and was still receiving weekly payments.	Different performance targets based on injury year and claim type^.
Treatment measure	Whether agents paid for the right treatment at the right time on the right claims at a reasonable cost.	Target based on growth in expenses across different types of medical treatment, which carry different weightings.
Sustainability measures		
Injured worker service measure	The outcomes of a survey of injured workers' satisfaction with agent service delivery.	81%
Quality decision measure^^	The outcomes of WorkSafe audits of the quality of agent decisions regarding initial eligibility, medical and related expenses and weekly payments terminations.	85%

* Includes workers who return to work part-time.
** Includes workers who return to work part-time.
^ For example, the target for primary mental injury claims where the worker was injured between July 1985 and June 1993 is for agents to reduce the number of these claims by 5 per cent.
^^ This is further discussed on page 156.

46 Measures relating to impairment benefits claims, premium collection and processing sustainability have not been included.

471. In Table 1 the 'return to work measures' and 'weekly payments measures' only include claims where a worker received more than 10 days of weekly payments. The 'base performance level' figures in Table 1 have been rounded to the nearest whole number.

472. The 2018-19 measures remained mostly the same, but WorkSafe removed:

- the 52-week weekly payments measure, further reducing the rewards available to agents to terminate claims
- the quality decision measure, instead making this a 'minimum compliance standard' in WorkSafe's contracts with the agents, which is subject to sanctions if the minimum requirements are not met.[47]

Are the financial rewards and penalties still influencing agent decisions?

473. In most of the claim files reviewed, the investigation found limited or no references to the financial reward and penalty measures. This differed from the claim files reviewed during the 2016 investigation, which included documented 'termination strategies' and references to the dates financial reward and penalty measures applied to a claim.

474. Like the 2016 investigation, this investigation reviewed a sample of agent staff emails. A review of these also provided limited overt evidence of the financial rewards and penalties influencing agent decisions.

475. However, a former agent employee interviewed during this investigation said that after the Ombudsman's 2016 investigation, agent staff were told to be 'careful' about what they wrote in emails. They said:

> The terminology used in emails would be very carefully considered. So, for example, the word 'termination' would almost never be used, for fear that somehow somebody would be looking for that … Records that were kept on claims, would not be complete records. Emails sent about claims would not necessarily be complete. …
>
> It was a very frequent discussion within the office about 'well, you can't put that in email, because somebody might see it'.

476. The former agent employee said staff were instructed to refer to 'terminations' as 'entitlement reviews'.

477. A CGU email showed CGU staff were also told:

> Ombudsman
>
> There is another review expected … just a reminder to be careful of what you put in writing as last time the … [Ombudsman] got access to emails sent. The message is write as if the worker was reading it.
>
> Management understands that of course we discuss things like entitlement reviews but it's all in the wording.

478. In reality, the former agent employee said agents 'absolutely' remained focussed on managing liabilities. They said they thought it was 'incredibly disappointing' to see 'a huge amount of resources' focussed on the financial rewards and penalties, rather than claims management. They further said:

> [A]t each and every agent that I've worked at there is a very strong focus on the … [financial reward and penalty] measures. They are discussed every day. It's an incredibly strong focus of case management in WorkSafe agents … Claim strategies to influence an outcome is part of daily work.

47 This is further discussed on page 157.

479. The former agent employee said agents put 'very little effort' into helping someone and 'doing the best to help them recover and get back into work'. They said instead:

> [T]he attention to profitability is incredibly high and you know profitability means achieving the best possible outcome on the WorkSafe … [financial rewards and penalties] and retaining the most … clients … Genuinely helping someone is the least of their concerns.

480. In response to the draft report, WorkSafe said it was 'unable to agree with this comment on the basis that performance incentives and resources are underpinned by a focus on the provision of assistance to workers to recover and return to work'.

481. Conciliation Officer D also said at interview that workers compensation is 'a very difficult area' which is 'financially driven'. They described it as a 'huge bureaucracy of a multibillion-dollar industry on an annual basis' and said:

> [A]lthough I don't agree … I understand the reasoning behind the remuneration process. These five companies are all private companies; they have shareholders and they have people they have to be responsible to and the maximisation of profits is their primary aim. Their secondary aim of course is fair and just compensation to injured workers in the state of Victoria, which sounds really easy but it's an extremely complex process.

These five companies are all private companies … and the maximisation of profits is their primary aim. Their secondary aim of course is fair and just compensation to injured workers in the state of Victoria.

– Conciliation Officer

482. Although the investigation identified limited documentary evidence that the financial rewards and penalties continue to influence agent decisions, compared with the 2016 investigation, it still found some evidence showing:

- agents' continued focus on terminating claims and maximising profit
- the influence of the rewards and penalties on agents' offers at conciliation.

Focus on terminations and maximising profit

483. Agent emails showed that since 2016, agents have on some occasions continued to refer to claims which had achieved a positive result for a financial reward and penalty measure as 'wins' or 'winners'. For example, one EML email referred to claims which needed to be reviewed 'URGENTLY' to determine a 'strategy for wins or losses'.

484. An Allianz email also referred to claims which had achieved a positive result as 'wins'. In response to the draft report, Allianz said:

> Allianz regrets the terminology used in the email referenced, and actions have been taken to ensure this terminology will not be repeated.
>
> … Our aim is to see all workers under our care obtain appropriate treatments and support throughout their recovery.

485. The investigation also identified examples of agents referring to the amount of money the business could make from the financial reward and penalty measures. An EML email said that once the performance target for the 26-week return to work measure had been met 'every claim thereafter is worth $54,285.00 to the business'. The email also said that the measure was worth $684,000 and had a 'downside' of $456,000 (ie the maximum penalty).

486. Another EML email showed it held a competition where staff were quizzed on the maximum amount of money EML could make from the 52-week weekly payment measure. The staff members who responded the quickest received free double passes to an AFL football game. EML told staff its performance against the measure was 'currently on track', but said 'we cannot take our foot off the accelerator as Maximum Reward for this measure is currently worth $687,000!'.

487. In response to the draft report, EML said:

> EML supports families via the Western Bulldogs' Community Foundation, which runs the free Sons of the West and Daughters of the West programs to improve the physical and mental health of people living and working in the west and give them a better sense of social connection.
>
> You have made comment in your Draft Report … concerning football tickets. These general seating tickets were awarded to staff who had undertaken volunteering in that program as a way of saying thank you for giving up their personal time for those communities. We feel that this context is important to highlight and acknowledge, and that the logical fallacy of identifying one – or a handful of questions casts an unfair light on what is a positive aspect of our corporate culture.

488. However, the email offering the tickets was sent to 'ALL EML MELBOURNE', suggesting the tickets were made available to all staff, not just those who had volunteered.

489. EML also highlighted that the tickets were the 'cheapest seats at the ground' and that it had 'provided other similar email engagement campaigns allocating tickets to staff'. EML outlined a few examples, which included emails where staff were quizzed about:

- EML's values
- key characteristics of communication 'that can really make a difference in a worker's experience with us'
- EML's Injured Worker Survey score.

490. In a different email, an EML Case Manager said 'here is another win' to a Return to Work Specialist, referring to a return to work outcome achieved on a claim. In response, the Return to Work Specialist said:

From: [redacted]
Sent: Tuesday, 10 April 2018 2:15 PM
To: [redacted]
Cc: [redacted]
Subject: RE: 26WK B@W Home Stretch

Brilliant!! Handy 75K made today, no biggie :D

[redacted] | Return to Work Specialist
EML
Level 6, 385 Bourke Street Melbourne, Victoria 3000
P 03 [redacted]
F 03 [redacted]
E [redacted]
W eml.com.au

491. Further emails were then exchanged as follows:

From: [redacted]
Sent: Tuesday, 10 April 2018 2:19 PM
To: [redacted]
Cc: [redacted]
Subject: RE: 26WK B@W Home Stretch

DO I get a portion of that?
Haha

From: [redacted]
Sent: Tuesday, 10 April 2018 2:22 PM
To: [redacted]
Cc: [redacted]
Subject: RE: 26WK B@W Home Stretch

Yep, it's been deposited into your offshore Cayman Island account… [Worksafe, just joking if you are auditing emails, please don't put me in the 2022 ombudsman report]

[redacted] | Return to Work Specialist
EML
Level 6, 385 Bourke Street Melbourne, Victoria 3000
P 03 [redacted]
F 03 [redacted]
E [redacted]
W eml.com.au

492. The sample of emails also showed agents' focus on terminating claims. For example, a Gallagher Bassett Technical Manager sent an email to a Team Manager congratulating a Senior Case Manager (also copied into the email) for terminating a claim. The email said:

From: [redacted]
Sent: Tuesday, 1 May 2018 8:51 AM
To: [redacted]
Cc: [redacted]
Subject: [redacted]

Hey guys,

This claim has had a 130 week termi issued today – Well done [redacted]

[redacted]

[redacted] great work to [redacted] another termi on time! ☺

[redacted] | Technical Manager | Gallagher Bassett Services Pty Ltd
Locked Bag 3570, GPO Melbourne VIC 3001
P: [redacted]
E: [redacted] | **W:** www.gallagherbassett.com.au

493. In response to the draft report, Gallagher Bassett said:

> The selective interpretation of an email to support a conclusion of a "focus on terminating claims" … without inquiring further to ascertain the context of the email, is disappointing. Had an inquiry been made, the investigator will have ascertained that the email is a celebration of a claim action that was made on time. The context is that Gallagher Bassett was, in the first half of 2018 (and still is), subject to formal WorkSafe warning regarding its systems that ensure 130 week entitlement assessments and decisions are made in accordance with legislation. The fact that the decision comprised a termination of entitlement is irrelevant. It was the completion of the assessment on time that was the point of the email.

494. An email from a CGU manager referred to weekly 'entitlement review' targets for staff and said they would be 'checking in' each week to confirm whether the target was met. The listed targets differed depending on the type of claims staff were managing. For example, Case Managers responsible for long term claims were required to review three claims each week and issue four terminations per month. The email also provided staff tips on 'where to look' for claims that could potentially be terminated.

495. In response to the draft report, CGU said:

> The full context of that strategy is that CGU's rate of termination comparative to the scheme is much lower than others, and in fact is the lowest of all agents. To better understand this particular statistical nuance, we developed a strategy whereby all long-term claims were to be systematically reviewed over a defined time period. Targets were set for the number of reviews to be completed on a weekly basis.
>
> Termination targets do not exist at CGU, and do not form part of performance discussions. What does exist is a regular review of claims to ensure appropriate entitlements for injured workers.
>
> Staff were advised that the outcomes of their reviews should be determined as either:
>
> - Maintain;
> - Vary; or
> - Termination of entitlements, in accordance with the legislation.
>
> The email also references a guide given to staff about the rate of termination. This guide was to provide an insight into the rate of termination to ensure we were meeting the reporting requirements under the scheme if we were to bring our termination rate up to scheme average.
>
> In relation to the identified email, it outlines that the goal is to assist the injured worker's return to work and further states that if the injured worker is entitled they will continue to be entitled, however our role is to conduct a review to ensure that entitlement still exists.

496. The former agent employee interviewed during this investigation said the agent they worked for included termination targets as part of staff performance reviews. They said:

> [W]hen that was introduced I raised with my manager that I don't feel that that's what we should be doing, this is not the way that we should work. The feedback that I got was well … [the agent's] termination numbers are too low and we need to improve them and this is the way that we're going to do it.

497. In response to the draft report, WorkSafe said it 'is not aware of "termination targets" being in performance plans for agent staff'.

Influence of rewards and penalties on offers at conciliation

498. Witnesses interviewed during the investigation gave evidence that the financial rewards and penalties influence agents' offers to resolve disputes at conciliation.

499. Conciliation Officer B said:

> [W]e're still getting agents saying to us 'we can't offer more than two weeks'. And they've worked that out based on nothing but their rewards. Because if they weren't basing it on rewards, they could offer more than two weeks … I've had workers say 'look, give us another 10 weeks and I'll go away', and they won't do it.
> …
>
> They ring back to the office, the … [Dispute Resolution Officers], and then they say 'we can't offer more than two weeks'. And when you ask them why, they're very cagey. They don't say 'because our medical evidence suggests that she has a work capacity'. They don't go near there. They just get very cagey and … say 'well that's all we're prepared to offer'. And that's all you get out of them.

500. Conciliation Officer A said there was still a 'culture' within the agents of sometimes 'putting the financial benefits of decisions before the merits of an actual decision'. They said this was 'still particularly relevant at the 130-week decision mark' and that Conciliation Officers still had difficulty resolving disputes about these decisions.

501. Conciliation Officer F said the financial reward and penalty measures gave agents 'no flexibility to move or to make offers' at conciliation and that:

> They'll say 'that's a measure that we can't go over' or 'this is the 13 week[s]' or 'this is the critical thing we can't make an offer on'. It restricts the genuine conciliation process.

502. The former agent employee interviewed during the investigation also said that the financial reward and penalty measures still influenced agents' offers at conciliation:

> [T]here would be conversations about what's the next measurement date for that claim and can we make a limited offer that would achieve … [the agent's] goals too … It's as simple as the person who was attending conciliation would come over to the technical specialist and say 'what do you need on this claim for it to be a win?', 'well I need it to be this many weeks', 'okay great, I'll make an offer'.

503. The sample of agent emails obtained also provided evidence of this, two examples of which are outlined below.

Example 1

Allianz emails referred to a 130-week termination disputed at conciliation, which the Conciliation Officer requested be withdrawn because Allianz did not have an arguable case. An Allianz Dispute Resolution Officer sent an email to the Conciliation Officer stating they disagreed with the Conciliation Officer's view and that Allianz would not vary or withdraw the decision. The email was copied to an Allianz Technical Manager, who responded 'you're probably aware we have no time on derived and so this needs to stick'. This appears to be a reference to the number of 'derived days' the worker had received weekly payments for, and suggests Allianz wanted to maintain the termination because it would negatively impact the 134-week weekly payment measure if it was withdrawn.

In response to the draft report, Allianz said:

> Allianz acknowledges the reference to the derived week count in this email exchange. We confirm we do not make decisions based on this measure and all evidence is examined as part of the conciliation process.

Example 2

CGU emails referred to a dispute resolved at conciliation by CGU agreeing to provide the worker weekly payments for about three months. A CGU Technical Advisor raised concerns that the claims team was not consulted prior to agreeing to this offer, because the Dispute Resolution Officer believed the relevant measures had already been 'breached'. The Technical Advisor said this was incorrect; the worker in this case had received about 45 weeks of weekly payments and the claim was eligible for a reward under the 52-week weekly payments measure. The Technical Advisor said the claim had been 'predicted as a potential save' and because of the agreement reached at conciliation, the claim would now 'breach' 52 weeks. A manager responded stating this fell short of their expectations, which was that consultation would occur prior to agreeing to any outcome at conciliation. The Technical Advisor responded stating:

From: [redacted]
To:
Cc:
Date: Thu, 29 Mar 2018 07:21:43 +1100
Attachments: image001.png (10.2 kB)

Hi [redacted]

Thanks for following this up

As discussed, I think this was just an oversight by the DRO as 9/10 there is consultation with the claims teams to discuss what can be offered to settle any dispute without breaching any measures

Kind regards

504. CGU said in response to the draft report:

> The example implies that CGU allowed financial targets to adversely impact offers at Conciliation. CGU disagrees with these findings and submits the emails have been taken out of context. CGU has in place a standard procedure whereby Dispute Resolution Officers are required to first discuss any proposed offers with the claims team responsible for the long-term management of the worker's claim.
>
> Dispute Resolution Officers do not have oversight of the worker's claim and may not have an in-depth understanding of the intricacies and nuances of the worker's individual circumstances.
>
> These consultations are intended to discuss the worker's condition and review any additional information that may not have been considered prior to attending at the Conciliation Conference and/or prior to any offer being made. This ensures that Dispute Resolution Officers make reasonable and appropriate offers.
>
> CGU acknowledges the wording of the emails suggest performance measures were a driver behind consultations taking place but submit this is not correct.

505. In response to the draft report, WorkSafe said it made changes in 2018-19 to the only remaining financial reward and penalty measure relating to terminations and introduced a 'second measurement point' to mitigate this issue.

Manipulation of claims to maximise financial rewards

506. This investigation also looked at whether since 2016, any of the agents have manipulated claims to maximise the financial rewards and avoid penalties.

507. The Ombudsman's 2016 report noted a number of examples between 2002 and 2016 of claim manipulations (or attempted manipulations), which included agent staff:

- recording false and inaccurate information on claims
- falsifying records
- paying more or less compensation on claims so that they would be eligible for financial rewards
- delaying the payment of compensation.

508. WorkSafe identified most of the manipulations through audits or monitoring of agent performance against the financial reward and penalty measures.

509. WorkSafe told the current investigation that it had not identified any instances of claims manipulation in 2017-18. However, it provided information about suspected manipulation it identified in August 2018 from its annual end of year verification process for the 2017-18 financial reward and penalty measures. This included a review of the 52-week weekly payments measure, which focussed on delays in weekly compensation payments due in June and July 2018.

510. From this review, WorkSafe identified a large number of claims where one of the agents, EML, had delayed making weekly compensation payments. WorkSafe also identified that EML had applied a payment 'block' to many of these claims in its payment system, which was not removed until just before the start of the new financial year. This gave the appearance that weekly payments on the claims stopped before 52 weeks, which would have improved EML's performance for the 52-week weekly payments measure.

511. WorkSafe raised concerns with EML about this practice and sought further information about the delayed payments. In response, EML maintained that there was no 'evidence of an orchestrated attempt' to manipulate the 52-week weekly payments measure. Instead, it said the 'block' was applied to stop staff making payments in error, which had been a significant problem at EML.

512. Based on EML's responses, WorkSafe said it was satisfied 'the concerns raised were understood and would be addressed appropriately'. WorkSafe said it also adjusted EML's performance outcome for the 52-week weekly payment measure by removing the claims to which the 'block' had been applied inappropriately through the verification process.

513. Although WorkSafe ultimately did not substantiate claims manipulation based on its review of the matter, this investigation received further information, including internal staff emails, which raised questions about EML's responses to WorkSafe about this matter and the reason the payment block was implemented.

514. The investigation provided this further information to WorkSafe for review in July 2019 and it subsequently decided to conduct a further investigation into the matter. WorkSafe said:

> These alleged matters concerning EML are taken very seriously by WorkSafe, given the potential impact on the delivery of benefits to injured workers, and the possible work practices involved. However, WorkSafe also wishes to pursue a further investigation before determining whether additional action is warranted or not. We are also required by … [WorkSafe's contract with the agents] to give EML procedural fairness and the opportunity to make formal representations before determining whether to take certain types of formal action under the … [contract].

515. WorkSafe requested EML provide a range of documentation and provide 'written representations' in response to a number of questions. Upon receiving the requested information from EML, which included details of an internal investigation it had undertaken, WorkSafe told EML it was 'not satisfied as to the rigour and independence of EML's investigation'. WorkSafe requested EML cease any further internal action and engaged an external legal representative to conduct an independent investigation of the matter. This investigation had not been finalised at the time this report was prepared.

516. In response to the draft report, EML said:

> EML takes any allegations concerning claims manipulation very seriously and we are well advanced in the process of investigating the matters alleged fully and completely. This includes forensic internal investigation by our risk and fraud consultants and comprehensive external forensic reviews of emails.
>
> We note with concern [the] paragraphs … of your Report regarding the use of the WorkSafe … [payment] System claims block as a management control which we commenced investigating internally in mid-August 2019 in response to the WorkSafe request. EML provided the documents and responses to the best of our ability in the timeframe designated by WorkSafe. To satisfy our own internal processes however, we continue to undertake the investigation internally ourselves. We anticipate that this will be finalised shortly, and the report submitted to our Board directly. We advise that the claims block was used during a period of change and the 52-week blocks were removed prior to 30 June 2018 at the request of WorkSafe … EML received no financial reward whatsoever for the 52-week measure for the year ending 30 June 2018.

Part Three:

WorkSafe's oversight

517. This investigation considered the effectiveness of WorkSafe's oversight of the scheme and whether this has improved since the Ombudsman's 2016 investigation.

518. The investigation focussed on WorkSafe's oversight of:

- agents' management of claims
- the IME system.

519. The investigation also examined the outcomes of reviews WorkSafe commissioned to identify opportunities for improving the management of the scheme.

Oversight of agents' management of claims

520. Although WorkSafe delegates the management of claims to the agents, the WIRC Act states:

- WorkSafe is directly liable to an injured worker to pay compensation in accordance with the Act (section 70).
- A function or power performed or exercised by an agent is taken to have been performed or exercised by WorkSafe (section 500(4)).
- Agents must act in accordance with the terms and conditions of their contract and any written directions by WorkSafe (section 501(2)). WorkSafe may terminate an agent's appointment if they fail to comply with any of these (section 501(4)).

521. This means WorkSafe has a role in overseeing agents' management of claims to ensure agents compensate injured workers appropriately.

522. The investigation re-examined the ways in which WorkSafe does this, which include:

- auditing the quality of agent decisions
- handling complaints about agents
- surveying injured workers about agent service delivery
- undertaking targeted 'health checks' of claims management issues.

523. WorkSafe has the power to direct an agent where it identifies an agent's decision 'wrongfully disentitled' a worker.[48] This may be prompted by an audit or complaint, for example.

524. WorkSafe said agents maintain authority on 'the vast majority of decisions', so it only escalates matters where an agent has 'clearly incorrectly disentitled a worker' and the agent is unwilling to alter its decision.

Quality decision audits

525. WorkSafe audits a sample of agents' claim decisions every year to 'ensure the quality of decision making and that injured workers receive their legal entitlement'. The audits aim to ensure that decisions are:

- made based on the merits of the claim
- supported by 'reasonable and appropriate' evidence
- made and communicated in a timely manner.

526. WorkSafe scores each decision as a 'pass' or 'fail' based on whether:

- the decision and ground(s) were supported by 'reasons' that were based on 'reasonable and appropriate evidence at the time of the decision'
- the decision was made in accordance with the WIRC Act.

48 WorkSafe said it may reach the conclusion that a worker has been 'wrongfully disentitled' where 'it is evident that the decision was not based on/supported by relevant facts and relevant legislative provisions and the worker has been disadvantaged by the decision'.

527. WorkSafe also specifies 'work practices' agents must follow, which WorkSafe said 'assist auditors when assessing compliance'. These include that agents must:

- take all reasonable steps to obtain and 'fairly and properly consider all relevant information prior to making a decision'
- provide reasons if any relevant evidence or information is 'disregarded or discounted'
- ensure that 'all relevant matters are considered'
- demonstrate that the evidence relied upon is 'appropriate given the circumstances of the claim' and that the evidence has been 'appropriately assessed to make a sound and fair decision'.

Changes since the Ombudsman's 2016 investigation

528. Since the Ombudsman's 2016 investigation, WorkSafe has made several changes to the audit process, including:

- expanding the types of decisions audited
- increasing the sample size from less than 700 in 2014-15 to over 1,700 in 2017-18
- increasing the frequency of the audits from twice yearly to monthly
- increasing the required pass rate from 80 per cent in 2014-15 to 85 per cent in 2017-18.[49]

529. WorkSafe financially penalises an agent if too many decisions fail the audits. Up until the end of 2017-18, agents could also get a financial reward if the number of decisions which passed the audits exceeded the minimum requirement. This occurred through the quality decision financial reward and penalty measure.[50]

530. This changed from July 2018 onwards, when WorkSafe introduced 'quality decision making' as a 'minimum compliance standard' in its contract with the agents. WorkSafe said it:

> [B]elieves this establishes quality decision making as a core and fundamental contractual requirement across all entitlement decisions. Rather than an agent achieving a positive incentive under the … [financial reward and penalty measure] for meeting the required standard they instead incur a remuneration reduction for failing to achieve minimum standards.

49 WorkSafe further increased this to 90 per cent in 2018-19.

50 The financial reward and penalty measures are further discussed on page 142.

2017-18 audits

531. In 2017-18, WorkSafe audited a total of 1,760 agent decisions, which included 440 decisions (88 per agent) in each of the following categories in the diagram below.

532. The investigation focused on WorkSafe's audits of weekly payment terminations, which comprised half of the audits WorkSafe conducted in 2017-18. Worksafe gave 98.5 per cent of the 880 audited decisions a pass, failing only 13 decisions (1.5 per cent).

533. To gauge how effectively WorkSafe oversees agent decisions through these audits, the investigation:

- examined the outcomes of the 880 weekly payments terminations WorkSafe audited in 2017-18
- sought further information from WorkSafe about 49 of the audit outcomes
- reviewed the claim files of 20 of the decisions audited.

534. Although the investigation only conducted in-depth reviews of a small proportion of the total claim decisions audited, these indicated some potentially concerning trends.

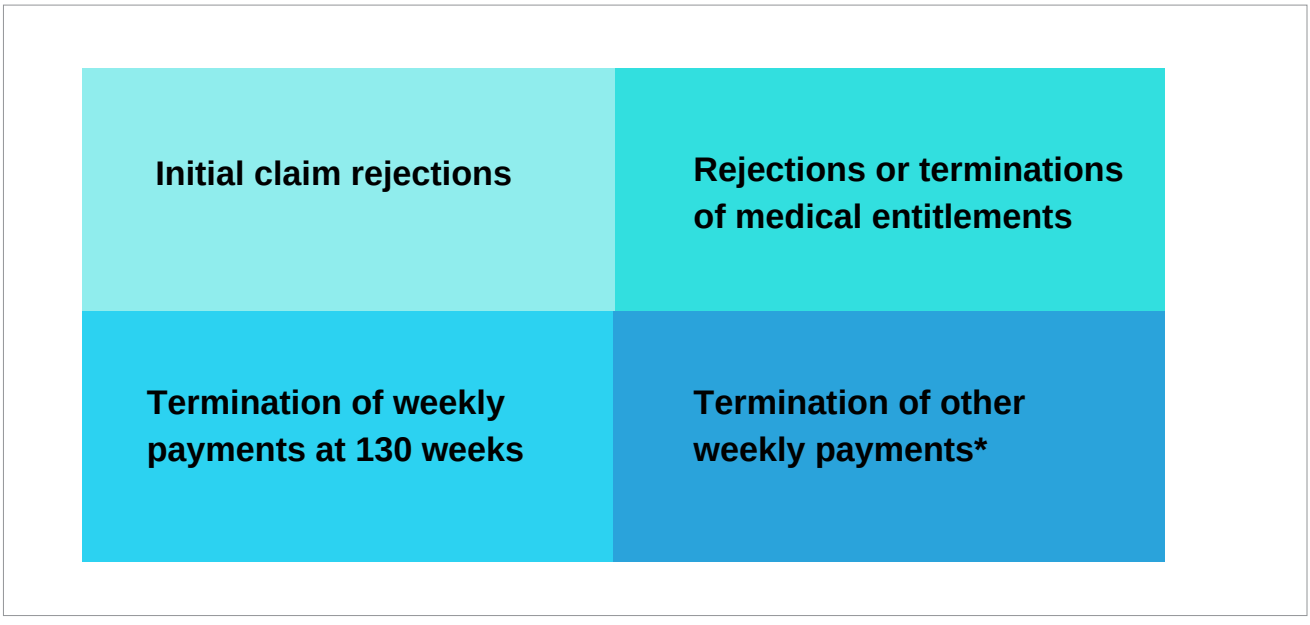
Questionable passes

535. WorkSafe requires agents to make 'sustainable' decisions, which are those that would have a reasonable prospect of success at court. However, the investigation identified that WorkSafe gave some agent decisions a 'pass', despite identifying issues regarding the strength of the decision or evidence relied upon by the agent.

536. In response to the draft report, WorkSafe said:

> We confirm the audits are conducted based on the information available at a point in time and findings are made within the parameters of the documented business rules (some of which are listed in … the draft Report) and audit protocols. In the context of the complex matters examined in the Draft Report, medical conditions may change over time and/or further information may become available resulting in decisions being varied or changed.

Types of decisions subject to WorkSafe's audits in 2017-18



*This includes terminations because a worker's injury is no longer considered work-related or return to work non-compliance terminations, for example.

537. The case study below is one example, where WorkSafe passed a Gallagher Bassett decision to terminate a worker's weekly payments, despite concerns about a 'perception of opinion shopping'.

Case study 37 – Termination passed audit despite 'perception of opinion shopping'

Ada was working at a café when in 2016, she injured her shoulder. She made a WorkCover claim which was accepted by her employer's agent, Gallagher Bassett. Ada returned to work part-time on modified duties and had shoulder surgery, funded by Gallagher Bassett.

In late 2017, Gallagher Bassett terminated Ada's entitlements after an IME reported that her condition was never related to her employment. This was despite Gallagher Bassett previously accepting Ada's injury was work-related, and two earlier IMEs confirming Ada's work had contributed to her injury. In its notice to Ada, Gallagher Bassett made no reference to the two earlier IME opinions and did not explain why it gave more weight to the new IME's opinion than the previous opinions.

Ada requested conciliation. Upon reviewing the decision, Gallagher Bassett's Dispute Resolution Officer identified concerns about the decision. The officer said although Gallagher Bassett 'may be able to argue' it was 'entitled' to rely on whichever IME report it liked, the 'problem' with the decision was that Gallagher Bassett paid for Ada to undergo surgery in early 2017. The officer also noted Ada was examined by another IME for her impairment benefit claim,[51] who concluded her presentation was consistent with the workplace incident and failed surgery.

WorkSafe's audit also identified concerns, but still passed the decision. The audit report said:

> It is not clear from the notice why the opinion of … [the new IME] was considered to have more weight than other opinions previously obtained. Given IMEs were previously obtained from different practitioners, this gives the perception of opinion shopping particularly as the latest IME has been used to terminate the claim.

When the investigation asked WorkSafe to clarify why the decision passed the audit, it said that the new IME had provided 'a valid opinion that the agent used to make their decision'. WorkSafe also noted that Gallagher Bassett provided the new IME the reports of the two previous IMEs to inform their assessment.

Prior to conciliation, Gallagher Bassett withdrew the termination and reinstated Ada's entitlements, two months after they were terminated.

51 An injured worker may make an 'impairment benefit' claim for a once-off lump sum payment, where they have a permanent impairment as a result of their injury.

538. In another case, Gallagher Bassett terminated a worker's weekly payments because she failed to comply with her return to work obligations. The decision passed WorkSafe's audit, despite concerns about the 'adversarial pathway' Gallagher Bassett took.

Case study 38 – Termination passed audit despite concerns about 'adversarial pathway'

Rebecca was working as a police officer when in 2014 she sustained a mental injury from workplace bullying and harassment. She made a WorkCover claim which was accepted by her employer's agent, Gallagher Bassett.

In mid-2017, Gallagher Bassett referred Rebecca to occupational rehabilitation after an IME concluded she had a capacity for part-time alternative duties. Rebecca gave Gallagher Bassett a letter from her psychologist stating she was too unwell to participate. Her psychologist said that her 'forced participation' in occupational rehabilitation was 'highly likely' to exacerbate her condition and he 'strongly recommended' she be excused on medical grounds from participating. He said '[f]ailure to do so could be considered both negligent and harmful'.

Rebecca did not attend the appointments and provided further letters from her treating psychologist and GP supporting her incapacity. Despite these, Gallagher Bassett found Rebecca had not reasonably complied with her return to work obligations and issued her a return to work non-compliance warning notice.* This was followed by a suspension and then termination of her weekly payments. Rebecca requested conciliation, but the dispute could not be resolved. Rebecca did not dispute the matter further at court. WorkSafe's audit highlighted issues regarding Gallagher Bassett's decision. It said:

- Rather than continuing to forward new appointment times to Rebecca which her treating doctors advised were not appropriate, further case management could have been undertaken to attempt to work with all parties rather than proceed down an 'adversarial pathway'.
- The IME opinion was six months old at the time Gallagher Bassett issued the termination. Given Rebecca, her GP and treating psychologist considered occupational rehabilitation services would be detrimental and her condition would/was deteriorating, Gallagher Bassett should have requested an updated IME opinion.

Despite these concerns, WorkSafe still passed the decision. When the investigation asked WorkSafe to clarify why the decision passed, WorkSafe said that while Rebecca's doctors believed she was unfit to participate in occupational rehabilitation, this was contradicted by evidence that Rebecca was 'running her own business from home'. It appears WorkSafe was referring to catalogue sales Rebecca undertook from home two hours per week.

WorkSafe said it formed the view at the time of the audit that Gallagher Bassett had 'reasonable medical and circumstantial evidence' to support their contention that Rebecca could have participated in occupational rehabilitation. However, WorkSafe said it had further reviewed the decision during this investigation and based on its 'expectations in the current environment', concluded the decision was not appropriate as it was reasonable for Rebecca to follow her doctors' advice. As a result, Gallagher Bassett withdrew the termination notice, as well as the preceding warning and suspension notices, more than a year after they were issued.**

* Further information about return to work non-compliance notices can be found on page 84.
** WorkSafe said that this did not result in Rebecca's entitlements being reinstated, because she was receiving a work pension and operating her own business, and her combined earnings exceeded any weekly payment entitlement.

539. The case study below is another example identified by the investigation, where Gallagher Bassett terminated a worker's weekly payments based on a contradictory IME opinion. The decision passed WorkSafe's audit, despite identifying that Gallagher Bassett should have clarified the IME's opinion.

Case study 39 – Termination passed audit despite 'conflicting opinions' from IME

Julie was employed as an airport worker when in late 2014, she injured her back and shoulder. She made a WorkCover claim, which was accepted by her employer's agent, Gallagher Bassett. She returned to work on light duties but later ceased after undergoing surgery.

In late 2017, Gallagher Bassett terminated Julie's weekly payments based on an occupational physician IME's opinion. The IME said Julie had some limited work capacity, despite stating two months earlier that she had no capacity for any work due to her:

> [S]evere pain, loss of capacity for prolonged sitting and standing, the effect of multiple psychotropic medications that she was on, as well as severe sleep disturbance, which renders her cognitive function suboptimal.

The IME did not explain why their opinion about Julie's work capacity changed from the previous examination, instead stating there had been no significant change in her condition. Julie requested conciliation, highlighting the 'conflicting opinions' from the IME. She stated:

> [The IME] noted there had been no significant change [since the first examination] only that my pain had increased, and my medication … [had also] increased. However now that I have increased pain and increased medication he now believes I have a capacity to work??

The decision passed WorkSafe's audit, but WorkSafe noted that Gallagher Bassett should have requested a supplementary report from the IME to clarify the change in opinion. When the investigation asked WorkSafe why the decision passed the audit, WorkSafe acknowledged the IME 'gave no clear reason why his opinion about the worker's capacity changed from the first examination in June to his examination in August'. WorkSafe said it would have been 'preferable' for Gallagher Bassett to clarify this, however, the IME 'did provide his expert opinion that the worker had a current capacity'.

At conciliation, the dispute could not be resolved. Julie did not dispute the matter further at court and remains without entitlements.

In response to the draft report, WorkSafe said:

> WorkSafe maintains its previous position in relation to this case study that the Agent's decision was supported by appropriate evidence.
>
> We agree that the second opinion of … [the IME] about 10 weeks after the previous report did not include specific reasoning about the change in … [the IME's] position, and the opinion included some comments that there had not been a significant change in the worker's condition.
>
> However, the earlier opinion had already contemplated … [the IME's] view that the worker might regain a capacity for work within a further period of three to six months … It is also clear that … [the IME] had considered the previous opinion before providing the further opinion that the worker had a work capacity.

Continued on next page…

> The later opinion was clear in stating … '[Julie] is not fit for pre-injury duties, however, has a capacity for restricted duties of mainly office and administrative type … In my opinion … [Julie] has capacity for customer service representative, receptionist, accounts clerk, and sales representative roles.'

Although the IME said in their first report that Julie 'might' gain a capacity for 'suitable office and administrative-type duties' within three to six months, they said this was dependent upon 'improvement in her overall mental health and pain management, in view of reducing her reliance on opioids'. Given the IME said in the second report there had 'not been a significant change' in Julie's condition since the first examination, and Julie reported increased pain and medication, the investigation remains of the view that it was questionable for Gallagher Bassett to rely on this opinion to terminate Julie's weekly payments. As a result, the investigation maintains its view that the termination should not have passed WorkSafe's audit.

While Julie did not initiate legal action, the investigation questions the sustainability of the termination if it were to proceed to court, in light of the inconsistencies in the IME's opinions and Julie's 'rather complex clinical picture', as described by the IME.

As a result, the investigation raised further concerns with WorkSafe about this matter after it responded to the draft report and it agreed to undertake a further review of the sustainability of the decision. The outcome of this had not been reached at the time this report was finalised.

540. In another case, Allianz terminated a worker's entitlements without assessing her secondary mental injury. The decision passed WorkSafe's audit, despite acknowledging that Allianz's failure to have the worker examined by a psychiatrist IME may 'impact on the sustainability of the decision'.

Case study 40 – Termination passed audit despite agent's failure to consider mental injury

Christine was working at a factory when in late 2015, she injured her shoulder. She made a WorkCover claim, which was accepted by her employer's agent, Allianz.

In early 2018, Allianz terminated Christine's weekly payments on the basis she was no longer incapacitated for work. Allianz relied on a general surgeon IME's opinion that she had recovered from her shoulder injury, however, the IME noted that Christine reported having a 'mental breakdown' the preceding week and was going to suicide. The IME said they did not pursue this further because it was outside their area of expertise, but drew it to Allianz's attention on several occasions throughout their report. Although Allianz attempted to speak to Christine's GP about her mental state, it did not arrange for a psychiatrist IME to examine her.

The decision passed WorkSafe's audit, despite concerns that Allianz's failure to have a psychiatrist IME examine Christine may 'impact on the sustainability of the decision'. When the investigation asked WorkSafe to clarify why the decision passed the audit, it highlighted that at the time of the termination, Christine's GP had not recorded a psychiatric condition on any certificates of capacity and Allianz had not funded any psychiatric treatment. WorkSafe said that on this basis, it considered the decision was based on 'reasonable and available evidence'.

Continued on next page…

However, the IME's report indicated Christine's psychological state had only recently deteriorated, which may explain why it was not recorded on the previous certificate and she had not requested Allianz fund any treatment yet.

Christine requested conciliation regarding the termination, but the dispute could not be resolved. Christine lodged a second claim for the mental injury and Allianz then arranged for a psychiatrist IME to examine her. The IME diagnosed Christine with a mental injury which they said was related to her original shoulder injury. However, Allianz relied on clinical notes from Christine's GP to reject the claim. Allianz said Christine had no entitlement to compensation because her mental injury was caused 'wholly or predominantly' by her employer's withdrawal of her duties, which was 'reasonable management action'.*

Christine requested conciliation again, but the dispute could not be resolved. She disputed the termination of her original claim and rejection of her mental injury claim at court. The matter remained unresolved at the time the draft report was provided to WorkSafe. In response to the draft report, WorkSafe reiterated its view that the termination correctly passed the audit because it was supported by appropriate evidence at the time. However, WorkSafe said that following further review, it considered it was appropriate to accept liability for the claim. It said:

> This case study relates to a complex matter with several injuries and claims. This included a decision to terminate weekly payments and medical expenses for the worker's claimed … shoulder injury … and [a decision] to reject a claim for psychiatric injury.
>
> WorkSafe maintains that the decision to pass the previous audit was justified and that the Agent's original decisions in relation to the worker's claims were appropriate taking into account the evidence available at the time of the decisions.
>
> The matter has been the subject of ongoing Magistrates' Court litigation since the audit and further evidence and medical opinions have been obtained. The matter has not yet resolved …
>
> WorkSafe has determined that it would be appropriate to reconsider this decision and has communicated this to the Agent.

Although WorkSafe believed Allianz should accept further liability for Christine's claim, it did not intervene to ensure Christine's weekly payments were reinstated from the termination effective date nearly two years prior. Instead, WorkSafe told Allianz to only reinstate Christine's payments if the court dispute could not be resolved by agreement between the parties. Ultimately the claim was settled following an offer by Christine's lawyer, which included the reinstatement of Christine's weekly payments ongoing from October 2019 when she underwent surgery. WorkSafe told the investigation that it would have been 'inappropriate to intervene further in the legal Court process and the settlement outcome agreed between the parties and their legal representatives on both sides in a complex litigated matter'. The investigation does not accept this explanation given WorkSafe's intervention would have led to Christine receiving substantially more than she had settled for. The investigation expects WorkSafe will rectify this matter given its responsibility to ensure injured workers receive appropriate compensation.

* Refer to page 71 for further information about the rejection of mental injury claims on this ground.

Questionable decisions to change audit outcomes

541. Agents may dispute WorkSafe's audit findings through a review process if they can provide additional information supporting their decision. The review process consists of an initial 'peer review' by a WorkSafe 'subject matter expert', which can be escalated to a review panel and then an appeal panel for a final determination.

542. Of the 880 weekly payments terminations WorkSafe audited in 2017-18, it initially failed 37 decisions. In 33 of these cases, the agent requested a peer review, which resulted in WorkSafe reassessing 24 of these decisions (nearly three quarters) as passes.

543. In some of these cases, it was unclear why WorkSafe overturned the fail, as the issues WorkSafe initially identified through the audit had not been fully resolved or addressed.

544. One example is outlined below, where CGU terminated a worker's weekly payments based on an IME's opinion that the worker would regain a work capacity with continued treatment, despite also recommending the worker's treatment cease. The decision initially failed WorkSafe's audit because the evidence did not support the decision. WorkSafe reassessed the decision as a pass upon peer review, despite acknowledging the quality of the decision remained 'questionable'.

Case study 41 – Termination reassessed as passing audit, despite remaining 'questionable'

Alesandro was working at a food processing plant when in 2015 he injured his back. He made a WorkCover claim, which was accepted by his employer's agent, CGU.

In early 2018, CGU terminated Alesandro's weekly payments based on an IME's opinion. The IME said Alesandro could not return to work, but that he would regain a work capacity within six months with continued treatment. However, the IME also said Alesandro's treatment should cease as it was not improving his condition. The IME also initially said CGU's proposed job options were unsuitable for Alesandro, but later supported two as appropriate after CGU requested three supplementary reports from the IME to clarify their opinion.

Alesandro did not dispute the termination of his weekly payments. Shortly after this, CGU also terminated Alesandro's entitlements to physiotherapy and hydrotherapy. The weekly payments termination initially failed Worksafe's audit because the available evidence did not support the decision. WorkSafe said CGU had relied on 'weak medical information' and highlighted:

- It was not clear how Alesandro would develop a work capacity given he was expected to self-manage with no structured treatment program. This implied a 'lack of monitoring and measurable goals'.
- The IME indicated that work capacity was effectively dependent on continued treatment which was no longer an option.
- CGU had not demonstrated Alesandro had a work capacity and there was no confirmation that his incapacity would not be indefinite.

Continued on next page...

- Of four proposed job options, only one was not likely to require English training.
- Alesandro's potential ability for re-employment was 'slim' based on his limited previous work experience and transferrable skills. Alesandro had been working in the same job for more than 40 years after migrating to Australia and had completed less than two years of schooling.

CGU requested WorkSafe undertake a peer review. This led to WorkSafe passing the decision, despite acknowledging the decision remained 'questionable'. When the investigation asked WorkSafe to clarify this, it said the decision was passed because:

- Alesandro had previously been employed with numerous employers with his current level of English skills.
- The IME was 'definitive' in his opinion that Alesandro would have a capacity within six months as a result of continued treatment and identified two job options as suitable when Alesandro regained a capacity.

WorkSafe said it noted the 'sustainability risks' the audit identified, but that 'on the balance', the evidence was 'reasonable and appropriate to support the decision'. WorkSafe also highlighted that CGU arranged for the IME to re-examine Alesandro two months after the termination to check whether he had regained a capacity as expected. In their further report, the IME said based 'purely on the compensable physical injury', they considered Alesandro could return to work at least part-time.

However, the IME noted Alesandro displayed 'pain behaviour' which continued to contribute to his condition, suggesting an examination with a pain specialist IME may have been warranted. The IME also disagreed with the recommended job options in the same vocational assessment report they previously considered, because the roles Alesandro was physically capable of required 'much better English language skills than he possesses'. This contradicted the IME's earlier opinion, where they said two of the options were suitable.

In its response to the draft report, WorkSafe reiterated its view that the termination correctly passed the audit because it was supported by appropriate evidence at the time. However, WorkSafe said that following further review, it considered it was appropriate to accept liability for the claim. It said:

> We maintain our previous comments to your office that the decision to pass the audit in relation to this claim was supported by appropriate evidence at the time. The worker had been assessed by an IME as being able to develop a capacity for two suitable employment options, and re-training had been approved and offered to the worker to enable a return to work.
>
> WorkSafe has conducted a further review of the merits of the worker's claim taking into account the evidence obtained since the previous reviews. We have recently become aware that, while re-training was approved and an English assessment was arranged for the worker to attend, the ultimate outcome of the assessment was that further English courses were not suitable. As a result WorkSafe has determined that it is appropriate to accept further liability for weekly payments.

WorkSafe confirmed CGU had agreed to overturn the decision and reinstate Alesandro's entitlements from the effective date of the termination.

545. In another case outlined below, Gallagher Bassett terminated a worker's weekly payments for failing to comply with his return to work obligations. Gallagher Bassett relied on an IME's opinion that the worker could return to work, despite all three of the worker's treating doctors stating he could not return until he completed a pain management program. The decision initially failed WorkSafe's audit, but was reassessed as a pass upon peer review, despite WorkSafe acknowledging the decision would 'unlikely be sustained should it ultimately proceed before court'.

Case study 42 – Decision reassessed as passing audit, but would likely be overturned at court

Yusuf was working in a warehouse when in mid-2016 he injured his back. He made a WorkCover claim which was accepted by his employer's agent, Gallagher Bassett. Yusuf had surgery in late 2016 but his condition did not improve.

In late 2017, Gallagher Bassett suspended and then terminated Yusuf's weekly payments because he did not make reasonable efforts to return to work. Gallagher Bassett relied on an IME's opinion that Yusuf could return to work performing sedentary duties full-time. However, Yusuf followed the advice of his three treating doctors, who said he could not return until he completed a pain management program. Yusuf requested conciliation. Upon review, Gallagher Bassett identified concerns regarding the termination, noting that Yusuf would 'be seen to have complied' with his treating doctors' advice. Gallagher Bassett also noted the 'difficulty' was that Gallagher Bassett could have waited for Yusuf to complete the pain management program 'prior to going down this path'.

The termination initially failed WorkSafe's audit because the grounds used were not supported by the evidence available at the time. WorkSafe noted:

- While the IME supported Yusuf returning to work regardless of whether he had completed the pain management program, it was not unreasonable for him to follow the advice of his treating doctors, particularly when all three agreed a return to work before the program was premature.
- It was unclear why further support was not provided to Yusuf to enable him to complete the pain management program and then liaise with his treaters to try to get him back to work.

Gallagher Bassett requested WorkSafe undertake a peer review. This initially confirmed the fail, but WorkSafe later passed the decision based on legal advice. When the investigation asked WorkSafe about this outcome, it referred to the legal advice, which noted Yusuf's doctors had not responded to some of Gallagher Bassett's requests for information about his return to work. The legal advice said that 'in the face of multiple attempts' to engage Yusuf's treating doctors, Gallagher Bassett was 'forced' to rely on the IME's opinion. It said that as a result, Gallagher Bassett had 'reasonable and appropriate' evidence to support the decision, but it would not be maintained if the matter ultimately went to court.

At conciliation, the matter could not be resolved, so Yusuf took the matter to court. Gallagher Bassett obtained further legal advice which indicated that in the absence of any support from his treating doctors, the court would 'unlikely be persuaded that a return to work at all prior to the completion of the pain management course was reasonable in the circumstances'. The matter was ultimately settled by Gallagher Bassett agreeing to provide Yusuf weekly payments for just under a year.

Failure to reinstate worker entitlements following audit

546. Where an agent decision fails an audit, WorkSafe said it reviews the decision to determine if the worker has been 'wrongly disentitled'. It said it does not automatically change the agent's decision because:

> WorkSafe may decide that the correct decision has been made to reject or terminate a worker's entitlements, but the decision may fail [the] audit on the basis of the incorrect ground being relied upon or the notice period provided to a worker not meeting legislative requirements … WorkSafe would not consider a worker to be wrongfully disentitled in these circumstances.
>
> In addition, the wrongful disentitlement review also takes into account all available information at the time of the review (eg the information available to the agent at the time the decision was made and any further information obtained following the agent's decision), where[as] the … Audit criteria is specific to the information available and relied upon at the time of the decision.

547. Of the 13 weekly payment terminations which failed an audit in 2017-18, WorkSafe only concluded the worker had been 'wrongfully disentitled' in four cases.[52] This meant that in the remaining nine cases, WorkSafe did not require the agent to overturn its decision.[53]

548. In some of these cases, it was unclear why WorkSafe did not conclude the worker had been 'wrongfully disentitled' and require the agent to overturn its decision based on the issues identified during the audit. In the three case studies on the following pages, two workers were required to contest their matters at conciliation or court to regain their entitlements; the entitlements of one other worker were reinstated only after the investigation's intervention.

52 In two of these cases, WorkSafe concluded the worker had been wrongfully disentitled because the agent did not provide the worker the required notice. As such, these decisions were withdrawn but new terminations were issued.

53 However, in two of these cases, the agent voluntarily decided to withdraw its decision.

549. In the following case study below, Allianz terminated a worker's weekly payments on the basis that his incapacity was unlikely to continue indefinitely, despite an IME's uncertainty about when he could return to work. The decision failed WorkSafe's audit because it was not supported by 'reasonable and appropriate' evidence. WorkSafe concluded the worker had not been 'wrongfully disentitled' based on an IME supplementary report, despite the IME stating that the duration of the worker's incapacity was 'still far from certain'.

Case study 43 – Termination failed audit, but was not overturned because of inconclusive IME supplementary report

Marco was working as a self-employed tradesman when in 2013 he injured his shoulder, back and knees. He made a WorkCover claim which was accepted by his agent, Allianz. Marco also later developed a secondary mental injury.

In mid-2018, Allianz terminated Marco's weekly payments on the basis that his incapacity for work was unlikely to continue indefinitely. Although an occupational physician IME said Marco was fit for a gradual return to work based on his physical injuries, a psychiatrist IME said he had no capacity and they were unsure when he could return. Marco requested conciliation, but the dispute could not be resolved. Marco did not take the matter to court.

The termination failed WorkSafe's audit because the grounds used were not 'supported by reasonable and appropriate evidence at the time of the decision'. WorkSafe noted:

- According to the psychiatrist IME, Marco's improvement was dependent on the successful introduction of treatment, which had not occurred at that time.
- There was no timeframe for the end of the incapacity, resulting in 'ambiguity' as to whether he was likely to develop a work capacity.

Allianz requested WorkSafe undertake a peer review, which confirmed the original fail. WorkSafe said:

- The use of the 'not incapacitated indefinitely ground' was 'predicated on clear timeframes' supporting when a work capacity would be established.
- The medical information on file did not support this and therefore it was 'inappropriate' to rely on this ground.

While Allianz ultimately accepted the audit outcome, it did not overturn the termination. When the investigation asked WorkSafe why the decision was not overturned, WorkSafe said it formed the view at the time that Marco had not been 'wrongfully disentitled' based on a supplementary IME report obtained after the termination. Although the IME said in this report that there appeared to be doubts about Marco having no capacity whatsoever, the IME said:

> Whether he will gain a capacity for suitable employment within the next 6-9 months is still far from certain and cannot be realistically commented upon until the modifications [treatment via medication] … have been set in motion and continued for some months.

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WorkSafe said it reviewed the matter again after receiving the investigation's request and that based on its 'expectations in the current environment', it had formed the view the decision did not align with WorkSafe's quality decision making standards. WorkSafe also concluded Marco had been 'wrongfully disentitled'. As a result, Allianz withdrew the termination in mid-2019 and reinstated Marco's entitlements. In response to the draft report, Allianz said:

> As noted in the draft report the termination was withdrawn in 2019 when contact was made with the worker to advise his entitlements had been reinstated. At this time we were notified the worker had made a return to work in part-time employment.

550. In another case, EML terminated a worker's entitlements for his back injury without assessing his neurological conditions. The decision failed WorkSafe's audit because without a neurological IME opinion, the impact of these conditions on the worker's capacity for work was unclear. WorkSafe did not require EML to overturn the decision despite acknowledging there was a 'material defect'.

Case study 44 – Termination failed audit, but was not overturned despite 'material defect'

Matthew injured his back at work in mid-2015. He made a WorkCover claim, which was initially rejected but later accepted by his employer's agent, EML. Matthew had a pre-existing back injury, but his employment was considered to have materially contributed to the new injury.

In mid-2018, EML terminated Matthew's weekly payments because he had a work capacity. EML relied on an occupational physician IME's opinion that Matthew could return to suitable employment. However, the IME highlighted that Matthew had neurological conditions, which were outside their area of expertise. EML did not arrange for an IME of an appropriate specialty to assess these conditions. EML also relied on a psychiatrist IME's opinion, which it obtained after Matthew attempted suicide. The IME said Matthew did not have a diagnosable psychiatric condition and he could return to work. Shortly after the termination, Matthew attempted suicide again. The decision failed WorkSafe's audit because EML did not gather 'reasonable and appropriate evidence' to support the grounds used. WorkSafe noted:

- The psychiatrist IME made no mention of Matthew's suicide attempt and stated he had not received any psychological or psychiatric treatment, but this was inconsistent with other available information.
- While the two IMEs supported Matthew having a work capacity, the impact of Matthew's neurological conditions on his work capacity had not been explored.

EML requested WorkSafe undertake a peer review. WorkSafe obtained legal advice, which resulted in it maintaining the original 'fail'. The legal advice said:

- The absence of an IME opinion on the neurological conditions was a 'material defect'. As such, EML had not gathered 'reasonable and appropriate evidence' to support the termination.

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- It was 'difficult to reconcile' the psychiatrist IME's opinion with Matthew's two suicide attempts, however, the IME had provided a 'considered report'.
- On the current evidence, there was a 'real chance' the ACCS may issue a direction if the worker disputed the termination.
- The termination was 'legally valid' but 'substantively weak'.

EML did not overturn the termination after receiving the audit outcome, nor did it obtain a neurological IME opinion as recommended by WorkSafe. It also did not provide information to the psychiatrist IME about Matthew's suicide attempts and psychological treatment, to clarify whether it changed their opinion.

The investigation asked WorkSafe why the decision was not overturned. WorkSafe said although it would have been 'preferable' for EML to have obtained further information about Matthew's other conditions, WorkSafe was satisfied that the evidence upon which the decision was based was 'reasonable and appropriate'. This is inconsistent with the legal advice, which described the absence of an opinion on these conditions as a 'material defect' and said EML had not gathered 'reasonable and appropriate evidence'.

Matthew requested conciliation regarding the termination, but the dispute could not be resolved. Matthew took the matter to court. The dispute was ultimately settled by EML agreeing to pay Matthew nearly nine months of weekly payments. This occurred about a year after the termination.

551. The case study below is another example, where Allianz terminated a worker's weekly payments for failing to comply with his return to work obligations. The decision failed WorkSafe's audit because there was insufficient evidence the worker's non-compliance was unreasonable. However, WorkSafe did not require Allianz to overturn the decision.

Case study 45 – Termination failed audit but was not overturned, despite insufficient supporting evidence

Khalid was working for a waste management company when in early 2016 he injured his back. He made a WorkCover claim, which was accepted by his employer's agent, Allianz.

In mid-2017, Allianz suspended and then terminated Khalid's weekly payments because he did not comply with his return to work obligations. Khalid had returned to work with his pre-injury employer, working alternative duties and reduced hours (five hours, five days per week). However, Allianz relied on an IME opinion that he could work full-time hours. This was contrary to Khalid's GP's opinion, which was that he was working to his maximum.

The decision failed WorkSafe's audit because an injured worker is only required to comply with their return to work obligations to the extent that it is reasonable. WorkSafe found that in this case, there was insufficient evidence to indicate Khalid's non-compliance was unreasonable. Allianz requested WorkSafe undertake a peer review, which confirmed the fail. However, WorkSafe did not require Allianz to overturn the decision.

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When the investigation asked WorkSafe why the decision was not overturned, WorkSafe said it was 'not entirely clear' why Khalid was unable to increase his hours. WorkSafe said his doctor provided no 'clinical justification', despite Allianz's 'numerous attempts' to understand the clinical reasons. WorkSafe said that after further reviewing the matter 'in the current context', it maintained its view that there was 'reasonable and appropriate evidence' to support the decision and Khalid was not wrongfully disentitled.

Khalid requested conciliation. The dispute was resolved by Allianz agreeing to provide weekly payments to Khalid for about eight months.

In response to the draft report, Allianz said it has 'completed a number of feedback and training opportunities' in relation to the return to work non-compliance process.

Failure to follow up actions identified through audits

552. WorkSafe sometimes identifies other action agents should take to address issues identified during audits, for example obtaining an additional IME opinion. However, prior to August 2019, WorkSafe had no formal process to check agents were complying with those requests.

553. The investigation identified that, as a result, agents sometimes did not take these actions and WorkSafe did not follow up on their implementation in a timely manner. Six examples identified by the investigation are outlined below.

Example 1

Gallagher Bassett rejected a worker's claim on the basis that it was not work-related. The decision failed WorkSafe's audit because it was not supported by the available evidence. WorkSafe also concluded the worker had been wrongfully disentitled. However, Gallagher Bassett did not accept the worker's claim and did not provide him payments until almost a year later.[54] WorkSafe told the investigation it had been 'in conversations' with a Gallagher Bassett staff member about the audit outcome, but that this person later left Gallagher Bassett. No further follow up occurred until about a year later when this investigation requested information from WorkSafe about the audit results.

Example 2

EML terminated a worker's entitlements based on the opinions of an occupational physician IME and psychiatrist IME.* The decision failed WorkSafe's audit. One of WorkSafe's reasons was that EML had not assessed all the worker's conditions and the impact of these on his ability to return to work. WorkSafe said the absence of an opinion on these conditions was a 'material defect' and EML needed to get a neurological IME opinion. However, EML did not do this, nor did it overturn the decision. As a result, the worker had to take the matter to conciliation and then court. EML ended up agreeing to pay him for about nine months.

* See case study 44 on page 169 for further details

54 The medical evidence indicated the worker was only incapacitated for work for a period of about two months. This meant he was only entitled to payments for this period.

Example 3

Allianz terminated a worker's entitlements based on two IME opinions. The decision failed WorkSafe's audit because there was insufficient evidence to support the decision. WorkSafe noted one of the IME opinions was 'inconsistent' and said Allianz should have requested a supplementary report from the IME to clarify their opinion. Allianz did not do this when it received the audit feedback and maintained its decision at conciliation. The worker took the matter to court. No outcome had been reached at the time of this investigation.

In response to the draft report, Allianz said:

> Since the implementation of the Quality Decision audits, Allianz has developed a structured process to ensure audit feedback is provided to case managers and technical managers. This includes distribution of audit comments to claims teams, and a standing agenda item at monthly technical manager meetings. These discussions cover audit issues and also quality comments. In 2017, audit feedback was incorporated into face to face technical manager training to ensure expectations were aligned to those of WorkSafe.
>
> Individual discussions are held by the compliance team with technical managers responsible for endorsing any failed decisions to mitigate repeat incidents do not occur.
>
> In accordance with the recent changes to WorkSafe's audit outcome process, the internal compliance team monitors the completion of corrective actions identified throughout the audit.

Example 4

EML terminated a worker's entitlements based on an IME opinion that his work-related injury had resolved. The decision passed WorkSafe's audit, but WorkSafe noted that the worker appeared to now be incapacitated because of a separate injury, for which he had another WorkCover claim. WorkSafe said EML should re-open the worker's other claim and provide payments to him for this injury. EML did not do this until three months later when it was identified during conciliation for the termination of his other claim. WorkSafe said the reason for the delay was 'unclear' and acknowledged that 'in this instance the claim was not monitored to ensure the agent undertook actions post the audit feedback'.

Example 5

Gallagher Bassett terminated a worker's entitlements based on an IME's opinion that she had a capacity for restricted duties.* The IME had examined the worker two months prior and concluded she was indefinitely incapacitated. The IME said nothing had changed since that examination but that she could return to work. The decision passed WorkSafe's audit, but WorkSafe said Gallagher Bassett should have asked the IME to provide a supplementary report to clarify the change in his opinion. Gallagher Bassett did not do this upon receiving the audit feedback and did not overturn its decision. The worker requested conciliation, but the dispute could not be resolved.

* See case study 39 on page 161 for further details

Example 6

EML terminated a worker's entitlements based on the opinions of two IMEs who said she could return to work. When EML notified the worker of the decision, she made a suicide threat and emergency services were called. This happened again later that month and the worker was admitted to a psychiatric facility. The termination passed WorkSafe's audit, but WorkSafe said the events subsequent to the decision called into question the psychiatrist IME's opinion. EML did not take any specific action in response to the audit feedback and maintained its decision when the worker requested conciliation. The worker was subsequently re-admitted to a psychiatric facility yet EML did not make any direct enquiries with the worker's treating doctors. At conciliation, the matter was referred to a Medical Panel. Based on the Panel's opinion, EML's decision was overturned and the worker's entitlements were reinstated. WorkSafe said that 'given the vulnerability of the worker', it 'did not have sufficient oversight or monitor the outcomes on this claim'.

554. WorkSafe told the investigation that it has changed its audit processes, and WorkSafe now follows up recommended actions identified during an audit. It said that as part of this process, agents will be required to respond to WorkSafe confirming recommended actions have been completed, or if they will not be completed, the reason(s) why.

555. WorkSafe said this process formally started as part of the 2019-20 audit program in August 2019.

Complaints about agent decisions

556. Complaints and stakeholder feedback also offer WorkSafe opportunities to check agents' performance and identify areas for improvement.

557. WorkSafe receives complaints from injured workers and other parties about claims management issues, but considers it has a limited role in complaints about agent decisions. This is because there is a dispute process available to injured workers to contest these decisions.

558. However, WorkSafe has a role in ensuring agents do not 'wrongfully disentitle' workers. WorkSafe may review whether this has occurred after receiving a complaint and can direct an agent to change a decision if appropriate.

559. In response to the draft report, WorkSafe said:

> WorkSafe considers the comment … that WorkSafe considers its role is limited is unclear and not accurate. WorkSafe's role is to ensure that decisions are made in accordance with the legislation and WorkSafe's policies. If decisions are made within these parameters and the agent has appropriately used its discretion to make a decision then it is appropriate that WorkSafe advise workers of their appeal rights.

560. The Ombudsman's 2016 investigation identified issues with WorkSafe's response to complaints and feedback, including:

- ineffective use of complaints data to identify potential systemic issues
- reluctance from WorkSafe to direct agents in response to a complaint
- a perception by some stakeholders that WorkSafe did not take adequate action regarding their concerns.

561. This investigation considered whether anything has changed.

Changes since the Ombudsman's 2016 investigation

562. Following the Ombudsman's 2016 investigation, WorkSafe redeveloped its complaints management framework. This included:

- revising its complaint policies
- commencing regular reporting of complaints data to WorkSafe's executive leadership team to identify and monitor trends
- improving the information on WorkSafe's website about how workers can complain to WorkSafe and other bodies.

WorkSafe's handling of complaints in 2017-18

563. In 2017-18, WorkSafe recorded 1,200 complaints in its Complaints Tracking System about claims management issues, of which 196 were categorised as complaints about claim decisions. However, when the investigation reviewed these, many did not relate to claim decisions and appeared to have been incorrectly categorised.

564. Only two complaints WorkSafe received in 2017-18 led it to conclude that a worker had been 'wrongfully disentitled'. In these cases, WorkSafe raised concerns with the relevant agent, which withdrew the decision.

565. This investigation reviewed 27 complaints about claim decisions WorkSafe received in 2017-18, about half of which were randomly selected.

566. The review identified continuing issues with WorkSafe's handling of complaints, including:

- referring workers to conciliation, when WorkSafe could have resolved the complaint itself
- accepting agent responses without questioning whether they are correct or reasonable.

Referring workers to conciliation

567. The investigation accepts that in many cases, it is appropriate for WorkSafe to refer workers with a complaint about an agent decision to conciliation. This may be appropriate in cases where, for example:

- a worker is unhappy with a decision but cannot provide evidence about why it was wrong
- there is a clear factual or medical dispute.

568. However, WorkSafe has a role in ensuring workers are not 'wrongfully disentitled', and it reached such a conclusion in two complaints in 2017-18. This suggests WorkSafe assesses each complaint it receives to determine whether it has a role in resolving the complaint or whether conciliation is the appropriate forum for the dispute. WorkSafe's assessment is important as its early intervention can mitigate the impacts of requiring a worker to proceed to conciliation or court, including a delay in any reinstatement of payments.

569. The investigation found that in some cases, WorkSafe initially reviewed the complaint and identified concerns with the agent's decision, but ultimately referred the worker to conciliation. It was unclear why WorkSafe did not take further action regarding these complaints in light of its concerns.

570. In the following case, a worker complained to WorkSafe about Gallagher Bassett's decision to terminate her 'top up' weekly payments based on an IME opinion, which was contrary to a previous binding Medical Panel opinion. Despite identifying multiple issues with the decision, WorkSafe told the worker to go to conciliation.

Case study 46 – WorkSafe referred worker to conciliation despite identifying 'inadequate' agent decision making

Gabrielle, a former police officer with a mental injury, returned to work part-time and was receiving 'top up' weekly payments because she could not return to full-time work.*

In late 2017, Gallagher Bassett terminated Gabrielle's payments based on an IME's opinion that she could increase her hours either in her current employment or in another suitable job. Although the IME said she could progressively increase to working full-time hours, they said there had been 'little change' in her presentation since she was examined by a Medical Panel in 2016. The Panel found Gabrielle was indefinitely incapable of working more than 15 hours per week as a result of her mental injury.

Gabrielle complained to WorkSafe about the termination and also requested conciliation. Upon reviewing the termination, WorkSafe noted the IME indicated there had been little change in Gabrielle's presentation since the Medical Panel, but also said she could increase her hours. A WorkSafe complaint officer outlined 'concerns' about the termination, which included:

- 'Inadequate decision making process'
- 'Use of … [IME] per se'
- 'Leading question of … [IME] by agent'**
- 'Semantics rather than sufficient change to warrant setting aside the Medical Panel Opinion'.

There was no record about what WorkSafe did as a result of these concerns, although it recorded the complaint was 'fully resolved'. The investigation asked WorkSafe to clarify this and it said its complaint officer assessed the 'appropriate course of action' for Gabrielle was to appeal via conciliation. WorkSafe said this was the 'correct decision' but did not explain why.

At conciliation the matter was referred to a Medical Panel and Gabrielle's entitlements were reinstated based on the Panel's opinion. By that time, Gabrielle had been without payments for almost six months.

In response to the draft report, WorkSafe said:

> [This] case study … relates to a matter where the complaint was considered fully resolved on the basis the worker was informed of the appropriate course of action for the worker to pursue, which was to appeal the matter via conciliation, though we acknowledge that some documentation was absent from this file.

* This case is also discussed on pages 114 and 132.

** Agents' use of leading questions to IMEs is discussed on page 57.

571. In another case, a worker complained to WorkSafe about Gallagher Bassett's termination of his payments, contrary to evidence he had no work capacity. WorkSafe told the worker to dispute the decision at conciliation, despite identifying the claim had not been 'managed properly'.

Case study 47 – WorkSafe concluded claim had not been 'managed properly'; worker waits a year for court to reinstate payments

Jarrod was working as a transport officer when in 2016 he sustained a mental injury from bullying and victimisation at his workplace. Jarrod made a WorkCover claim in 2017, which was accepted by his employer's agent, Gallagher Bassett.*

In mid-2017, Gallagher Bassett terminated Jarrod's payments based on an IME's opinion that he was no longer incapacitated for work. This IME's opinion predated a further decline in Jarrod's mental health from escalated bullying, which led him to cease work. Jarrod requested conciliation but the matter could not be resolved.

In late 2017, Jarrod complained to the Minister responsible for WorkSafe about Gallagher Bassett's termination of his claim. He stated his dispute was rejected despite medical reports from his treating doctors indicating a continuing workplace injury and incapacity for work. Jarrod also raised concerns about his employer influencing the outcome of the dispute and said 'I believe I am being railroaded through the system in the hope that I am worn [down] and give up'.

Upon review, WorkSafe concluded Jarrod's claim had not been 'managed properly' by Gallagher Bassett. WorkSafe identified issues with Gallagher Bassett's decision, including that:

- Gallagher Bassett relied on an IME report completed when Jarrod was back at work full-time. However, the IME noted he was at risk of relapse if the industrial issues at his workplace were not resolved. WorkSafe noted the 'industrial issues' mentioned in the IME's report 'were the accepted causative factors for the onset of the worker's compensable injury' and asked Gallagher Bassett to comment on its decision in light of these comments.
- Gallagher Bassett stated in a file note it would pay Jarrod weekly payments if he lodged a new claim (given he was now not working), however, it had not communicated this to him.

WorkSafe exchanged several emails with Gallagher Bassett outlining its concerns and asked Gallagher Bassett to apologise to Jarrod and tell him he needed to make a new claim. In response, Gallagher Bassett maintained that its original termination was evidence-based. WorkSafe prepared a response to Jarrod from the Minister finalising his complaint on the basis that he could make a new claim.

In line with WorkSafe's advice, Gallagher Bassett encouraged Jarrod to make a new claim and told him it would 'likely be accepted'. Jarrod then made a new claim for a mental injury and high blood pressure caused by the ongoing bullying and harassment at his workplace. After investigating the claim and referring Jarrod to an IME, Gallagher Bassett rejected his claim based on the new IME's opinion that Jarrod's mental injury was in 'remission' and he was able to return to work. Gallagher Bassett did not provide the IME any information about Jarrod's previous claim or reports from his treating doctors that supported his inability to work.

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Jarrod made another complaint to the Minister, this time about Gallagher Bassett's rejection, concerning:

- potential bias in the investigation of his claim, because several of the witnesses interviewed were the perpetrators of the bullying
- the weight of medical evidence indicating he was unable to work, which was contrary to the IME's opinion
- his employer influencing the process which led Gallagher Bassett to reject his claim.

Jarrod noted:

> I am now at the tail end of my accrued annual leave and will be left without income over the Christmas period. I do not understand how a brief visit with an IME [carries] more weight than my 3 treating physicians, one who claims 'the likelihood of a [cardiovascular] event such as a stroke and or death is imminent' yet somehow I can return to a hostile work environment without any resolution, for normal hours and normal duties … my intentions are simply to be allowed time to recover and return to a job that I loved without this rollercoaster of emotions further destroying my health.

Upon review of the rejection, WorkSafe concluded Gallagher Bassett's communication with Jarrod and its handling of his claim 'painted a different picture'. WorkSafe requested Gallagher Bassett verify that it set 'proper expectations' for Jarrod about his new claim and asked it to review both the rejection and termination of Jarrod's first claim. In response, Gallagher Bassett said it was 'adamant' Jarrod had no entitlement to compensation. WorkSafe accepted the response and finalised Jarrod's complaint. The Minister subsequently wrote to Jarrod advising him that the most appropriate method to resolve his concerns was conciliation.

Because Jarrod's dispute could not be resolved at conciliation, he took the matter to court. A Magistrate referred questions to a Medical Panel which in mid-2018 concluded Jarrod had an incapacity for work because of the bullying at his workplace. Jarrod's entitlements under his original claim were reinstated, at which time he had been without payments for almost one year.

In response to the draft report, WorkSafe said:

> [This] case study … relates to a complex matter where the worker was proceeding with litigation through his solicitors, at the same time as making Ministerial complaints, and communicating with the agent directly. We consider that WorkSafe pursued an active approach to this worker's complaints, including ongoing communication with Gallagher Bassett and requesting actions to be taken to assist the worker.

* This case is also discussed on page 64.

I am now at the tail end of my accrued annual leave and will be left without income over the Christmas period. I do not understand how a brief visit with an IME [carries] more weight than my 3 treating physicians, one who claims 'the likelihood of a [cardiovascular] event such as a stroke and or death is imminent' yet somehow I can return to a hostile work environment without any resolution, for normal hours and normal duties.

– Injured worker

572. Witnesses interviewed during the investigation also raised concerns about WorkSafe's failure to take adequate action regarding complaints. Conciliation Officer B said:

> [Y]ou sort of give up [raising issues with WorkSafe] after a while because you think you're not going to get anywhere with them. So, I tend to take very few things to WorkSafe … I encourage the workers' reps [representatives] to take it to WorkSafe because they sometimes have … a better result than what I do … I think they [WorkSafe] rely on their policy and guidelines, rather than looking at things on their merits for individuals. I think that's a big problem … they take an 'across the board' view of everything, rather than assessing the merits of each case.

573. Conciliation Officer D said:

> WorkSafe … [doesn't] want to know a lot of … things. It suits them not to know, because they don't want to know the bad news – they don't want to know that at conciliation an agent can't make an offer beyond X number of weeks because of a policy that they made. Because it doesn't make them look good.

Acceptance of agent responses

574. Witnesses interviewed by the investigation also raised concerns about WorkSafe's willingness to accept agent explanations.

575. At interview, Conciliation Officer B said WorkSafe tended to 'back the agent' rather than take steps to resolve complaints. Conciliation Officer G said WorkSafe 'protect[s] the agents more than they should' instead of looking at it independently and saying 'we're not prepared to let you do this'.

576. Conciliation Officer C said they had raised concerns about individual claim decisions with WorkSafe in the past, and its response was that it was 'up to the agent'. The Conciliation Officer said this type of response 'makes you consider whether it is even worth contacting WorkSafe at all'.

577. A worker representative said in their experience, WorkSafe seemed more reluctant than previously to intervene in agent decision making. The representative said WorkSafe often defended agents' decisions as 'reasonable' without looking at the merits of them. The worker representative said:

> Their mentality from my point of view is 'oh if an agent says its right, it must be right'. And we say to them … 'you need to look at everything, and yes, you might win at conciliation, you might have an arguable case at conciliation, but realistically, are you going to win at court?'

578. In the following case, a worker complained to WorkSafe about Xchanging's termination of their payments based on an unclear IME opinion. Despite identifying concerns about the strength of Xchanging's decision, WorkSafe closed the worker's complaint because Xchanging said they should let the dispute process 'run its course'.

Case study 48 – WorkSafe closed complaint despite concerns about the 'strength' of decision

Louisa was working as a healthcare worker when she sustained a mental injury after she was harassed by a client. She lodged a WorkCover claim in 2016 and was examined by a psychiatrist IME who diagnosed her with PTSD and depression. Xchanging accepted her claim.

In early 2017, Xchanging arranged for the same IME to examine Louisa. This time the IME concluded Louisa had a different mental injury, but said her symptoms had resolved enough for her to return to work. Xchanging requested several supplementary reports from the IME because the IME's opinion about Louisa's injuries was not clear. For example, the IME said:

- She had an 'adjustment disorder with features of traumatisation' caused by work, but this disorder had now resolved.
- She had no current psychiatric condition but rather 'some mild symptoms'.
- She was 'engaged in long term psychotherapy for constitutional non-work related matters' but did not explain what these matters were.

Despite the IME's unclear opinion, Xchanging terminated Louisa's weekly payments. Louisa requested conciliation. Xchanging acknowledged discrepancies in the IME's opinion, however, maintained that its decision was 'arguable'. The Conciliation Officer referred the dispute to a Medical Panel.

Louisa also complained to WorkSafe and the Ombudsman about the IME's conduct during the examination, their overall opinion regarding her mental injury and Xchanging's reliance on the IME's report to terminate her claim. In her complaint, Louisa stated:

> Of course based on … [the IME's] report my payments have been terminated. I have been suicidal and depressed with no options to return to work because I was made redundant last year in August whilst on WorkCover, I have been given no re-training options even though it has been suggested on numerous occasions. It's obvious … [the IME's] report conflicts [with] her first report and now I have been forced to take the matter through the conciliation process … The process was horrific! I feel even more traumatized, there was heavy evidence presented by my GP and Psychologist to show that I am still unfit for work, Xchanging acknowledges that the reports are conflicting but they refused to change their decision.

WorkSafe reviewed Xchanging's decision. It noted the inconsistencies in the IME's opinion and that Louisa's treating doctor had diagnosed PTSD and depression and said her symptoms could return if she went back to work. WorkSafe raised concerns with Xchanging about the 'strength' of the termination, which it noted 'paid no regard to the treating psychologist's report' and did not appear to resolve the 'various views' of the IME. WorkSafe acknowledged Xchanging 'may be reluctant to withdraw the termination now' as a Medical Panel referral was underway, but said it wanted Xchanging to 'consider the worker's situation' and the issues WorkSafe identified.

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In response, Xchanging told WorkSafe the matter was a 'medical dispute' which would be determined by a Medical Panel, so they needed to 'let this process run its course'. WorkSafe responded to Xchanging on the same date thanking it for considering the matter further and said it would close the complaint.

Two months later, a Medical Panel concluded Louisa had a work-related mental injury and incapacity for work. Xchanging reinstated her payments as a result. By that time, Louisa had been without payments for over three months.

In response to Louisa's complaint, this office contacted WorkSafe to raise concerns about its lack of action following Xchanging's termination. While WorkSafe initially defended Xchanging's decision, it ultimately accepted there were 'grounds for challenging the reasonableness of Xchanging's decision to terminate, and then not reinstate, payments' to Louisa.

In response to the draft report, WorkSafe said:

> [T]he worker initially complained to WorkSafe on about 29 May 2017 about an IME opinion. WorkSafe reviewed the matter and raised various specific issues with the agent on 14 June 2017. The agent advised WorkSafe that it believed there was a genuine medical dispute, and also that there was already a process underway for a Medical Panel referral with an examination booked for 11 July 2017. The claim was resolved through that process, and WorkSafe also spoke at length with the worker to express regret about her negative IME experience, and to inform her that the relevant IME was no longer approved to undertake independent medical examinations for WorkSafe.

In response to the draft report, Xchanging said that after the Medical Panel's examination of Louisa, it received information that Louisa had returned to work. Xchanging said this was inconsistent with what Louisa had told the Panel. Notwithstanding this, the investigation focussed on the evidence available at the time Xchanging issued the termination and WorkSafe responded to Louisa's complaint. The investigation remains of the view that, at this time, Xchanging did not have sufficient evidence to terminate Louisa's entitlements.

579. In another case, WorkSafe supported Gallagher Bassett's decision to require a worker to attend occupational rehabilitation, despite having insufficient evidence about the worker's capacity to participate. Gallagher Bassett's advice to the worker and WorkSafe about the worker's requirement to attend occupational rehabilitation was inconsistent with the Claims Manual, which WorkSafe failed to identify in its handling of the complaint.

Case study 49 – WorkSafe closed complaint based on incorrect advice from agent

Jennifer was working as a gaming attendant when in 2011, she fell over at work, injuring her back, hip and arm.* In 2016, a Medical Panel concluded Jennifer's physical injuries had largely resolved, but she was suffering from a secondary mental injury made worse by chronic pain. The Panel concluded Jennifer had no current work capacity at that time and this was likely to continue indefinitely.

In 2017, Gallagher Bassett referred Jennifer to an IME to assess her physical capacity. The IME concluded she could not return to her pre-injury work but could work in a different job. The IME also said Jennifer could participate in occupational rehabilitation. Without assessing Jennifer's mental injury, Gallagher Bassett referred her to an occupational rehabilitation provider.

In mid-2017, Jennifer complained to WorkSafe about Gallagher Bassett's decision and said she was too unwell to attend occupational rehabilitation. WorkSafe raised concerns with Gallagher Bassett about why occupational rehabilitation was arranged before an IME had assessed Jennifer's mental injury. It also highlighted that all of Jennifer's treating doctors said she could not work now or in the 'foreseeable future'.

In response, Gallagher Bassett told WorkSafe that Jennifer did not require a work capacity to attend the type of occupational rehabilitation arranged. However, this was incorrect according to the WorkSafe Claims Manual.** WorkSafe did not identify this error and accepted Gallagher Bassett's response. WorkSafe closed Jennifer's complaint, telling her she was required to participate in occupational rehabilitation.

Jennifer attended the occupational rehabilitation appointments scheduled for her, but wrote to Gallagher Bassett and WorkSafe on several occasions raising further concerns that she was too unwell to participate. Jennifer's treating doctor also raised concerns with Gallagher Bassett about the 'adverse effect' this was having on her 'physical and mental health'.

Gallagher Bassett eventually arranged for Jennifer to be assessed by a psychiatrist IME in the month after WorkSafe closed her complaint. The IME concluded that Jennifer's mental injury was of such severity that she was unable to return to any form of work. The IME also said Jennifer was not fit to participate in occupational rehabilitation of any kind. As a result, Gallagher Bassett ceased Jennifer's occupational rehabilitation.

* This case is also discussed on page 70.

** The worker in this case was referred for a vocational assessment and the Capacity Support Service (CSS). The WorkSafe Claims Manual states that workers may only be referred to CSS if they have a capacity for employment based on a current IME opinion.

580. In the following case, a worker complained to WorkSafe about Gallagher Bassett's requirement that she attend occupational rehabilitation, as she believed she had no capacity to participate. Without assessing the reasonableness of Gallagher Bassett's decision, WorkSafe closed the complaint.

Case study 50 – WorkSafe closed worker's complaint despite 'unclear' agent response

Colleen was working as a nurse when she injured her back in late 2013.* She continued to work and then made a WorkCover claim in mid-2014, which was accepted by her employer's agent at the time. She ceased work in late 2014 due to her injury. In 2015, a Medical Panel concluded Colleen had aggravated a pre-existing spinal condition and she was unable to work as a result.

In late 2017, Colleen complained to WorkSafe about Gallagher Bassett's requirement that she participate in occupational rehabilitation services and a computer course. Gallagher Bassett based its decision on an occupational physician IME's opinion that Colleen had a capacity to engage in these services, however, the IME also diagnosed her with a chronic pain syndrome. Gallagher Bassett did not refer Colleen to a pain specialist IME, which was the correct speciality to assess this condition. Colleen said she her case manager was 'harassing' her to attend these services despite her incapacity.

WorkSafe asked Gallagher Bassett to address Colleen's complaint. Gallagher Bassett responded to WorkSafe stating it had 'investigated' the complaint and found that Colleen's case manager had contacted her on three occasions over two weeks regarding her retraining. It noted Colleen's assigned case manager was no longer employed by Gallagher Bassett and it had told Colleen this. Gallagher Bassett did not comment on Colleen's concerns that she was being required to engage in occupational rehabilitation and retraining when she did not have capacity. WorkSafe subsequently closed Colleen's complaint. There was no record of the reason for this and whether Colleen was informed of the outcome.

The investigation asked WorkSafe to clarify these issues and it acknowledged Gallagher Bassett's response was 'unclear in parts' and did not meet WorkSafe's 'expectations with respect to the standard and content of communications appropriate in the context of a complaint management and resolution process'. WorkSafe said:

> WorkSafe acknowledges that the content of this email in isolation (and absent any evidence of further communication/enquiries between WorkSafe and Gallagher Bassett with respect to this matter) does not provide the level of clarity or detail for WorkSafe to have formed an appropriate level of comfort that the complaint had, so far as possible, been properly addressed from a client service perspective … WorkSafe also acknowledges a formal response to the injured worker from WorkSafe would have been appropriate and this expectation has been reinforced with our … [Agent] Complaints Team.

This matter was ultimately resolved because Gallagher Bassett ceased Colleen's occupational rehabilitation services pending a Medical Panel examination.

* This case is also discussed on page 69.

581. In another case reviewed by the investigation, a worker complained to WorkSafe about Gallagher Bassett's termination of her entitlements based on a contradictory IME opinion. WorkSafe closed the complaint because it was 'satisfied' Gallagher Bassett had 'followed correct procedures' in making the decision, despite Gallagher Bassett providing no specific response to the concerns raised.

Case study 51 – WorkSafe 'satisfied' with agent decision making despite contradictory IME opinion

Margaret was working at a university when in 2017, she fell over at work, injuring her neck, shoulder and back.* Margaret made a WorkCover claim which was accepted by her employer's agent, Gallagher Bassett.

In late 2017, Gallagher Bassett terminated Margaret's payments based on an IME opinion that she was no longer incapacitated for work. The IME said in their report that from a physical perspective, Margaret's injuries had resolved and she was able to return to her pre-injury duties. However, the IME also said Margaret had an incapacity for pre-injury duties and this was indefinite, noting she suffered from chronic neck and back pain. Margaret complained to WorkSafe about Gallagher Bassett's termination of her payments, stating:

- A specialist assessment, paid for by Gallagher Bassett, had concluded she would benefit from attendance at a pain management program.
- One of the IME reports cited by Gallagher Bassett in its termination decision acknowledged she suffered from chronic neck and back pain, yet Gallagher Bassett stated her injuries had resolved.
- Her treating doctors maintained her injuries had not resolved and the purpose of her attendance at the pain management program was to assist her return to work.
- Gallagher Bassett's actions were 'unprofessional and unethical' and the result would 'hinder … [her] return to work as soon as possible'.

WorkSafe asked Gallagher Bassett to respond to Margaret's complaint. Gallagher Bassett responded to WorkSafe stating:

> Independent medical evidence was relied upon in the making of these decisions. Our area can not make, alter or review an Adverse Decision notice. If the injured worker has further medical evidence that may cause these decisions to be reviewed then I recommend that she email this to the claims team and request … [Gallagher Bassett review its decision] … [Margaret] will need to exercise her right of appeal directly to the Accident Compensation Conciliation Service.

Gallagher Bassett did not address Margaret's concern that one of the IME opinions it relied upon was contradictory. Despite this, WorkSafe told Margaret it was 'satisfied' Gallagher Bassett had 'followed correct procedures' in making its decision and that it considered her complaint resolved. WorkSafe encouraged her to request Gallagher Bassett review the decision if she had further medical evidence. There was no record on the complaint file indicating WorkSafe considered Margaret's concerns about the IME's opinion. Margaret disputed the termination at conciliation and the matter was referred to a Medical Panel. The Panel concluded she had a current work-related injury that rendered her incapacitated for work. It disagreed with the IME's opinion which Margaret had complained about to WorkSafe. Gallagher Bassett reinstated Margaret's payments based on the Panel's opinion, about five months after they were terminated.

* This case is also discussed on page 126.

Injured worker survey

582. WorkSafe also receives feedback about agents' management of claims through its survey of injured workers.

583. Although the Ombudsman's 2016 investigation did not examine the effectiveness of the survey, some WorkSafe and agent executives said it was a key mechanism to ensure the quality of agent decision making.

584. The survey measures workers' perception of their agent's service delivery based on 'key events' across six areas.

585. The survey is linked to a financial reward and penalty measure, which means that WorkSafe may financially reward an agent if more than a minimum percentage of workers surveyed were happy with its service. WorkSafe may also financially penalise an agent if too many workers were unhappy with the service they received. In 2017-18, all five agents met or exceeded the minimum target of 81 per cent, with results ranging from 81 to 83 per cent.

586. WorkSafe surveys about 5,000 workers each year. However, the survey primarily focuses on workers who have received less than 130 weeks of weekly payments, because these make up the majority of claims in the scheme.

Table 2: Injured worker survey questions

Focus area	Questions relate to whether the agent:
Communication	• was courteous and polite • listened to the worker's point of view • treated them with dignity and respect
Claim eligibility	• contacted the worker to acknowledge they received the worker's claim • provided the worker every opportunity to submit information • contacted the worker by phone to tell them whether their claim had been accepted or rejected • clearly explained the reasons for the decision • resolved all of the worker's queries during this period
IME examinations	• contacted the worker before the examination • clearly explained to the worker the reason for the examination and what may happen afterwards • clearly explained to the worker what the IME report said and how it affected their claim
Return to work	• discussed returning to work with the worker • explained the worker's role in their return to work, their employer's obligations and the support available to assist them to return to work
Treatment	• answered any questions the worker had regarding their entitlement to treatment or services in a timely manner
Adverse decisions	• told the worker the reasons for the decision, the date their payments would stop and their right to appeal the decision

Table 3: Injured worker survey weightings	
Claim cohort	**Weighting**
Workers who have received weekly payments for less than 20 weeks	45%
Workers who have received weekly payments for 20 to 89 weeks	29%
Workers who have received weekly payments for 90 to 133 weeks	10%
Workers who have received weekly payments for 134 weeks or more	13%
Workers with a major injury*	3%

* Refers to claims where an agent has paid at least $20,000 in hospital expenses, as well as paying for attendant care, external case management or car/home modifications.

587. As this investigation focussed on complex claims where workers received weekly payments for 130 weeks or more, the value of the survey in understanding whether agent decision making on these claims has improved since 2016 is limited.

Health checks

588. 'Health checks' are another way WorkSafe oversees agent decision making and claims management. WorkSafe defines a 'health check' as a 'high level review of a sample population of claims', which can be initiated for a number of reasons. For example, it may be prompted by issues identified from data reporting, complaints, or as part of an 'ongoing program review'. WorkSafe said that once it completes a health check, 'a view is formed on any future action required'.

589. Although the Ombudsman's 2016 investigation did not examine the effectiveness of WorkSafe's health checks, this investigation looked at recent health checks to see whether they have strengthened WorkSafe's oversight of agent decisions.

2017-18 health checks

590. In 2017-18, WorkSafe undertook 17 health checks related to claims management, which included a review of agents' acceptance and rejection of claims, terminations of weekly payments, medical treatment decisions and agents' use of occupational rehabilitation.

591. The investigation focussed on the two health checks most relevant to the scope of this investigation. These related to WorkSafe's review of:

- claims likely to exceed 130 weeks
- long term claims, where the worker was injured more than five years prior.

Effectiveness of health checks

592. It is positive that WorkSafe proactively undertakes targeted health checks of different claims management issues; however, the investigation's ability to examine their effectiveness or the validity of their findings was limited by WorkSafe's poor record keeping.

593. WorkSafe was unable to provide the investigation basic information about the two selected health checks, such as the specific claims reviewed, when they were reviewed, how the claims were selected, and the outcomes of the reviews.

594. WorkSafe told the investigation this was 'due to the unavailability of documentation'. The only documentation it could provide the investigation were copies of internal presentations it delivered on learnings from the health checks.

595. Although the investigation focussed on two health checks, WorkSafe acknowledged record keeping had been a larger problem. WorkSafe said it had identified that historically, 'its approach to capturing, recording and reporting on the outcomes of health checks relating to claims has not been consistent'. WorkSafe told the investigation that from 2018-19 onwards, all health checks would be 'captured, recorded and reported' in the same way as its audits through its audit system.

596. The two health checks the investigation reviewed are summarised below based on the limited information WorkSafe could provide the investigation.

Health check 1 – Review of claims likely to exceed 130 weeks

In 2017-18, WorkSafe decided to undertake a health check of claims where the worker was likely to receive weekly payments past 130 weeks.* This was prompted by an increase in the weekly payments being paid to injured workers across the scheme, due to:

- a reduced number of terminations across the scheme
- a higher number of long term claims
- growth in mental injury claims.

The sample of claims reviewed included:

- mental injury claims likely to reach 130 weeks in 2018
- physical claims exceeding 122 weeks without a termination.

WorkSafe said its 'learnings' from the review included that these claims are 'complex in nature' and 'a high level of multi-disciplinary and claim specific management skills and knowledge' was required to 'mitigate claim progression'. WorkSafe further said:

- These claims required 'greater focus and intervention' to 'increase chances of positive scheme outcomes'.
- There were 'opportunities to improve claims management'.
- The '[v]olume of unsustained terminations' was 'impacting performance'.

WorkSafe outlined 'key areas of focus' for these claims, which included:

- 'Worker engagement/rapport/accountability'
- 'Quality Decision Making / Dispute minimisation'
- 'Oversight of litigated matters / Medical Panel referrals'
- 'Focus on retraining / OR engagement'
- 'Treatment for drug / alcohol addictions'
- 'Manage secondary psych claims as per primary MI [mental injury] claims'
- 'Preventing high volume medications or wean off asap'.

WorkSafe also outlined findings specific to the physical injury claims reviewed.

Physical injury claims

In about 60 per cent of the physical injury claims reviewed, WorkSafe noted that the relevant agent had concluded the worker was indefinitely incapacitated for all work. WorkSafe's review of these claims highlighted some of the factors which may influence claim complexity and long term incapacity for work. These included:

- significant injuries (eg an acquired brain injury)
- physical claims with 'serious' secondary mental injuries
- post surgery complications
- workers nearing retirement age who are unlikely to return to work
- workers with limited functional capacity and transferrable skills.

The remaining 40 per cent of claims had been terminated, but these decisions had been overturned through the dispute process. About two thirds of these were overturned based on a Medical Panel opinion. Of these, WorkSafe noted:

- three quarters involved workers with secondary mental injuries
- three quarters involved workers on 'substantial' medication, particularly opioids
- just under half of the workers were over 55 years old.

WorkSafe said its 'key messages' from the review of physical injury claims were that:

- Agents were correctly applying the 130-week 'test'.
- There were no claims which the agent had inappropriately classified as 'no capacity indefinitely'.
- A Medical Panel is unlikely to conclude a worker has capacity for suitable employment where they are over 55, their pre-injury job was physical, and they have limited transferrable skills.

* A worker's weekly payments cease at 130 weeks unless they are found to have no current work capacity and that this is likely to continue indefinitely.

Health check 2 – Review of long term claims

In 2017-18, WorkSafe undertook a health check of long term claims based on concerns about their growing complexity. WorkSafe said they were becoming more complex due to '[claim] duration, age of worker, growing mental injury and the large number that have had their ongoing entitlement validated by the medical panel'. During the health check, WorkSafe reviewed a sample of about 300 claims where the worker had been injured between five and seven years prior and was still receiving weekly payments.

WorkSafe said the 'learnings' from the health check included:

- Claims were being 'actively managed' by agents, with no missed termination opportunities.
- Most claims where the worker could possibly gain a future work capacity had had their entitlements validated by a Medical Panel.
- Some claims management opportunities existed but would require a 'significant time investment' by agents.

WorkSafe concluded its 'current claims management methodologies' were 'no longer able to improve outcomes for long term injured workers'. It said a 'new approach was required' to 'better meet injured worker's individual needs'.

Following the health check, WorkSafe said it started a pilot of an 'Enhanced Claims Model' in late 2017, which involved developing tailored 'action plans' to meet individual workers' needs. A Medical Advisor, lawyer and key WorkSafe and agent staff were involved in reviewing selected claims and developing these plans. WorkSafe said these '[f]ocused reviews with highly capable attendees' provided 'clarity' on:

- understanding key barriers to a worker's return to suitable employment
- a clear strategy that could possibly progress a claim.

However, WorkSafe highlighted the financial cost and time commitment involved and said that 'quality of implementation and ongoing focus' could 'not be assured'. The reasons WorkSafe provided for this included 'staff turnover', 'capability' and 'competing priorities'.

WorkSafe said the learnings of the pilot had been used to develop an ongoing twice-yearly health check for long term claims, which involves WorkSafe providing support to agents in the management of complex long term claims. WorkSafe said that as part of this, WorkSafe undertakes 'desktop reviews' of relevant claim files or attends a case conference with the agent to identify strategies to manage the claim. WorkSafe said the health checks commenced in November 2018 and since then it has reviewed a total of 374 claims.

Oversight of the IME system

597. WorkSafe is responsible for appointing IMEs to examine injured workers and provide an opinion about their condition, work capacity and treatment. IMEs can be medical practitioners, dentists, physiotherapists, chiropractors, osteopaths and psychologists.

598. WorkSafe has quality assurance processes to ensure its IMEs and their reports meet required standards. WorkSafe also handles complaints from injured workers and other parties about IMEs, and manages part of the IME booking system.

599. This investigation re-examined the effectiveness of WorkSafe's oversight of the IME system and whether this has improved since the Ombudsman's 2016 investigation.

IME appointment

600. Any medical practitioner or allied health professional wanting to become an IME must complete an application and induction process managed by WorkSafe.

601. At the time of the Ombudsman's 2016 investigation, WorkSafe's selection criteria had been in place since 2003. The investigation identified that although WorkSafe strengthened the selection criteria over time, it failed to protect the system from inappropriate appointments. In one case, WorkSafe reappointed an IME using the criteria, even though the IME had been found guilty of previous professional misconduct.

Changes since the Ombudsman's 2016 investigation

602. In June 2018, WorkSafe implemented a new appointment process for IMEs, which requires them to:

- submit an application and written submission to WorkSafe
- undergo a series of phone interviews to ensure they meet WorkSafe's selection criteria and have 'exceptional behavioural and communication skills'.

603. A WorkSafe panel reviews each application to assess whether the prospective IME meets WorkSafe's requirements.

604. WorkSafe also introduced new selection criteria, tailored to suit each medical and allied health discipline. Among other things, the new criteria require a prospective IME to:

- perform a minimum of eight hours 'direct clinical care' each week aligned to the IME's chosen specialty
- have a minimum of five years full-time work experience as a practitioner in that specialty
- have the necessary insurance
- be registered with the Australian Health Practitioner Regulation Agency (AHPRA) without conditions.

605. Successful applicants must participate in an induction process that covers their legislative obligations, reporting expectations and WorkSafe's policies. IMEs must also complete training in relation to conduct and agree to meet service standards at the end of the induction process.

606. As at May 2019, WorkSafe had 269 IMEs under its new criteria.

607. WorkSafe can suspend or revoke an IME's registration if they fail to meet WorkSafe's IME Service Standards (the Standards), which have been updated since the Ombudsman's 2016 investigation. The Standards set out WorkSafe's expectations about matters such as conduct during examinations and the content and structure of IME reports. They require IMEs to notify WorkSafe of significant matters such as formal complaints and changes to their AHPRA registration.

608. In 2017-18, WorkSafe took action against five IMEs following investigations into misconduct, breaches of the Standards and recurring complaints. This resulted in:

- the resignation of two IMEs
- a decision to take no further action regarding one IME
- a warning for one IME
- a one-month suspension for one IME.

609. An external review WorkSafe commissioned in early 2019[55] identified a potential gap in WorkSafe's oversight of IMEs once appointed, as WorkSafe did not proactively check if IMEs continued to meet the new criteria throughout their three-year appointment term. The review found this created a risk that IMEs who no longer met the criteria would continue conducting examinations. For example, IMEs might stop performing the minimum of eight hours direct clinical care per week or have conditions imposed on their registration by AHPRA.

610. WorkSafe told the investigation that it has since gained access to AHPRA's medical practitioner registration system so it can identify any changes to an IME's registration status.

Stakeholder feedback regarding new selection criteria

611. Some witnesses raised concerns with the investigation about the new requirement that IMEs engage in eight hours of direct clinical care each week.

612. One IME representative interviewed during the investigation said this had resulted in some experienced medical practitioners not being re-appointed as IMEs because they could not demonstrate eight hours of clinical practice per week. The representative said in introducing this change, WorkSafe 'threw the baby out with the bath water' and there was 'a great skill level lost'. The representative said this change also resulted in WorkSafe 'under-appointing' the number of IMEs required to meet the demand of appointments requested by agents.

613. A representative from the Australian Medical Association said there was a 'level of artificiality' in the changes to WorkSafe's IME criteria. They said there had been a lack of explanation and 'openness' from WorkSafe about why eight hours of clinical practice was considered the appropriate measure for medical practitioners to be considered suitable as an IME, and that it had 'got a lot of people upset'. They further said that:

> The number of doctors who are falling off the system or out of the system simply because they are not meeting the eight hours, but they're not necessarily doctors who don't have the capacity to do the work … the result is a lot of doctors who might have incredible skill sets but are not practicing in a clinical sense of treating patients are locked out.

55 PricewaterhouseCoopers, *WorkSafe Victoria IME Management*, Internal Audit Report (March 2019).

614. By contrast, a WorkSafe Clinical Advisor told the investigation that they believed the new criteria was an 'improvement' because it had caused a lot of IMEs with 'outdated' opinions to 'drop out'. They said in the past some IMEs were 'semi-retired' and not as 'up-to-date in their clinical practice', but that the new criteria had changed this.

615. In response to the draft report, WorkSafe said:

> WorkSafe notes that it did undertake significant external consultation including through the IME Clinical Reference Group, a presentation to the AMA [Australian Medical Association] WorkCover/TAC committee, the establishment of a working group with representative from the College of Surgeons and consultation with various medical faculties and peak bodies in relation to the IME criteria.

Quality assurance

616. Once IMEs are appointed, WorkSafe oversees the quality of reports they produce through quality assurance processes. Reports are assessed against the IME Service Standards which, among other things, set out requirements for the content and structure of reports.

IME Service Standards – IME reports

The IME Service Standards set out standards for IME reports. Among other things, they say reports should:

- contain reasons for all opinions expressed
- be consistent in that opinions should accord with examination findings
- be 'free of advocacy and/or bias for any party'
- be in 'plain English' and 'avoid the use of jargon or language that is too technical'
- provide an 'accurate diagnosis based on references to a detailed and accurate history and an appropriate and thorough clinical examination'
- contain 'clear and unambiguous professional opinions' and, where required, 'recommendations based on science and with reference to best practice medicine or best clinical practice'
- present an 'evidence-based approach to evaluating symptoms and clinical findings, as far as practicable'
- note if there is 'insufficient clinical information to make a diagnosis'
- be 'independent and impartial', and not contain any 'value judgements or personal comments'
- contain 'only relevant information'.

Changes since the Ombudsman's 2016 investigation

New IME Quality Assurance Framework

617. Since 2016, WorkSafe has introduced a new IME Quality Assurance Framework which, according to WorkSafe, provides:

> [A] connected approach focusing on building capability and supporting IMEs and claims staff in providing independent and non biased opinions. Ensuring that supports are in place and of the highest quality, will be important to help drive improved quality reports and detailed information and opinions that support the management of an injured worker's return to health.

618. In response to the draft report, WorkSafe said:

> We confirm that the IME Quality Assurance Framework also includes recruitment, induction, [and] taking appropriate action in relation to IMEs who do not meet performance standards. We also note that further improvements arising from the review of the IME Quality Assurance Program are being implemented.

Peer reviews

619. At the time of the Ombudsman's 2016 investigation, WorkSafe's quality assurance process consisted of peer reviews of IME reports. WorkSafe describes these as a 'proactive management practice that is used to assess the level of quality of IME reports through the structured program that engages peers to review and comment against a set of standard criteria'.

620. Since 2016, WorkSafe has made changes to its peer review process so that:

- Its selection of IMEs for review is informed by the frequency and nature of IME complaints.
- There is a documented process to ensure claims are reviewed where an IME report is found to be 'significantly deficient'.

621. WorkSafe only completed 11 peer reviews in 2017-18, to allow it to prioritise the redevelopment of its IME Quality Assurance Framework. In 2018-19, WorkSafe conducted ten peer reviews, with another 14 in progress as at May 2019.

New clinical desktop reviews

622. WorkSafe also introduced a second IME quality assurance process in October 2018, involving 'clinical desktop reviews' of IME reports. WorkSafe states that these reviews 'provide another quality layer' and allow WorkSafe to conduct a 'more agile, responsive review and in greater numbers'.

623. As distinct from peer reviews, WorkSafe states clinical desktop reviews are designed for 'quick resolution of one-off issues that require feedback to IMEs, in particular quality of reports, suggested improvements and education'. The reviews are conducted by one of WorkSafe's Clinical Advisors.

624. WorkSafe may conduct a clinical desktop review based on a complaint from an injured worker or agent about the quality of the IME report or where an IME is new to the scheme, for example. WorkSafe states an IME report is considered 'suitable' for this type of review in circumstances where:

- there are factual inaccuracies in the IME's report which are evident from supporting documents provided to the IME
- the IME failed to adequately or appropriately answer the agent's questions
- the content and/or format of the IME's report does not meet the IME Service Standards

- the IME's opinion does not accurately reflect the assessment findings reported
- WorkSafe has received more than two complaints about the IME within four weeks that directly relate to the IME report.

625. WorkSafe completed 39 clinical desktop reviews between October 2018 and May 2019.

New IME Performance Management Framework

626. In addition to expanding the quality assurance processes, WorkSafe also introduced an overarching IME Performance Management Framework. The framework outlines specific actions WorkSafe will take when IME report deficiencies are identified, to ensure performance management of IMEs is handled in a consistent way.

627. The framework was developed in response to an external review which identified that WorkSafe had no formal policies, guidelines or other documentation outlining remedial action where an IME's performance is considered unsatisfactory because of peer and desktop reviews and/or complaints. The review highlighted that a lack of clarity about this 'increases the risk of IMEs who may be underperforming continuing to provide services to injured workers'.[56]

Limitations of quality assurance processes

628. While WorkSafe has expanded and improved its IME quality assurance processes since 2016, the investigation found that their value has been limited because WorkSafe does not give reviewers complete information when they undertake a peer or clinical desktop review of an IME report.

629. WorkSafe gives the reviewer the IME's report and the agent's referral letter to the IME. WorkSafe does not give the reviewer copies of other documents the IME received to inform their opinion, including previous IME reports, Medical Panel opinions, reports from the worker's treating doctor(s) and occupational rehabilitation reports. For complex claims, this documentation provides crucial background information about the worker's history.

630. The limitations of the approach became evident when WorkSafe arranged a clinical desktop review of one IME's reports as a result of issues identified during this investigation. The investigation read a number of the IME's reports when reviewing cases and observed that they sometimes contained similar, if not identical, comments and conclusions. This included statements that:

    - The worker presented with a significantly disproportionate emotional response to their physical injury.[57]
    - The worker could return to work, despite a history of incapacity.
    - There had been a 'significant change' in the worker's condition since a previous Medical Panel opinion.

631. Agents used the IME's reports to terminate workers' entitlements. In two thirds of these cases, the agent's termination was withdrawn or overturned through the dispute process.

632. WorkSafe arranged for one of its Clinical Advisors to undertake clinical desktop reviews of 10 of the IME's reports. The Clinical Advisor is a leader in their field and has been involved in the WorkCover scheme for about 15 years.

56 PricewaterhouseCoopers, *WorkSafe Victoria IME Management*, Internal Audit Report (March 2019)

57 Referred to by the IME as 'functional overlay'.

633. From these reviews, WorkSafe concluded that the IME's opinions were 'appropriate' but identified opportunities for improvement. It said:

> The review of a sample of … [the IME's] reports highlights that … [they] had used similar wording or repetitive language within some of … [their] reports. While it was noted that the ultimate opinion was seen to be appropriate based on the context and body of each report … [the IME's] opinions were in general seen to be brief in nature. It was flagged that … [their] opinions were often not well explained or supported by examples from the history and the examination taken. To ensure that further quality improvements are seen within … [the IME's] reports, WorkSafe will provide feedback to … [the IME] about these findings and will conduct further quality reviews on a sample of … [the IME's] reports.

634. The investigation looked at the Clinical Advisor's written feedback for the 10 reports. While WorkSafe had stated that the IME's opinion in each case was 'appropriate based on the context and body of each report', the Clinical Advisor concluded that:

- There was some evidence of bias in four of the reports. The Clinical Advisor said one report was not free from bias and three reports were potentially not free from bias.
- There was an incomplete explanation in nine reports, which left the opinions open to interpretation by agent staff.
- There was possibly a 'discrepancy between the reported assessment findings and the outcome, opinion or recommendations of the report' in four reports.
- It was 'difficult to comment specifically' on six reports where the IME concluded there had been a 'material change' in the workers' condition since a Medical Panel examination, without reviewing the Panel's opinion. WorkSafe did not give the Clinical Advisor a copy of the Medical Panel opinion.

635. The investigation interviewed the Clinical Advisor and gave them an opportunity to review all of the documentation considered by the IME. After reviewing these documents, the Clinical Advisor expanded on their original criticisms and said:

- The IME's opinions were often 'unclear' and 'inadequately explained'.
- In most of the cases where there was a previous Medical Panel opinion, there was insufficient evidence to support the IME's view that the worker's condition had materially changed. The Clinical Advisor formed a different view to the IME and, in some cases, said the worker's condition appeared to have actually worsened.
- Instead of basing opinions on 'objective clinical science', the IME referred to subjective information in their assessment of workers' conditions. For example, the IME often commented that workers had a disproportionate emotional response to their physical injuries. The Clinical Advisor disagreed with these comments and indicated they had limited bearing on a worker's capacity for work. However, the Clinical Advisor noted that agent claims staff sometimes interpreted the comments as meaning workers were not being 'truthful' and 'therefore there's nothing there'.

636. In response to the draft report, the IME said they had been subject to three peer reviews over a six-year period. The IME said one of these reviews recommended some improvements to their reports, but that the most recent review concluded their reports met WorkSafe's requirements.

637. The IME said that the 10 cases the Clinical Advisor reviewed generally involved 'complex injuries', with 'both a physical and psychological component' and that the IME's reports 'concentrated on the physical assessment'.

638. The IME said that their reports were 'usually submitted in a standard format, using standardised headings' and the injuries reviewed were a similar type. The IME said this 'may explain the commonality of the language used in the reports'.

639. The IME acknowledged that:

- They made references to work restrictions, but in some cases did not expand on these.
- Their explanations in some reports were 'brief' and 'would have benefitted from greater detail'.
- Where they identified emotional responses to physical symptoms, this should have been more thoroughly outlined.
- Where they commented on changes since a previous Medical Panel, the IME 'relied heavily on changes in examination findings' and it would have been beneficial to support these with other changes.

640. The IME said they 'take on board the reviewer's comments that without detailed explanation, the report submitted could be subject to interpretation'.

641. Three examples of complex claims involving a report by this IME (whom we call 'IME Y'), which was reviewed by WorkSafe's Clinical Advisor, are outlined on the following pages. In each case, the Clinical Advisor provided negative feedback about the IME's report.

Example 1

Hamish was working as a tradesman when in 2013 he injured his neck.* He ceased work and made a WorkCover claim which was accepted by his employer's agent at the time. His claim was later managed by Xchanging.

In early 2016, a Medical Panel concluded that Hamish was indefinitely incapable of returning to any form of work because of his persisting neck injury and a secondary mental injury. In forming its opinion, the Panel considered Hamish's symptoms, his age (he was in his early 50s), his limited work experience and few transferrable skills, his low formal education level, his lack of any effective computer skills and his absence from the workforce since 2013.

About a year later, Xchanging arranged for Hamish to be examined by IME Y to assess his physical injury. After examining Hamish, IME Y concluded:

- Hamish could now return to suitable employment (despite having not worked for four years).
- Hamish's employment was partially responsible for his impairment, but he presented with a significantly disproportionate emotional response to his physical injury.
- There had been a material change in his condition since the Medical Panel's examination.

In late 2017, Xchanging relied on IME Y's opinion to terminate Hamish's weekly payments. Hamish disputed the decision at conciliation and the matter was referred to another Medical Panel. In mid-2018, the Panel came to the same conclusion as the previous Medical Panel: Hamish was indefinitely incapacitated for all work. The Panel noted that based on its 'judgement, expertise and experience' it came to a different conclusion to IME Y regarding Hamish's capacity for work. Xchanging reinstated Hamish's weekly payments. When undertaking an initial clinical desktop review of IME Y's report in this case, WorkSafe's Clinical Advisor said IME Y's opinion did not seem to be supported by his assessment of Hamish. The Clinical Advisor also said that although the report appeared to be free of bias, incomplete explanation left IME Y's opinions open to interpretation.

At interview after having reviewed further documentation, the Clinical Advisor said 'objective clinical science' did not indicate a 'material change' in Hamish's condition since the 2016 Medical Panel. The Clinical Advisor also commented on IME Y's assessment that Hamish could return to 'suitable employment', which required consideration of Hamish's injury, previous work experience, education, age, and where he lived. The Clinical Advisor said unlike the previous Medical Panel's assessment of these factors, IME Y's opinion appeared solely based on whether Hamish could physically perform the jobs Xchanging proposed, and not whether the jobs were 'realistic' based on all of the factors which must be considered. The Clinical Advisor said IME Y's approval of the jobs was 'unrealistic' because they had not considered the retraining required, location of the proposed jobs, Hamish's age, and length of time since Hamish had last worked.

In response to the draft report, IME Y said:

> I take on board the observation that my explanations [in this case] could have been expanded upon. In future, I will incorporate more detail into the answers to the questions posed, in particular with regard to any evidence of an emotional response to the examination, changes since the Panel convened and greater detail regarding my recommendations for return to work and retraining.

* This case is also discussed on page 134.

Example 2

James had been working as a police officer for nearly 40 years when in late 2012, he injured his lower back.* James made a WorkCover claim, which was accepted by his employer's agent, Gallagher Bassett. James returned to work on light duties but ceased completely in early 2014 due to pain from his injury.

In mid-2016, a Medical Panel concluded that James was indefinitely incapacitated for all work. The Panel considered James' employment options were limited having regard to his injury, his age (he was in his early 60s), place of residence in country Victoria and inability to drive a car for longer than 30 minutes.

About a year later, Gallagher Bassett arranged for James to be examined by IME Y. After examining James, IME Y concluded:

- James could now return to work performing modified duties (despite not having worked for nearly four years).
- James's employment was partially responsible for his impairment, but he presented with a significantly disproportionate emotional response to his physical injury.
- There had been a 'significant change' in James's presentation since the Medical Panel examined him about one year prior.
- All four job options that the Medical Panel previously considered were not appropriate were now suitable for James.

In late 2017, Gallagher Bassett relied on IME Y's report to terminate James' weekly payments. James disputed the decision at conciliation and the matter was referred to another Medical Panel. In mid-2018, the Panel came to the same conclusion as the previous Medical Panel, that James was indefinitely incapacitated for all work. Gallagher Bassett reinstated James's weekly payments based on the Panel's opinion.

WorkSafe's Clinical Advisor told the investigation at interview that they considered the factors listed by IME Y were not 'significant enough to say that there was a material change' in James's condition since he was assessed by the Medical Panel. The Clinical Advisor noted IME Y's opinion included subjective comments about James's presentation at examination and said 'I would rather rely on objective signs to demonstrate [material change]'.

The Clinical Advisor said they came to a different conclusion regarding IME Y's recommendation that James was fit to return to suitable employment. They said that although James might have had a 'theoretical' ability for suitable employment, it was 'unlikely he would be able to find suitable employment' having regard to his age, residential location, and need for retraining.

In response to the draft report, IME Y said that on reviewing the case, there was some objective evidence of change in James's condition; however, IME Y accepted this was not specifically identified within their conclusions. IME Y said they accepted their conclusions were 'not adequately explained' and that they would endeavour to 'more comprehensively' address both material changes and recommendations for return to work.

* This case is also discussed on page 204.

Example 3

Theodore was working as a machine operator when in the late 1990s he injured his back.* Theodore made a WorkCover claim, which was accepted by his employer's agent, Gallagher Bassett. Theodore made several attempts to return to work but had to stop work completely a year after his injury.

Between 2000 and 2016, Theodore was examined by five separate Medical Panels each of which concluded he was suffering from a back injury and chronic pain syndrome. The Panels which considered his work capacity concluded he was indefinitely incapable of returning to any work. Theodore was also diagnosed with a secondary mental injury.

In late 2016, Gallagher Bassett arranged for IME Y to examine Theodore. IME Y noted there had been a significant deterioration in Theodore's spinal movements. However, IME Y concluded there was 'no physical basis for his current impairment', contrary to the findings of five previous Medical Panels. Despite not having worked for over 16 years, IME Y concluded Theodore could now return to work performing his pre-injury duties as a machine operator. IME Y also said Theodore could participate in occupational rehabilitation and that there had been a material change in Theodore's condition since he was examined by the previous Medical Panel.

Gallagher Bassett relied on IME Y's opinion to require Theodore to participate in occupational rehabilitation. Theodore requested conciliation and complained to the Ombudsman because he believed he did not have the capacity to attend. Following enquiries by the Ombudsman, Gallagher Bassett told Theodore he no longer needed to participate.

When undertaking an initial clinical desktop review of IME Y's report in this case, WorkSafe's Clinical Advisor said:

> [IME Y] stated the injured worker has a capacity to return to work performing pre-injury duties. This opinion is inadequately explained by the IME taking into consideration the injured worker has not worked for 16-17 years, has no other current skills and has documented functional difficulties which had been also noted by two medical panels.
> ...
> The opinions provided are inadequately explained and supported. In the absence of further explanations and details in answers to questions, there are potential discrepancies in the opinions provided which could be open to interpretation by the case managers reading the report at the agent who may not have the same medical background.

At interview after having reviewed further documentation, the Clinical Advisor queried IME Y's opinion that there had been a material change in Theodore's condition since the Medical Panel opinion, noting they did not provide any specific examples regarding how his back injury had changed. The Clinical Advisor also disagreed with IME Y's opinion that Theodore could return to his pre-injury duties, stating they thought it was unlikely he could return to alternative duties, let alone pre-injury duties.

In response to the draft report, IME Y said:

> In this case, I reached the opinion that the impairment was now predominantly psychological and that the physical injuries from 20 years ago had now settled. I will accept that this was not well defined in my report.

* This case is also discussed on page 67.

642. In addition to commenting on the three individual cases, IME Y said in response to the draft report:

> I have had the opportunity to reflect on my practice, my report writing and also the manner in which the reports are received. I have also had the opportunity to reflect on the emphasis that is placed on the various components of the assessment; in particular, assessing the emotional response of workers to the evaluation. Whilst I note the absence of such features is a useful clinical finding, the presence of such features should be presented in a way which the reader can attribute the appropriate weight to the information. In addition your report has caused me to reflect on the importance of such findings in isolation of other validity test results.
>
> I have also considered the issue of changes in the interval since the Panel last convened and will be carefully reviewing my recommendations in such cases. I have also considered further how to quantify a material change. This is likely to require further discussion and I have already raised this at a Peer Review.
>
> Since I received your letter, I have already made changes as to how I present reports
>
> - I am ensuring that the evidence to support my conclusions is fully disclosed
> - That I explicitly address the findings within my responses to the questions posed
> - That the balance of the evidence is addressed whilst presenting and summarising my findings.
>
> I would stress that the observation of potential bias is particularly concerning as I have always taken an independent role and will now reflect very carefully to ensure that not only my reports are independent, but are also seen to be independent.

Other sources of information about IMEs

643. Noting the proportion of claims reviewed where a termination based on IME Y's opinion was later overturned or withdrawn through the dispute process, the investigation asked WorkSafe if it captures data regarding:

- the proportion of individual IME opinions which have led to adverse decisions by agents
- the proportion of those decisions that are subsequently overturned through the dispute process (either at conciliation, court or by a Medical Panel).

644. WorkSafe said it does not have regular reporting on adverse decisions that are as a result of an individual IME opinion, although it has reported on this in the past on an 'ad-hoc basis'. WorkSafe said there were 'certain complexities' which meant it could not accurately report on this.

645. WorkSafe also said Medical Panel outcomes could not 'necessarily be directly linked to an IME opinion' because:

- A Medical Panel may consider further information which was not available to the IME at the time of their examination of the worker.
- An injured worker's presentation may change from the time of their examination by the IME to that of the Panel, as the worker may have had 'further medical appointments, diagnostics or treatment in that time'.

Complaints about IMEs

646. WorkSafe handles complaints about IMEs, which provide another source of feedback about IMEs and the quality of their reports. In 2017-18, WorkSafe received 276 complaints about IMEs.

647. WorkSafe has a dedicated team to handle IME complaints, which is separate from the team that handles complaints about agents.

Changes since the Ombudsman's 2016 investigation

648. In response to the Ombudsman's 2016 investigation, WorkSafe made changes to its IME complaints policies and procedures so:

- Workers are not required to put their complaint in writing.
- WorkSafe shares complaints about IMEs with the team that oversees the IME quality assurance processes.

Effectiveness of complaint handling in 2017-18

649. To examine the effectiveness of WorkSafe's handling of IME complaints, this investigation reviewed:

- WorkSafe's policies and procedures for IME complaints
- WorkSafe's records for 24 IME complaints in 2017-18, about half of which were randomly selected.

650. Although WorkSafe has made some changes to its handling of IME complaints since 2016, this investigation identified that:

- There is a lack of clarity around WorkSafe's role in IME complaints.
- In some cases, WorkSafe has accepted IMEs' responses to complaints without considering whether they were reasonable.
- There is no clear process for referring complaints between WorkSafe's IME complaints and agent complaints teams.

Lack of clarity around WorkSafe's role in IME complaints

651. WorkSafe has three policies and procedures dealing with IME complaints.

652. Firstly, it has an IME complaints procedure which outlines the steps WorkSafe takes upon receipt of an IME complaint. However, the procedure does not define the types of IME complaints WorkSafe can handle.

653. The procedure says WorkSafe:

- obtains the worker's consent for WorkSafe to contact the IME about their concerns
- writes to the IME about the worker's concerns and seeks their response
- provides the outcome to the worker and IME.

654. The procedure sets out detailed advice about administrative steps such as where to save documents in WorkSafe's system, but it is silent on whether WorkSafe reviews the IME report that is the subject of the complaint to form its own views on the issues raised by the worker.

655. Secondly, the WorkSafe Claims Manual provides further advice about IME complaints. It states that 'the nature of the IME complaint determines how the complaint will be handled' and that WorkSafe only investigates 'administrative complaints'. However, the Claims Manual does not define an 'administrative complaint' or provide examples.

656. The Claims Manual further states that 'other complaints about the professional and ethical conduct of IMEs' may be referred to more appropriate bodies, such as the Medical Practitioners Board of Victoria or the Health Services Commissioner. WorkSafe also does not define these terms or provide examples.

657. WorkSafe introduced a third policy dealing with IME complaints in June 2019, in the form of its new IME Performance Management Framework. It outlines 'issues' relating to IMEs and the relevant 'performance management actions' WorkSafe should take. This framework is not confined to complaints; it also covers concerns identified through the IME quality assurance processes.

658. The Performance Management Framework states that WorkSafe may write to an IME and seek their response where a worker raises concerns such as:

- an IME causing the worker pain during the examination
- excessive appointment wait times
- an IME recording the examination without the worker's consent
- factual errors in the IME's report.

659. The Performance Management Framework states that where a worker disagrees with an IME opinion, WorkSafe should refer them to conciliation. While the conciliation process can resolve disputes about agent decisions, it cannot address deficient IME opinions.

660. In the sample of IME complaints the investigation reviewed, there were cases where WorkSafe did not take any action regarding complaints about IME opinions despite the opinions potentially breaching the IME Service Standards. These include requirements that an IME report:

- contain reasons for all opinions expressed
- be consistent in that opinions should accord with examination findings
- be free of advocacy or bias for any party
- contain 'clear and unambiguous' professional opinions.

661. While WorkSafe considers these issues in its quality assurance reviews of IME reports, it does not appear to consider complaints about the same issues.

662. In response to the draft report, WorkSafe said:

> We confirm that WorkSafe has developed a new work practice on the complaints process and have recruited a specialist to oversee all IME complaints. It categorises all complaints and will investigate further if the issue raised is factual, an agent issue, behavioural, a breach of service standards or a conflict of interest issue.

663. The following is an example of a complaint about an IME opinion, which WorkSafe declined despite the worker's concerns that it had no basis.

Case study 52 – WorkSafe 'unable to intervene' despite concerns about unfounded IME opinion

Damien was working as a police officer when in 2010 he developed PTSD after attending traumatic incidents.* Damien made a WorkCover claim which was accepted by his employer's agent, Gallagher Bassett.

In 2017, Gallagher Bassett arranged for an IME to examine Damien. The IME concluded Damien continued to suffer from PTSD and was indefinitely incapacitated for all work.

Gallagher Bassett requested a supplementary report from the IME, noting the IME commented that Damien played golf twice a week. Even though the IME already concluded Damien was indefinitely incapacitated for work, Gallagher Bassett asked whether his 'level of commitment in regards to this activity' translated to Damien having at least a partial capacity for suitable employment or capacity to participate in occupational rehabilitation.

In response, the IME said that when he saw Damien three months ago he had no capacity, but that it was 'possible' he had 'improved now'. The IME did not explain how or why. Based on the IME's supplementary report, Gallagher Bassett required Damien to participate in occupational rehabilitation.

Damien complained to WorkSafe about the IME's supplementary report. He said his 'main concern' was that there was no basis for the IME's statement that it was 'possible' he had improved, when the IME had not reassessed him. WorkSafe did not take any action and told Damien it was 'unable to intervene' as his complaint related to the IME's opinion. WorkSafe told him it would 'make a note' of his concerns but said:

> WorkSafe does not strictly govern the content of a medical report, instead setting guidelines for the structure of the report and leaving the composition of the report to the discretion of the IME.

Gallagher Bassett subsequently withdrew its requirement for Damien to participate in occupational rehabilitation after he made a complaint to his local MP.

* This case is also discussed on page 58.

664. In another case, WorkSafe told an injured worker's daughter it was unable to look into her complaint about an IME's opinion, despite the IME relying on incorrect information.

Case study 53 – WorkSafe fails to look at complaint about IME opinion, later overturned by Medical Panel

Lana was employed as a packer when in 2002 she developed pain in her shoulder, neck and arm from repetitive work. She ceased work in late 2002 and made a WorkCover claim which was accepted by her employer's agent, Gallagher Bassett.

In 2005, a Medical Panel concluded that Lana was no longer suffering from physical injuries, but had developed a pain disorder. The Panel concluded she was indefinitely incapacitated for all work as a result. A series of IMEs between 2005 and 2016 also said she was indefinitely incapacitated for work as a result of her pain disorder and a secondary mental injury.

In 2017, Gallagher Bassett arranged for a psychiatrist IME to examine Lana. The IME concluded Lana had major depression with psychotic symptoms, but did not comment on whether she had a pain disorder as diagnosed by the previous Medical Panel and other IMEs. The IME said the cause of her mental injury was 'uncertain' but 'risk factors' included:

> [H]er status as an immigrant, and early refugee, time of life issues, divorce and then separation from her de facto, and initially at least, some sort of musculoskeletal problem that has now reportedly resolved.

The IME further said:

> Employment is now only a cause, if it causes a physical injury. If it does not cause a physical injury now, then employment is not the cause.

This was contrary to the Medical Panel's opinion that although Lana's physical injury had resolved, she had developed a pain disorder as a result of the original injury.

Lana's daughter complained to WorkSafe by phone about the IME's opinion. A file note about the phone call said Lana's daughter told WorkSafe she was 'not happy' with parts of the report, including the IME's reference to Lana being a refugee. Lana was not a refugee, but rather had migrated to Australia to reunite with family members. WorkSafe took no action regarding the complaint and told Lana's daughter it was unable to intervene as her concerns related to the IME's opinion.

Gallagher Bassett terminated Lana's entitlements based on the IME's report. Lana requested conciliation and the matter was referred to a Medical Panel. The Panel concluded Lana was indefinitely incapacitated for all work, as a result of a severe chronic pain disorder and depression, caused by her original physical work injury. The Panel disagreed with the IME's opinion, noting that the 'risk factors' the IME highlighted were 'general risk factors for psychiatric illness', but said they did not significantly contribute to Lana's condition. The Panel also said contrary to the IME's opinion, 'persisting physical injury' was 'not a prerequisite for the development of chronic pain disorder'.

Gallagher Bassett reinstated Lana's entitlements based on the Panel's opinion, three months after they were terminated.

665. The following case is another example, where WorkSafe took no action regarding a worker's complaint about an IME opinion, despite the worker identifying several inaccuracies and missing information in the report.

Case study 54 – WorkSafe unable to look at 'anything relating to the opinion or the context of a report'

James had been working as a police officer for nearly 40 years when in late 2012, he injured his lower back.* James made a WorkCover claim, which was accepted by his employer's agent, Gallagher Bassett.

In mid-2016, a Medical Panel concluded that James was indefinitely incapacitated for all work. About a year later, Gallagher Bassett arranged for James to be examined by an IME. The IME concluded:

- Despite not having worked for nearly four years, James could now return to work performing modified duties.
- James's employment was only partially responsible for his impairment.
- There had been a 'significant change' in James's presentation since the Medical Panel examined him about one year prior.

James complained to WorkSafe about the IME's report, raising concerns that it was 'not an entirely accurate and true account of all that was discussed' during the examination. James raised several concerns about inaccuracies and missing information in the report and queried how the IME reached some of their conclusions.

WorkSafe did not take any action regarding the complaint and told James it was unable to intervene in 'anything relating to the opinion or the context of a report'. WorkSafe told him it could only raise concerns with an IME when the Service Standards had been breached. However, it is unclear whether WorkSafe reviewed the IME report upon receiving the complaint and why it concluded the IME's report complied with the Service Standards. In WorkSafe's written outcome to James, it stated:

> As discussed, I have closed your complaint because the resolution you would like is a change to the opinion provided by … [the IME]. This resolution can't be achieved through the complaints process; however the Accident Compensation Conciliation Service may be able to help you.

Although the ACCS can resolve disputes about claim decisions, it does not have a role in changing an IME opinion or addressing concerns about a deficient opinion.

Gallagher Bassett terminated James's weekly payments based on the IME report and he requested conciliation. The matter was referred to another Medical Panel which came to a different conclusion to the IME. Gallagher Bassett reinstated James's entitlements based on the Panel's opinion.

* This case is also discussed on page 197.

666. In another case reviewed by the investigation, WorkSafe declined a complaint about an IME opinion because the IME had not breached the IME Service Standards. However, it is unclear how WorkSafe formed this view.

Case study 55 – WorkSafe declines to look at complaint about inconsistent IME opinion

Mary was working in finance when she developed a mental injury from work-related stress, bullying and harassment.* In 2013, Mary made a WorkCover claim, which was accepted by her employer's agent. Mary was examined by a Medical Panel in mid-2016, which concluded she was indefinitely incapacitated for work.

In mid-2017, the agent managing Mary's claim, Gallagher Bassett, arranged for her to be examined by an IME. The IME provided an inconsistent and contradictory opinion in their report stating that Mary's mental injury was 'in remission' and she had 'recovered', but that her treatment should continue and she was unable to return to work. The IME also said the cause of Mary's mental injury was no longer work-related, contrary to previous IME and binding Medical Panel opinions.

Gallagher Bassett relied on the IME's opinion to terminate Mary's entitlements because her mental injury was no longer work-related. Mary complained to WorkSafe, querying how the IME concluded her injury was no longer work-related after four years. WorkSafe did not take any action regarding Mary's complaint and finalised it on the basis that the IME had not breached the IME Service Standards. It is unclear how or why WorkSafe formed this view and whether it reviewed the IME report.

Mary requested conciliation regarding the termination. When Gallagher Bassett reviewed the decision, it acknowledged that the IME's opinion was 'unclear'. At conciliation the matter was referred to another Medical Panel, which disagreed with the IME's opinion that Mary's mental injury was 'in remission' and that it was no longer work-related. Gallagher Bassett reinstated Mary's entitlements based on the Panel's opinion.

* This case is also discussed on page 33.

IME responses not assessed by WorkSafe

667. WorkSafe's policies and procedures say it can deal with 'administrative' complaints about IMEs. However, where WorkSafe decides to write to an IME about a worker's complaint, it is unclear whether WorkSafe assesses the adequacy and reasonableness of the IME's response. There is no information in WorkSafe's IME complaint procedure about this step. The procedure states:

> Once you have received a response from the IME, you will need to then send an outcome letter to both the IME and the worker. … Once this has been completed, you can then close the complaint.

668. WorkSafe told the investigation that the IME's response is 'always' reviewed before the complaint is finalised. However, the sample of IME complaints the investigation reviewed suggested this does not always occur, as WorkSafe finalised some of the complaints based on IME responses which did not address the worker's concerns.

669. The following case study is one example, where a worker complained to WorkSafe that an IME told her at the examination she did not have a work capacity, but stated the opposite in his report.

Case study 56 – WorkSafe closed complaint despite unclear IME response

Roseanne was working as a gaming attendant when in late 2011 she suffered a mental injury due to work stress and verbal abuse. She made a WorkCover claim which was accepted by her employer's agent. In 2014, a Medical Panel concluded Roseanne was indefinitely incapacitated for all work.

A few years later in mid-2018, Roseanne's agent arranged for a psychiatrist IME to examine her. The IME concluded Roseanne had a capacity to return to work when only the work-related psychiatric condition was considered. However, the IME said there had been no 'material change' in Roseanne's condition since she was examined by the Medical Panel.

Roseanne complained to WorkSafe that the IME told her at the examination they believed she did not have a work capacity, but stated the opposite in their report. WorkSafe wrote to the IME asking them to respond to Roseanne's concerns.

The IME's response to WorkSafe did not address Roseanne's concerns, as the IME said their report did not contradict the opinion they provided at the examination that she had no work capacity. However, the IME made no reference to their comments in their report that Roseanne had a work capacity.

WorkSafe finalised Roseanne's complaint based on the IME's response and told her:

- Medical opinions and recommendations could only be changed by the provider of that opinion.
- After reviewing her concerns and further information, the IME stood by their original opinion. If Roseanne disagreed with any decision Xchanging made based on an IME opinion, she could request conciliation.

When the investigation sought further information from WorkSafe about its handling of this complaint, Worksafe acknowledged it had not 'fully addressed' Roseanne's concerns when it closed her complaint. WorkSafe noted that the agent did not make an adverse decision about Roseanne's entitlements based in the IME's report, but said:

> WorkSafe acknowledges that there is an opportunity to further improve our IME complaints handling process to integrate all relevant areas of WorkSafe at the earliest opportunity to ensure all aspects of a complaint are addressed.

670. In another case, WorkSafe closed a worker's complaint based on the IME's response, without considering whether factual inaccuracies in the IME's report affected the overall opinion of the IME.

Case study 57 – WorkSafe closed complaint without assessing IME's response

Natalie was working as a marketing manager when in early 2012, she developed a mental injury from bullying in the workplace. She made a WorkCover claim which was accepted by her employer's agent.

In mid-2017, Natalie's agent arranged for her to be examined by a psychiatrist IME who concluded:

- Natalie's condition was largely in remission.
- From a psychiatric point of view, she could return to work in suitable employment and participate in occupational rehabilitation.
- Natalie had received treatment from a psychologist for some years and now attended every two to three months. There was 'no clinical worth' in such infrequent psychological treatment.

Natalie complained to WorkSafe about a number of factual inaccuracies in the IME's report. This included the IME's statement that Natalie saw her psychologist every two to three months, when she actually attended every two to three weeks. Shortly after Natalie complained, her agent terminated her entitlement to psychological treatment based on the IME's opinion.

WorkSafe wrote to the IME about her concerns. In response, the IME apologised and accepted they had made errors in the report, including their reference to the frequency of Natalie's psychological treatment. The IME said the errors did not change their opinion. However, the IME's opinion was based on the IME's incorrect belief that she attended a psychologist every two to three months. It does not appear WorkSafe identified this, as it did not further clarify the IME's opinion and finalised Natalie's complaint based on the IME's response.

Natalie's agent ultimately reinstated her entitlement to psychological treatment as an act of good faith after a privacy breach was identified.

In response to the draft report, WorkSafe said:

> WorkSafe notes that in relation to this matter, further engagement with the IME occurred in relation to errors in report. The IME apologised and corrected the errors within the report which related to [the] client's age and treatment frequency. No further action was taken as [the] IME explained the errors in the report were not material and did not change the medical opinion of his recommendation from [the] report. WorkSafe informed the injured worker of the apology and the scope of WorkSafe's ability to intervene where independent medical opinions are being challenged. The injured worker was advised of their rights to appeal to conciliation as the appropriate body to consider these types of disputes.

The investigation accepts the IME said their opinion had not changed, however, given their opinion about the appropriateness of Natalie's treatment was based on an error, WorkSafe should have further clarified this.

Miscommunication between complaints teams

671. Sometimes complaints to WorkSafe raise concerns about an IME report as well as action taken by an agent.

672. The IME complaints team cannot handle concerns relating to an agent, as these are dealt with by a separate team. However, there is no documented process for referring these matters between the two teams.

673. The investigation found that in some cases, this led to inefficient handling of complaints, an example of which is set out below. In this case, a worker complained to WorkSafe about an IME report, as well as Gallagher Bassett's management of his claim. A lack of communication between WorkSafe's two complaints teams meant the worker's concerns about Gallagher Bassett's claim decisions were overlooked.

Case study 58 – Bureaucratic approach to complaint handling leaves worker's complaint unresolved

Jason was working as a truck driver when in 2015 he suffered an injury to his knee. Jason made a WorkCover claim which was accepted by his employer's agent, Gallagher Bassett.

In 2016, Gallagher Bassett arranged for a psychiatrist IME to examine Jason because he had been receiving psychological treatment. The IME concluded Jason did not have a work-related mental injury, so Gallagher Bassett told Jason it would not fund any psychological treatment.

In mid-2017, Jason complained to WorkSafe's IME complaints team about inaccuracies in the IME's report. In response, the IME complaints team told Jason:

- WorkSafe could not intervene in matters relating to the IME's opinion.
- If Jason had any concerns relating to Gallagher Bassett, he could contact WorkSafe's agent complaints team.

Jason recontacted WorkSafe's IME complaints team raising further concerns about factual inaccuracies in the IME's report. He also complained that Gallagher Bassett did not give the IME important information, including that he had been admitted to hospital for stress just prior to the IME examination. The IME complaints team wrote to the IME about the factual inaccuracies Jason raised and the IME apologised for the errors, which they said were typographical mistakes. The IME complaints team reiterated to Jason that it was unable to deal with his concerns about Gallagher Bassett and that he needed to make a separate complaint to the agent complaints team.

A couple of weeks later, Jason wrote to the IME complaints team again and raised additional concerns that Gallagher Bassett was withholding IME reports from him. It was apparent that Jason did not understand the distinction between WorkSafe's two complaint teams. Accordingly, the IME complaints team referred Jason's concerns to the agent complaints team and asked them to contact him. However, this did not occur and the agent complaints team closed Jason's complaint in late 2017 'pending receipt of information that has been requested from complainant'. It appears this was an error, as there was no evidence that either complaints team asked Jason for any further information. WorkSafe did not take any further action on this issue.

674. In another case, a worker's partner complained to WorkSafe about three IMEs, as well as Xchanging's management of the claim. WorkSafe's IME complaints team told the worker and her partner that it was unable to assist with their concerns about Xchanging and that they needed to make a separate complaint to the agent complaints team.

Case study 59 – WorkSafe failed to refer agent complaint to relevant team

Lena was working as a financial officer when in 2002 she suffered a serious stress-related heart condition at work.* Lena made a WorkCover claim, which was accepted by her employer's agent. Lena later developed a secondary mental injury.

Between 2015 and 2017, Lena's partner complained to WorkSafe's IME complaints team on her behalf about three IMEs. WorkSafe did not take any action regarding the complaints as Lena and her partner did not consent to WorkSafe contacting the IMEs about their concerns.

When discussing the IME complaints, Lena and her partner told WorkSafe they were also concerned about decisions of Lena's agent, Xchanging, including a decision to send her to an IME from the incorrect specialty for her injuries. The IME complaints team did not refer their concerns to WorkSafe's agent complaints team, instead telling Lena and her partner to contact WorkSafe's agent complaints team themselves.

* This case is also discussed on page 53.

Booking of IME appointments

675. Historically, agents have been responsible for booking all IME appointments, which allowed them to choose the IME that examines an injured worker. However, this changed following the Ombudsman's 2016 investigation.

Changes since Ombudsman's 2016 investigation

676. To prevent agents' selective use of IMEs,[58] WorkSafe took over responsibility for booking all psychiatrist IME appointments in mid-2017. Under the new process, an agent must contact WorkSafe when it needs a psychiatrist IME to examine an injured worker, and WorkSafe books an appointment with an available IME.

677. WorkSafe said it targeted psychiatrist IME bookings as 'the highest priority' because injured workers with mental injuries (whether primary and secondary) have the 'highest risk of becoming complex and having long term work absence'.

58 This issue is further discussed on page 48.

Effectiveness of new booking process

678. WorkSafe told the investigation there had been a range of improvements since this change in practice, which included:

- 'Elimination of the possibility of agent selection bias by WorkSafe making over 16,000 IME appointments centrally'
- 'Improved transparency over service delivery, particularly around timeliness and requests to reschedule appointments'
- 'Development of clear service delivery standards for booking appointments'
- 'Minor improvements to service delivery to improve client experience; for example if a worker has already attended a psychiatric IME, any subsequent IMEs should be scheduled with the same examiner'
- 'Improved engagement with IMEs resulting from the single point of contact for scheduling appointments. Clear, positive feedback was received from many IMEs reporting that having a single booking contact for the scheme as a whole was beneficial'.[59]

679. WorkSafe also reported a range of negative outcomes from this centralised process, including increased wait times of up to 30 calendar days for non-urgent appointment bookings. This is contrary to WorkSafe's IME Service Standards which require non-urgent appointments to be booked within seven days.

680. In response to the draft report, WorkSafe said:

> While weekly payments should not be adversely affected by this, there have been instances where treatment approvals have been impacted. The delays also impact the client experience and the timeliness of entitlement decision-making.

681. WorkSafe told the investigation that the 'root cause' of the delays was 'ultimately a mismatch between supply and demand'. WorkSafe highlighted:

- higher demand for IMEs because of 'excessive levels of cancellations' of IME bookings, and higher volume of primary and secondary mental injury claims
- lower supply in psychiatrist and psychologist IMEs because they are paid far less than through other medical work
- an increase in workload based on 'poor administrative practices by agents' such as late delivery and large volumes of material before examinations.

682. WorkSafe reported that some issues which the new process sought to address have remained the same, for example:

- the selection of IMEs based on availability instead of proximity to the worker or ensuring an adequate spread of IMEs used
- instances of agents providing IMEs voluminous and unnecessary documentation prior to examinations
- limited change in the volume of requests for supplementary reports.

59 WorkSafe's service standards require 80 percent of assessments for initial liability decisions to be booked within two days; 80 percent of 'urgent appointments' within two days; and 80 per cent of all other appointments within seven days.

683. In 2018, WorkSafe surveyed psychiatrist IMEs who had participated in the new centralised booking process. The IMEs provided mixed responses, which included:

- 'Booking process is streamlined and efficient. Staff are very supportive and responsive'.
- 'I am now getting steady referrals, and the system is transparent and straightforward'.
- 'I think it is much fairer to the workers. Generally it works ok but there are a lot of cancellations'.
- 'Because the appt isn't made by the person actually requesting the IME there is sometimes confusion around length of appointment and report delivery times'.
- 'The agents are not always sending documents and often need to be reminded'.

684. Witnesses interviewed in the investigation echoed the issues WorkSafe identified regarding its new IME booking process. A former agent employee stated that in their experience, the wait times for psychiatric IME appointments were 'astronomical'. The former employee said they had seen examples where the timeframe between a claim being identified as needing an IME examination and the actual examination taking place was 'greater than six months'. They said:

> It will often sit at WorkSafe for an extraordinary amount of time before WorkSafe are able to book in an appointment … For the claims where a liability decision needs to be made they'll make that booking pretty quickly. That's the focus of their attention and then for others they seem to sit there for a really long time.

685. A worker representative raised similar concerns at interview about delays in psychiatric IME appointments being booked, noting the impact this often had on a worker's ability to receive treatment.

686. Conciliation Officer G said at interview that the new booking process was 'worse than it ever was'. They said the booking delays sometimes affected the timely resolution of disputes at conciliation, because they were reliant on the worker being examined by an IME. The Conciliation Officer said:

> There's so many steps to the process and there's so much delay around it now. It seems to take three or four weeks to get an appointment and before if it was recognised that we needed a psych appointment straightaway, I could get that information from the agent rep[resentative] that afternoon, and I could put it in a progress certificate and say 'Here's your appointment coming up. So we're going to have a follow up two weeks later once we have the report'. You were able to keep the momentum up, which is what injured workers in that space really need. I was so hamstrung … [for] the last two that I've had to organise, and I thought 'gosh, if this is progress, we're really in strife'. And it's mental health … it's the last thing that people need delay on.

687. An IME representative interviewed by the investigation said:

> What was a flawed process with the agents, they [WorkSafe] lifted it up, created another layer of bureaucracy and gave it to that other layer of bureaucracy to do [the] same process.

688. WorkSafe told the investigation that its new booking process would remain as a 'business as usual' practice until a new service model is developed as part of WorkSafe 2030. WorkSafe also said it was making a number of further changes to the booking process to address the issues identified during the pilot.

689. In response to the draft report, WorkSafe also said:

> To address critical issues in the short to medium term, the following changes have been made to address the imbalance in supply and demand:
>
> - WorkSafe has commenced work to reduce over-reliance on IMEs and reduce the level of cancellations.
> - WorkSafe reviewed its fee schedule for IMEs. In April 2019, WorkSafe increased the fee for psychiatric IMEs by 25% and made other changes to the fee structure, such as providing a higher fee if there were more than 200 pages of reading material. Anecdotal evidence suggests the fee structure increase has had an overall positive impact of psychiatry IMEs engagement, with a small increase in [the] number of appointments being made available for WorkSafe claims.

Reviews commissioned by WorkSafe

690. Over the last few years, WorkSafe has commissioned a number of reviews to identify opportunities for improving the management of the scheme. This investigation considered three reviews, which looked at:

- factors that lead to long term claims and the consequences for injured workers
- how occupational rehabilitation services are used and the barriers for workers returning to work
- the application of restorative justice principles to the scheme.

691. The issues identified by these reviews echo those identified by the Ombudsman's 2016 investigation and this follow-up investigation, particularly in relation to the management of complex claims.

Victorian Injured Worker Outcomes Study (VIWOS)

692. In July 2015, WorkSafe engaged the Institute for Safety, Compensation and Recovery Research (ISCRR)[60] to examine:

- factors influencing the development of 'long term' claims[61]
- the impact of long term claims on injured workers
- ways to reduce claim duration and improve return to work outcomes for injured workers with long term claims.

693. The review was conducted in three phases, which included:

- interviewing long term injured workers and key stakeholders
- analysing WorkSafe data for long term claims
- research into other Australian and international workers compensation schemes.

694. The review was finalised in late 2018 and found that long term work-related injury resulted in 'numerous negative outcomes' and was characterised by 'ongoing poor health and financial hardship'. The review identified a range of barriers long term injured workers face in returning to work, which included:

- delays across all stages of the claims process
- disputes about agent decisions, which were 'characterised by complicated dispute resolution processes'

60 The ISCRR was established as a partnership between Monash University, WorkSafe and the Transport Accident Commission. Its primary role is to facilitate research and best practice in the areas of injury prevention, rehabilitation and compensation.

61 For the purpose of this review, 'long term' claims were defined as those where a worker received weekly payments for more than 52 weeks (one year).

- frequent changes in claims management staff, which required workers to repeat themselves, resulted in 'loss of case history', increased the likelihood of disputes and delayed workers' recovery and return to work
- difficulty finding healthcare providers to offer treatment under the WorkCover system
- agents' requirement that workers attend frequent IME appointments and 're-tell' their story to different examiners
- the delivery of occupational rehabilitation services with a 'one size fits all' approach, rather than tailoring their services to individuals' needs
- employers' 'avoidance' of their return to work obligations, which, combined with workers' difficulty in finding new employment, prolonged the length of some claims.

695. The study concluded:

> Australian and international practice evidence suggested that client screening based on the risk factors for long-term injury that were identified, combined with early and targeted vocational rehabilitation appears the most effective strategy for preventing longer-term claims ...
>
> To enable this, the workers' compensation system needs to be capable of facilitating early contact and referral and sharing of information in a way that reduces administrative delays. Effective communication and relationship building between WorkSafe Agents, service providers, employers and injured workers was identified as one of most critical enablers for recovery and return to work.

696. Based on the outcomes of the review, WorkSafe developed a range of initiatives to 'improve services' to injured workers and employers by making services more 'client-focused and prevention-led'. Some of these initiatives have formed part of WorkSafe's 2030 strategy, detailed later in this report.

Occupational Rehabilitation Quality Improvement Review

697. In 2017, WorkSafe engaged ISCRR to examine the effectiveness of occupational rehabilitation services in assisting injured workers to return to work, and the experiences of those involved in these services.

698. The review was prompted by a decline in the number of workers returning to work, despite the increased investment in occupational rehabilitation services from 2007 to 2016. The last major review of occupational rehabilitation services was conducted in 1987. WorkSafe stated the goal of the review was:

> In line with WorkSafe's Strategy 2030 focus on offering tailored products, services and support, the proposed OR [occupational rehabilitation] strategic review aims to ensure the best OR services are available for Victorian workers for generations to come.

699. The review was finalised in December 2017 and identified 'both positive and negative experiences' with occupational rehabilitation services. Workers' 'negative experiences' were associated with perceptions of 'unrealistic expectations' of return to work, 'communication challenges' and services that did not match the needs or expectations of the worker. In contrast, workers' 'positive experiences' were associated with perceptions that occupational rehabilitation providers were 'helpful, supportive, listened to them and provided services tailored to their needs'.

700. Occupational rehabilitation providers reported barriers to providing services to injured workers, which included:

- late referrals from agents
- disagreement with treating doctors about workers' ability to engage in occupational rehabilitation
- employers' inability to offer suitable duties
- inadequate funding towards training for injured workers
- challenges with workers who were often 'angry and frustrated' with the claims process and had 'issues' with their employers.

701. Some occupational rehabilitation providers reported agents were using occupational rehabilitation 'as a means to measure compliance' and in some cases, a 'tool to cut benefits'. They also raised concerns that agents did not consider the impact of psychosocial issues in return to work and placed 'unrealistic expectations on how long it took to support the injured worker back to work'.

702. The review made a number of recommendations to WorkSafe, which included that it:

- facilitate early and targeted referral of injured workers to occupational rehabilitation services
- promote information sharing between stakeholders
- explore opportunities to involve the injured worker through 'channels other than formal letters'
- invest in 'activities and programs' aimed at 'reducing stigma' associated with accessing workers compensation.

703. In response to the review, WorkSafe said it provided 'few new insights' and repeated 'historical issues'. However, WorkSafe said it was liaising with occupational rehabilitation providers to 'address key areas', including referral approaches.

Restorative Justice Project

704. In an effort to reduce disputes and look at alternative dispute resolution methods, WorkSafe engaged RMIT's Centre for Innovative Justice[62] to undertake a project to:

> [E]xplore opportunities to apply restorative justice processes and principles in both the enforcement and claims processes, with the aim of meeting the needs of injured workers and their families, repairing or healing harm already caused to them and avoiding potential harm that might arise as a result of the claims or enforcement processes.[63]

705. The review, which was finalised in June 2018, describes 'restorative justice' as:

> [A] broad range of practices that seek to repair the harm caused by a crime (or other wrong), by collectively including those with a stake in the wrongdoing in its resolution. Such practices facilitate the exploration of what happened, how people were affected, and what needs to happen to repair or make amends for the harm, to make sure it does not happen again, and to bring about positive changes for all those concerned.

706. Among other things, the review aimed to inform WorkSafe's and the State Government's response to issues identified by the Ombudsman's 2016 investigation.

62 The Centre for Innovative Justice researches, advocates and applies innovative ways to improve the justice system with a particular focus on therapeutic jurisprudence, restorative justice and non-adversarial dispute resolution.

63 RMIT, Centre for Innovative Justice, *Restorative Justice Opportunities within WorkSafe Victoria: Final Report to WorkSafe Victoria* (May 2018).

707. The review concluded there were 'clear opportunities' for restorative justice practices in the WorkCover scheme and stated:

> Critically, existing processes do not provide people with the opportunity to explain to employers the impact the incident has had on their lives, to receive apologies from employers, or to have input into prevention measures that might ensure no one else has to go through what they have endured.

708. However, the review noted concerns about the application of restorative justice practices in a 'no fault' scheme, which included that:

- restorative justice practices could 'expose injured workers to the risk of further harm' given the power imbalance between employers and employees
- employers would 'rarely if ever agree to participate in a process that involved expressing regret, apologising, or admitting responsibility' if it could be used against them in potential legal proceedings.

709. The review acknowledged that in some cases 'parties may regard the practical risks of participating in the process as too significant'. The review also noted that restorative justice practices were not designed to replace the scheme's 'formal legal frameworks' or to address 'shortcomings or limitations' in those frameworks.

710. The report recommended, among other things, that WorkSafe:

- establish a pilot restorative justice conferencing program
- explore opportunities for other improvements to the enforcement and claims processes.

711. In response to the review, WorkSafe said it was considering:

- how to progress the establishment of a model for restorative justice conferencing pilot
- which of the 'numerous opportunities and strategies' offered in the review should be progressed; were already progressed as part of WorkSafe's 'Strategy 2030'; and which were 'not practical for WorkSafe to implement'.

WorkSafe 2030

712. In considering what further changes to the scheme are needed, the investigation took into account considerable work already underway as part of WorkSafe's 2030 strategy.

713. WorkSafe announced the strategy in 2017, describing it as a 'long term strategic response' to address 'immediate problems'. WorkSafe states these problems include:

- The WorkCover scheme is 'complex and, for some, difficult to access and navigate'.
- 'WorkSafe is heavily paper-based, which makes response times slow and cumbersome'.
- 'WorkSafe's IT systems are fragmented and antiquated, and are not able to share data and information'.
- 'WorkSafe's lack of digital technology puts unnecessary cost burdens on the scheme'.

714. WorkSafe states the strategy has two main goals:

- 'for WorkSafe to be a stronger, proactive, "prevention-led" health and safety regulator'
- for WorkSafe to design its services 'with the needs of people at the very heart of everything we do'.

715. WorkSafe's strategy involves a range of changes to the way it manages the WorkCover scheme and regulates the health and safety of Victorian workplaces. Some of these changes are in response to the Ombudsman's recommendations from her 2016 investigation.

716. WorkSafe told the current investigation:

> [W]e believe our WorkSafe 2030 transformation, including our adoption of a specific customer experience strategy and our technology upgrades enable us to continually improve and evolve to meet our clients' changing needs, contributing to our objective of being a prevention-led health and safety regulator.

717. Key initiatives and changes under WorkSafe's Strategy 2030 include:

- an 'Innovation Centre'
- technology changes
- changes to its complaints management
- a multidisciplinary IME pilot
- a psychiatric hospital substitute pilot
- a 'WorkWell' campaign.

Innovation Centre

718. As part of WorkSafe 2030, WorkSafe created an 'Innovation Centre' to 'test and develop small-scale pilot projects' and 'create or improve products, processes or services to enhance the experience of all workers and employers who come into contact with WorkSafe'.

719. These projects have included the:

- recovery assistance pilot
- recovery hub
- mobile case management program
- transition support program.

Recovery assistance pilot

720. WorkSafe established a 'recovery assistance pilot' in 2017 in collaboration with one of WorkSafe's agents, EML. The pilot adopted a 'human-centred approach' and delivered intensive case management support to nine injured workers with long term claims.

721. The pilot was run by a full-time Recovery Support Officer, who conducted 'detailed forensic case file reviews' and undertook regular face-to-face discussions with each worker to 'understand what they needed to improve the quality of their day to day lives'.

722. WorkSafe reported that the benefits of this tailored approach to case management for workers with complex claims was 'clear', stating:

> We found that by focusing on injured workers' function, in other words 'what they can do' the … [Recovery Support Officer] was able to provide more intensive support that aimed to achieve recovery goals that were more centred on return to life and community reintegration.

723. WorkSafe said that:

- Following completion and evaluation of the pilot, the program had now been implemented across all agents for 2019-20.
- The program focusses on long term injured workers who have been receiving weekly payments for more than four years as at December 2018.
- Each agent is required to identify workers who may be suitable for the program using a range of criteria, but WorkSafe endorses each case to ensure suitability.

Recovery hub

724. The recovery hub is a program focussed on offering a greater level of support to injured workers during rehabilitation and return to work. The program includes:

- a phone-based support service to assist workers to fill out a claim form
- a text message based service to provide treatment information and recovery advice for workers with a lower back injury
- a 'digital tool' for workers to provide feedback during their return to work experience.

725. WorkSafe told the investigation that these supports had been positively received by workers involved in the program and it was looking to develop the program further.

Mobile case management program

726. WorkSafe introduced a mobile case management program in 2017 which offers face-to-face case management at the early stage of a complex claim to ensure 'recovery and RTW programs are tailored to the individual worker's needs'.

727. In 2017-18, WorkSafe introduced a financial reward and penalty measure to encourage agents' use of the program.

Transition support program

728. WorkSafe introduced a transition support program in 2017 to support workers approaching the 130-week review of their entitlements. The program was initially piloted through Gallagher Bassett and included a 'dedicated transition support officer'. Their role was to tell injured workers about external services that could support them in managing their finances, health and social needs 'independently of the scheme'.

729. In July 2019, WorkSafe said it had extended this program 'across the scheme'.

Technology change

730. As part of its 'Strategy 2030', WorkSafe is creating a 'Customer Relationship Management' system. WorkSafe states the new system will provide employers and injured workers access to an online portal, 'myWorkSafe' to 'assist clients to manage their interactions with WorkSafe online, and enable WorkSafe to deliver tailored advice and guidance'.

731. WorkSafe said it is also investing in improved 'data and analytics', through better software and additional staff resources. WorkSafe states these changes will 'allow WorkSafe to identify emerging health and safety trends and return to work issues, and tailor the services provided for those who need support'.

Complaints management

732. In mid-2017, WorkSafe redeveloped its website to include information about how workers can complain to WorkSafe and other bodies. It also introduced an online complaint form. These changes were made in response to the Ombudsman's 2016 recommendations.

733. WorkSafe states it is also:

- conducting training to 'improve the capability of agents, providers and staff in the areas of quality decision making and person-centred approaches'
- conducting monthly and quarterly reports of complaints to identify trends
- upgrading its complaints management system to facilitate more timely complaint handling.

Multidisciplinary IME examination pilot

734. In July 2017, WorkSafe introduced a multidisciplinary IME examination pilot program for workers requesting spinal surgery to provide 'a more holistic approach to treatment for spinal complaints'. The program 'fast-tracks' workers for a review by a spinal surgeon and pain management specialist who:

- examine the worker at the same time
- offer less invasive, alternative treatment options in cases where surgery is not considered appropriate.

735. WorkSafe said that as at 1 February 2019, almost 400 multidisciplinary IME examinations had been conducted as part of the program and of these, more than half of the workers selected the alternative treatment proposed. WorkSafe stated this program has also led to a 'significant reduction' in disputed claims proceeding to conciliation.

Psychiatric hospital substitute pilot

736. During the investigation, WorkSafe said it was implementing a trial to examine alternatives to hospital bed-based services for workers with mental injuries likely to be at risk of re-admission.

737. WorkSafe said this was designed to 'reduce, if not prevent, unnecessary and inappropriate hospitalisations' and included 'comprehensive clinical assessment, ongoing clinical interventions, collaboration with the worker's wider health-care team and links with other services as needed'.

738. WorkSafe told the investigation:

> WorkSafe will be implementing an evaluation framework across mental services to assess the impacts of these types of initiatives, the effectiveness of community mental health treatment and the best recovery pathways that result in positive outcomes for our workers.

WorkSafe WorkWell

739. In 2018, WorkSafe announced a 'WorkWell' campaign, designed to 'improve the mental health and wellbeing of every Victorian worker'. The $50 million program includes WorkSafe offering funding to employers for programs and initiatives focussed on worker mental health and wellbeing.

740. WorkSafe states:

> The WorkWell model is an integrated approach to workplace mental health and wellbeing and combines the strengths of disciplines such as OHS, health promotion, and psychology. It has the potential to optimise both the prevention and management of mental injury and illness in the workplace.

Conclusions

741. Most WorkCover claims are neither complex nor contentious. Many injured workers require only medical treatment for their injury; and of those who have time off work, about three quarters return within six months. More than 80 per cent of injured workers surveyed by WorkSafe in 2017-18 were satisfied with the management of their claim.

742. This investigation focussed on 'complex claims', which primarily involved workers who had not worked and had been receiving weekly payments for 130 weeks or more. At the end of 2017-18, there were 4,544 of these claims, making up about a quarter of the 18,519 active weekly payments claims in the scheme, or about seven per cent of the total 63,085 active claims (including those involving medical treatment only). This investigation reviewed 102 complex claims files in depth, in addition to considering a range of other evidence.

743. Although complex claims do not represent the majority, these workers are likely to have more challenging health conditions and represent a substantial and disproportionately high cost to the WorkCover scheme and broader society.

744. The investigation revisited issues the Ombudsman identified in 2016, to establish whether the Ombudsman's recommendations had improved agent decision making and the effectiveness of WorkSafe's oversight of complex claims.

745. While these recommendations resulted in some changes to policies, procedures and practices, the evidence suggests that they were not enough to change agent behaviour and stop unreasonable decision making on complex claims.

746. After two investigations by the Ombudsman and a number of reviews commissioned by WorkSafe, the evidence points to this being a systemic problem. In too many complex claims, the system is failing to achieve one of the scheme's objectives under the *Workplace Injury Rehabilitation and Compensation Act 2013* (Vic), which is to ensure appropriate compensation be paid to injured workers 'in the most socially and economically appropriate manner, as expeditiously as possible'.

747. As piecemeal changes have proven unsuccessful in tackling these problems, more significant changes to the way complex claims are managed are needed to ensure better outcomes for these most vulnerable injured workers.

Unreasonable decision making by agents

748. The investigation identified that unreasonable decision making by agents on complex claims has continued. It found evidence of the same issues the Ombudsman identified in 2016, including agents:

- 'cherry picking' evidence to terminate or reject a worker's entitlements, even where the opinion relied upon was unclear, contradictory or inconclusive
- 'doctor shopping' and sending workers to 'preferred' or 'agent-friendly' IMEs, based on a belief they would provide an opinion that was unfavourable to the worker
- maintaining decisions at conciliation which were 'arguable', but had no reasonable prospect of success at court
- terminating workers' entitlements without sufficient evidence of 'material change' since a previous Medical Panel opinion.

749. The investigation also uncovered new issues relating to agents' use of surveillance and return to work non-compliance notices on complex claims. While agents may legitimately use these as claims management tools, the investigation identified some instances where agents misused them to try to terminate workers' entitlements.

750. These issues, combined with the continuing high rate at which decisions are withdrawn or changed through the dispute process, suggest agent decision making on complex claims has not improved. Rather, the evidence obtained by the investigation, which included randomly selected claims, suggests that the Ombudsman's 2016 investigation only scratched the surface regarding the extent of unreasonable decision making on complex claims, and that it is greater than first realised.

751. Such unreasonable decision making is at odds with the scheme's objectives and contributes to negative outcomes for already vulnerable injured workers. As illustrated by many of the case studies in this report, these include financial hardship, secondary mental injuries or psychological symptoms, and delayed recovery and return to work.

752. The dispute process should provide a 'safety net' to ensure injured workers receive their legal entitlements, but unreasonable decisions are slipping through the cracks. Agents continue to defend 'arguable' decisions during conciliation, even if they have no reasonable prospect of success at court, rendering Conciliation Officers hamstrung to resolve such disputes. Conciliation Officers also reported particular difficulties resolving factual disputes. The result is that injured workers are left to contemplate the costly, stressful and time-consuming path to court if they wish to dispute a decision further. Most workers simply give up.

The effect of financial rewards and penalties on agent decisions

753. As commercial organisations, it is not unreasonable for agents to expect to profit from managing WorkCover claims. One way they achieve this is through the financial reward and penalty performance measures set by WorkSafe. The measures also contribute to WorkSafe's objective of maintaining a financially viable scheme.

754. WorkSafe has made a number of positive changes to these measures since 2016 to provide a stronger focus on quality decision making and sustainable return to work outcomes.

755. Although the investigation found less documentary evidence that the financial rewards and penalties continue to influence agent decisions, compared to the Ombudsman's 2016 investigation, it still found some evidence showing:

- agents' continued focus on terminating claims and maximising profit
- the influence of the rewards and penalties on agents' offers at conciliation.

756. This evidence included agent staff emails where staff referred to claims which achieved a financial reward as 'wins'; congratulated staff for terminating claims; discussed the monetary value to the agent of terminating individual claims; and referred to targets for terminating claims. Examples were also identified where agents' offers of compensation at conciliation were motivated by the impact the offer would have on the financial reward and penalty measures.

757. Additionally, the investigation received evidence that some agent staff have made efforts to conceal certain behaviours and practices identified by the Ombudsman's 2016 investigation, including agents' focus on managing liabilities.

758. This evidence, when combined with the extent of continued unreasonable decision making by agents on complex claims identified by this investigation, raises questions about the suitability of commercial organisations to manage these claims. As distinct from WorkSafe as the statutory authority charged with managing the scheme, agents have a vested interest in the outcome of individual claims arising from the commercial nature of their organisations, as well as the financial reward and penalty measures.

WorkSafe's oversight

759. Although WorkSafe delegates its claims management functions to the agents, it retains a role in overseeing agents' performance to ensure injured workers receive their legal entitlements.

760. WorkSafe has made a number of changes to its oversight mechanisms since 2016 but is still not optimally using them to address unreasonable agent decision making on individual complex claims and to identify and respond to systemic issues.

761. Following the Ombudsman's 2016 investigation, WorkSafe increased the financial rewards and penalties agents may receive through its quality decision audits, to further encourage good decision making. While this was a positive change, it was of limited benefit because WorkSafe has not held agents accountable for unsustainable decisions identified through the audits. In its 2017-18 audits, the investigation found instances where WorkSafe:

- passed questionable decisions where the agent had only one piece of supporting evidence
- readily re-assessed failed decisions as 'passes' when disputed by the agent, even if they would not hold up at court
- did not require the agents to overturn most of the failed decisions.

762. In light of the above, the extent to which the audits enforce WorkSafe's quality decision making expectations is questionable. The upshot of this is that only the courts - in the very small portion of cases that end up at court – are holding agents accountable for making sustainable decisions.

763. Complaints and stakeholder feedback provide WorkSafe opportunities to check agents' performance; however, its role in complaints about agent decisions is ill-defined and unclear. On the one hand, WorkSafe considers agents maintain authority on the vast majority of decisions and that the dispute process is the appropriate mechanism for an injured worker to dispute an agent decision. On the other hand, WorkSafe has the power to direct an agent to change a decision and has established a procedure for when it identifies a worker has been 'wrongfully disentitled'.

764. This has led to inconsistent approaches in the way WorkSafe handles complaints and missed opportunities for WorkSafe to rectify poor decisions.

765. The injured worker survey also provides WorkSafe valuable feedback about agent performance, but it does not concentrate on workers with complex claims. Given the risks and complexities of these claims, there is scope for WorkSafe to increase its focus on complex claims through the survey and other oversight mechanisms.

766. WorkSafe has expanded its quality assurance mechanisms for IME reports since 2016; however, their value has been limited by the cursory nature of the review process. This, combined with the superficiality of the IME complaints process, where WorkSafe's role appears to be confined to that of a 'post box', has restricted WorkSafe's ability to identify potential concerning trends regarding individual IMEs and agents' use of them.

767. WorkSafe's handling of complaints about IMEs and agent decisions by two separate teams has also created inefficiencies and meant injured workers' concerns have sometimes been overlooked or considered in isolation, without a holistic look at their claim.

768. WorkSafe has implemented a number of initiatives to improve workers' experience of the scheme since the 2016 investigation, and this work will continue with the delivery of its 2030 strategy. However, the investigation has shown that workers' experience of the scheme is most significantly affected by unreasonable agent decision making. WorkSafe appears reluctant to adequately deal with this when it is brought to their attention, based on its view that agents have delegated authority to manage claims and that conciliation and the courts are the appropriate mechanisms to ensure workers are appropriately compensated. It begs the question whether WorkSafe feels beholden to the agents, dependent on their participation to deliver a financially viable scheme.

769. The investigation has revealed that too often agents are making unreasonable decisions which have a detrimental impact on the injured worker, and the dispute process is not an adequate 'safety net' for these workers. It is time consuming, stressful and costly (in the case of the court), and the way agents act during the process can be adversarial and driven by questionable motives. Given WorkSafe's statutory responsibility to ensure appropriate compensation is paid to injured workers 'in the most socially and economically appropriate manner, as expeditiously as possible', it must do more.

Opinion

770. Pursuant to section 23(1)(b) of the Ombudsman Act, the Ombudsman is of the opinion that in the complex claims featured in this report, Allianz, CGU, EML, Gallagher Bassett and Xchanging acted in a manner that was:

    - unreasonable by terminating or rejecting workers' entitlements without sufficient evidence; and issuing return to work non-compliance notices to workers in unreasonable circumstances
    - unjust by failing to withdraw unsustainable decisions during conciliation; and conducting surveillance of injured workers without adequate justification.

771. Pursuant to section 23(1)(g) of the Ombudsman Act, the Ombudsman is of the opinion that in the complex claims featured in this report, the following agents' termination of workers' entitlements without sufficient evidence of 'material change' since a previous Medical Panel opinion, was wrong:

    - Allianz
    - EML
    - Gallagher Bassett
    - Xchanging.

772. Pursuant to section 23(1)(b) and (g) of the Ombudsman Act and based on the evidence obtained by the investigation, the Ombudsman is of the opinion WorkSafe acted in a manner that was unjust and wrong by:

    - assessing the terminations in case studies 37 to 42 of this report as passing its quality decision audits
    - not overturning the terminations which failed its quality decision audits in case studies 43 to 45 of this report
    - failing to intervene in the injured workers' complaints about agent decision making in case studies 46 to 48 of this report.

773. The Ombudsman recognises that subsequent to WorkSafe's original handling of these matters, WorkSafe required the relevant agents to overturn the decisions in case studies 38, 41 and 43. In the remaining case studies mentioned at paragraph 772, with the exception of case studies 39 and 40, the decisions had already been remedied through the dispute process, either as a result of a Medical Panel opinion, the agent withdrawing the decision or the worker accepting an offer to resolve the dispute.

Recommendations

To the Victorian Government

Management of complex claims

A fundamental characteristic of Victoria's workers compensation scheme is the outsourcing of claims management functions to claims agents. Although most other Australian state and territory workers compensation schemes outsource claims management to agents, many other international schemes do not; in these jurisdictions, claims are managed in-house by the relevant government authority.

The financial viability of the scheme is imperative; however, a balance must be struck so that the scheme can achieve both objectives of financial sustainability and appropriate compensation for injured workers. At present, the system is failing to achieve the latter in too many complex claims.

Recommendation 1

Commission an independent review of the agent model to determine how and by whom complex claims should be managed, taking into account:

a. the need to ensure appropriate compensation is provided to injured workers, as well as the financial viability of the scheme

b. the experience of other accident compensation schemes, including Victoria's transport accident scheme (managed by the Transport Accident Commission) and other national and international workers compensation jurisdictions.

Dispute resolution process

The first stage of Victoria's dispute resolution process is conciliation, which offers injured workers a free and informal avenue to dispute claims decisions. Although a considerable proportion of disputes are resolved at conciliation, the level of unreasonable decision making on complex claims remains unacceptably high and too many unreasonable decisions are 'slipping through the cracks'.

There is evidence of agents maintaining unreasonable decisions during conciliation because they have an 'arguable case', despite the requirement that they only maintain decisions with a reasonable prospect of success at court. Where a dispute cannot be resolved at conciliation, injured workers may initiate legal proceedings, however, this option is expensive and protracted. As a result, many injured workers choose not to go to court and there are no other avenues available to them to dispute a decision after unsuccessful conciliation.

This contrasts with the workers compensation dispute resolution processes of most other Australian states and territories, which encompass a tribunal or arbitration, allowing a binding determination to be made on the merits of a decision, without requiring the injured worker to go to court.

Recommendation 2

Introduce a new dispute resolution process which:

a. allows for binding determinations on the merits of claims decisions, including factual disputes; is inexpensive; and provides timely outcomes

b. complements the existing dispute resolution processes of conciliation and legal review at court.

Victorian Government response:

Accepted both recommendations.

The Minister for Workplace Safety, the Honourable Jill Hennessy MP said the Victorian Government accepted both recommendations, stating she was 'committed to reform' and 'disturbed by the findings' of the investigation.

A letter from the Minister is included at Appendix 3.

Given the time it will take to implement these recommendations, the Ombudsman makes the following recommendations to WorkSafe to address the immediate issues identified by the investigation.

To WorkSafe Victoria

Recommendation 3

Establish a dedicated business unit to independently review disputed decisions when requested by workers following unsuccessful conciliation. Where necessary, WorkSafe should use its existing powers to direct agents to overturn decisions which do not have a reasonable prospect of success at court (ie would not be sustainable).

Recommendation 4

Amend its quality decision making audit procedure to ensure that:

a. only sustainable decisions pass

b. unsustainable decisions identified through the audit process are overturned.

Recommendation 5

Establish a centralised complaints process which triages and provides a single point of contact for all complaints about the claims process, including agent decisions and IMEs.

Recommendation 6

Update the Claims Manual, and provide training to agent staff, to:

a. require that agents make sustainable decisions

b. require that agents provide reasons in an adverse decision notice if they have disregarded or discounted any relevant evidence or information in making the decision

c. clarify and expand the requirements about agents' use of surveillance, including what constitutes 'adequate evidence', record keeping standards and the use of surveillance in mental injury claims

d. clarify the circumstances in which agents should refer a worker to a psychiatrist IME for assessment of a potential secondary mental injury

e. provide guidance on the appropriate IME specialty to assess workers with chronic pain syndrome or a pain disorder

f. provide guidance on the rejection of mental injury claims under section 40(1) of the WIRC Act (reasonable management ground), including the evidence required to support a decision on this ground

g. provide clarification and greater guidance regarding the circumstances in which it is appropriate to issue a return to work non-compliance notice, including assessment of whether a worker has made 'reasonable efforts' to comply with their obligations

h. provide guidance on the evidence required to show a 'material change' in a worker's condition since a previous Medical Panel examined them and provided an opinion.

Recommendation 7

Increase WorkSafe's oversight of the following claims management activities by agents, through targeted 'health checks' or audits:

a. agents' use of surveillance

b. mental injury claims rejected under section 40(1) of the WIRC Act (reasonable management ground)

c. return to work non-compliance notices

d. terminations of 'top up' weekly payments provided under section 165 of the WIRC Act (or section 93CD of the Accident Compensation Act).

Recommendation 8

Amend the Injured Worker Survey measure so that it better targets complex claims, which may include:

- increasing the focus on complex claims in the current survey; or
- introducing a separate survey of workers with complex claims.

Recommendation 9

Introduce a contractual requirement regarding the timeframe in which agents must respond to:

a. requests for reinstatement of weekly payments

b. requests for medical and like treatment.

Recommendation 10

Establish a mechanism enabling the regular review of Medical Panel outcomes to identify potential trends in:

- IME opinions
- agents' use of IMEs
- agent decision making.

Recommendation 11

Amend its IME Quality Assurance processes to ensure that reviewers are provided all of the documentation the IME considered to inform their examination of the worker and prepare their report.

Recommendation 12

Ensure IMEs consider the definition of 'suitable employment' in the WIRC Act when forming opinions about whether a worker has a current work capacity, by:

a. amending the relevant template question(s) so that IMEs are required to detail how they considered each factor in the definition of 'suitable employment' when providing their opinion, similar to the way in which Medical Panels address this

b. providing training to IMEs on what constitutes 'suitable employment'.

Recommendation 13

Provide different time allocations for independent medical examinations of injured workers with 'complex claims' and remunerate IMEs for these accordingly.

Recommendation 14

Provide guidance and/or training to IMEs regarding:

a. what constitutes 'material change' in a worker's condition since a previous Medical Panel examined them and provided an opinion

b. how surveillance material should be considered when forming an opinion about a worker's work capacity.

Recommendation 15

Undertake a further review of the issues identified by the investigation regarding IME Y and engage with them direct to ensure any necessary changes to their practices occur.

WorkSafe response:

Accepted all recommendations.

Colin Radford commenced in the role of WorkSafe Chief Executive in November 2019. On behalf of WorkSafe, he accepted all recommendations. A letter from the new Chief Executive is included at Appendix 4.

Appendix 1: WorkSafe's response to the draft report

Before finishing in the role of Chief Executive in November 2019, Clare Amies responded to the draft report on behalf of WorkSafe. General comments she made on behalf of WorkSafe in response to the draft report are outlined below. Comments in relation to specific issues or case studies have been incorporated in the relevant sections throughout the report.

General Comments

WorkSafe has made strenuous efforts, within the existing claims model, to focus on continuous improvement of its management of complex claims (defined as those claims where an injured worker has been in receipt of weekly payments for 130 weeks or more), including implementing in full the recommendations made in your 2016 report.

These changes have been implemented within the parameters of the current claims management model for complex claims and WorkSafe recognises that the service delivery model for complex claims requires wholesale change.

WorkSafe 2030 is premised on the changing nature of work and workplaces in Victoria, while also addressing the immediate challenges you have outlined in the Draft Report. WorkSafe 2030 is a wholesale transformation of the way in which WorkSafe operates and delivers services to the community. WorkSafe's strategy has two key goals:

- to provide Victorian employers, workers and the community with the information they need to ensure a prevention-led approach is taken in every workplace; and
- to provide every injured worker with a tailored service to ensure they recover and return to work as soon as it is safe to do so.

Implementation of the many, interrelated components of the strategy (a few of which are described in the Draft Report) will increasingly enable WorkSafe to ensure resources are focussed on delivering tailored, personalised services to injured workers with the most complex needs. I would welcome the opportunity to discuss a number of immediate actions that are being taken, as well as a new service delivery model for injured workers with complex needs, the long-term approach for transformation of the management of complex claims and WorkSafe's oversight of complex claims.

...

Responses to Case Studies ... [37 – 48]

WorkSafe is unable to accept the draft opinion ... of the Draft Report in relation to WorkSafe's handling of case studies ... [37 to 48] as being 'unjust and wrong'.

Many of the case studies involved complex claims issues with competing evidence for and against the decisions made by the agents. WorkSafe staff have pursued appropriate reviews of the relevant claims, including through the quality decision making audits, the wrongfully disentitled review process, the Ombudsman investigation process, and ongoing communication with the agents about the decisions.

WorkSafe has demonstrated a responsive approach in reconsidering the claims over time, including being open to consider new evidence and developments, and requesting agents to make further payments of compensation on several of the claims.

We also disagree with the findings in relation to the cases studies involving complaints.

...

Concluding Comments

In relation to the Preliminary Conclusions in the Draft Report we advise:

WorkSafe acknowledges that the investigation has identified recurring issues with respect to decision-making in relation to complex claims, though we also emphasise that by their very nature complex claims present unique and specific challenges with respect to decision-making, which requires the synthesis of complex medical evidence, social considerations and personal circumstances.

WorkSafe has made strenuous efforts to enhance quality decision-making including implementing significant changes to its QDM oversight and frequency of audits and ... [financial reward and penalty] measures. In this context, the ... [measures have] continued to evolve since 2016, with a focus on encouraging improved service delivery, recovery and return to work support (being underpinned by quality decision making in respect of entitlements). Importantly, the QDM is an integral tool in assessing agent performance and also provides a gateway for WorkSafe to address poor performance via the Agent contracts.

WorkSafe is unable to accept your conclusion that the extent to which its current audits enforce WorkSafe's quality decision making expectations is questionable. Audits are conducted based on the information available at a point in time and findings are made within the parameters of the documented business rules and audit protocols.

WorkSafe has also implemented significant changes to its IME oversight regime and for this reason we do not agree that the review process is cursory in nature. The IME Quality Assurance Framework goes beyond peer review of reports, it also includes oversight of recruitment, induction, ongoing education and taking appropriate action in relation to those IMEs who fail to meet the required standards. However, it is important [to] emphasise that the role of an IME is to provide an independent medical opinion within the parameters of their clinical expertise and the WIRC Act. WorkSafe's oversight of IMEs occurs within this established framework.

Furthermore, WorkSafe is unable to agree with the preliminary conclusion that Agents are motivated only by financial or commercial gain. That is not our experience in our interactions with the vast majority of the employees of the Agents in the day to day administration and management of the workers' compensation scheme. WorkSafe has a number of specific objectives under the *Workplace Injury Rehabilitation and Compensation Act 2013* namely to:

- manage the accident compensation scheme as effectively, efficiently and economically as is possible; and
- manage the accident compensation scheme in a financially viable manner; and
- ensure that appropriate compensation is paid to injured workers in the most socially and economically appropriate manner and as expeditiously as possible ...

So while WorkSafe recognises that it administers the workers compensation scheme in partnership with commercial organisations and within the confines of the legislative framework, we seek to achieve a balance between the payment of just and appropriate compensation and financial sustainability of the scheme for all Victorians.

However, WorkSafe acknowledges that while it has implemented a number of oversight mechanisms, and enhanced the numbers and frequency by which Agent decision-making is reviewed, there is further opportunity to strengthen and coordinate our oversight and regulatory activities, creating clearer escalation points for WorkSafe's oversight interventions and consequences for non-compliance with agreed standards and expectations. WorkSafe would also acknowledge that there is scope to integrate and centralise its complaint management and oversight function to capture all aspects of a complaint, including both in relation to claims management and IME performance.

Appendix 2: Agents' responses to the draft report

General comments each of the agents made in response to the draft report are outlined below. Comments in relation to specific issues or case studies have been incorporated in the relevant sections throughout the report.

Allianz

Allianz Australia Workers' Compensation (Victoria) Limited ('Allianz'), as an Agent of WorkSafe, is deeply committed to providing quality service. We are very cognisant that developing and maintaining the trust of workers, employees, key stakeholders and the community more broadly is critical in any arena, not least of all, the Workers Compensation environment – and in fact gives us our social license to operate.

Allianz operates in accordance with our agency agreement with WorkSafe who delegates authority to Allianz and its agents to collect premiums and administer claims in line with relevant legislation and policies. In partnership with WorkSafe, Allianz works within the framework, policies and procedures set by WorkSafe and operates in an open, collaborative and transparent manner to ensure WorkSafe's objectives are being met. Allianz deeply values our partnership with WorkSafe and is responsive to WorkSafe's oversight to meet the objectives of the scheme and its stakeholders.

Allianz manage workers compensation policies for 80,068 Victorian Employers representing 35.9% of the scheme's policies. Allianz also oversee and provide claims management services for 17,221 workers injured in Victoria. We recognise that the decisions we make every day impact the lives of injured workers and their families, sometimes at one of the most vulnerable times in their lives. We take our obligations seriously and endeavour, in collaboration with WorkSafe, to establish claims management processes that ensure that workers have access to their correct entitlements under the relevant legislation and in line with the framework and targets prescribed by WorkSafe.

Allianz has worked collaboratively with WorkSafe, to undertake a number of initiatives since your original investigation in 2016 …

Allianz's commitment to continuous improvement across our service program, people practices and internal processes is further evidenced in the investment made and additional program of initiatives that we have subsequently put in place to ensure we are providing quality services to support Victorian workers recovering from workplace injuries …

The draft report, insofar as it relates to Allianz, references 13 complex claims with adverse decisions in the period **2017-18**. Nine of these claims were referenced in relation to 130 week decisions.

We continue to refine our model using multiple feedback mechanisms to improve our claims management services. Many positive customer-centric initiatives have been put in place in 2018 and 2019 and continue to evolve. We have seen year on year improvement in our worker service results since 2016-17 and our 2018-19 result was 2.35% points higher at 82.32%.

A number of the examples cited in your draft report had also been identified through internal and WorkSafe monitoring and we have already built revised processes and practices into our claims management model. Instances referenced in your draft report have been captured by initiatives we have since implemented and support those improvements previously identified.

…

Allianz and its staff are committed to supporting workers, employers, WorkSafe, key stakeholders and the wider Victorian community in administering a fair and transparent workers compensation scheme. We have a proud and long history with assisting the community in this space and have shown how we have continued to implement practices and made investments to improve the service delivery to injured Victorian workers.

In its response to the draft report, Allianz also provided details of initiatives it has undertaken to address the areas of focus in the draft report, as well as initiatives implemented since the Ombudsman's 2016 investigation. These included:

- staff training on quality decision making, return to work non-compliance requirements, business ethics and managing mental injury claims
- establishing specialist teams and creating new specialist positions
- reviewing and updating internal procedures
- undertaking compliance audits.

Allianz also provided two case examples where it achieved positive outcomes for two injured workers with significant injuries, through tailored support delivered by the newly established Capacity Support Specialist role.

CGU

At CGU, we continue to develop our customer service strategy which focuses, not just on quality decision making, but also on developing employee capability to deliver the best possible experience for injured workers, employers and external stakeholders.

We acknowledge there can always be improvements made to the management of claims and we confirm that we have continuously worked to address any concerns made by the Ombudsman and/or WorkSafe, particularly around the quality of decision making.

In our letter to you of 19th April 2019 … we re-affirmed our action plan and commitments made following the first "own motion" investigation into claims management practices. In that letter, we provided extensive detail around:

1. Reinforcement of appropriate standards of behaviour and internal and external communications including mental health awareness and empathic, professional and timely communications;

2. Quality evidence-based reviews and decision making;

3. Quality adverse decision-making principles including legislative requirements, sound and proper decision-making processes and communicating with injured workers;

4. Training material developed in conjunction with WorkSafe on the key components of the agent remuneration package and how it links to quality decision making and service delivery;

5. Processes to undertake senior reviews of adverse decisions; and

6. Processes to review requests for conciliation including new evidence and appropriateness of initial decision.

In that same letter, we outlined the continuing challenges of establishing and continuing to build upon the technical capability of our employees. CGU understands the importance of investing in our employees, however we also recognise there are difficulties in locating and retaining talented individuals in a technically complex personal injury scheme. A quarter of CGU's claims management and technical support personnel have been part of CGU for less than two years.

This is one of the reasons why improving decision making has been, and remains, CGU's primary area of focus in management of workers compensation claims, highlighted by the resources we have put in place to educate and uplift the technical capability of our employees.

In addition to our learning and development program that offers continuous training opportunities to all employees, we have introduced a range of initiatives, including:

- Improving the management and awareness of claims with mental injuries to enhance support for injured workers;
- Training on evidence-based decision making;
- Quality training to ensure adverse decisions are communicated effectively;
- Embedding of a new senior review process;
- Embedding a quality review procedure to ensure only appropriate decisions proceed to a conciliation conference.

In the recently released draft report, the Ombudsman has expressed the opinion that claims agents across the scheme acted in a manner that was:

- Unreasonable … by terminating or rejecting workers entitlements without sufficient evidence;
- Issuing return to work non-compliance notices to workers in unreasonable circumstances;
- Unjust by failing to withdraw unsustainable decisions at conciliation; and
- Conducting surveillance of injured workers without adequate justification.

In context, the review has focused on claims where a complaint had been made to the Ombudsman, or where there was a dispute on foot through referral to the Medical Panel. This means that the review isn't a reflection of the overall management of all claims in our portfolio, but a narrow tranche of claims which are already in the process of some form of dispute.

CGU currently has 5,369 claims under management. Of those, 1,030 fall within the >130 week complex claim criteria used for the purposes of this review.

…

As a general profile, many of the claims highlighted in the draft report and CGU's >130+ week portfolio identifies:

- Issues of workplace conflict prior to the claim being lodged;
- Low motivation to return to work during the life of the claim;
- Inactive participation in rehabilitation and job retraining programs;
- Non-compliance and non-attendance at appointments and organised programs to assist recovery and return to work;
- Disconnection from the workplace very early in the claim process; and
- Disconnection from community within 6 months and in some cases estrangement from family and friends within 12 months.

Prevailing research clearly articulates that return to health and return to work is the best outcome for an injured worker.

Our staff develop strategies to assist injured workers in their recovery, often with the assistance of rehabilitation and job retraining providers. However, critical to any recovery, is an injured worker's motivation to recover and return to work; and without that motivation a recovery is highly unlikely.

The draft report highlights and criticises the actions taken by Claims Consultants in trying to break the cycle of compensation and attachment to compensation entitlements, and in some cases those actions are highlighted in the report as provocative, unreasonable or inappropriate.

However, the purpose of these actions is genuinely aimed to disrupt the compensation cycle and activate return to work opportunities.

There is also a contextual disconnect between a desktop review of activities in isolation of a discussion with those involved in day-to-day claim management activities. The sterile nature of a desktop review fails to reveal the day-in day-out semantics of claims activity and provides no opportunity for anecdotal information which would provide a much broader and realistic context to the issues. Conversations with Claims Consultants would provide a much wider lens to claims activities and behaviours, as information recorded on claims files can sometimes be marginalised for privacy reasons.

...

While it may be alleged that the effect of financial rewards drives an agent's decision making, the reality is that decisions must be supported by evidence and facts – otherwise they will not be sustainable in the longer term with regard to review and audit procedures. At CGU, we believe our responsibility is to:

(1) Manage the scheme in accordance with the legislation;

(2) Ensure appropriate compensation is paid to those who are injured in the course of their employment; and

(3) Provide a satisfactory return to our shareholders

To achieve this outcome, there must be tension on all three aspects.

While the draft report focuses on the financial incentives offered to agents, there is little if any focus on or analysis of the financial penalties that are in place should we not achieve the desired scheme outcomes around service, sustainability and helping injured workers return to work ...

In FY19, CGU received 53% of the available revenue which was 30% less than the prior year. This was due to changes in the target setting for ... [financial reward and penalty] measures. The potential penalty to CGU for not achieving the ... [measures] is approximately $6.1 million dollars.

...

[O]ur priority is the care and support we provide for injured workers to help them return to work at the appropriate time.

We consider it relevant to the draft report that customer satisfaction across the scheme is at its highest ever level – and would be ahead of all other schemes nationally. CGU's most recent customer satisfaction score was 90.24%.

Satisfaction is monitored across six key events in the claim process:
1. Independent Medical Examination;
2. Adverse Decisions;
3. Return to Work;
4. Communication;
5. Treatment; and
6. Eligibility.

Satisfaction is assessed randomly across all cohorts of claims at various stages of claim development, and this is important to note in the context of service being provided to all injured workers by CGU, and other agents.

EML

We welcome your review and the insights it provides to help ensure that the Victorian workers compensation scheme continues to abide by its legislative obligations, reflects community expectations and standards, has sustainability and most importantly, addresses the needs of injured workers and their employers.

EML is committed to our continuous improvement journey. We have demonstrated an improvement trajectory in our three years in Victoria.

Our work is yielding dividends, with our latest worker satisfaction rating at 87%, which we believe is unprecedented. This reflects the commitment of our people to do the right thing, help our customers get better and back on with their lives and their vocation. However, we acknowledge that there are areas for improvement, and we will ensure we do so.

EML has subsidised the operations of EML Vic over the last three years, the entire period of operation. During this time the business has operated at a loss. EML remains committed to investing in workers compensation claims management in Victoria. Our objectives extend deep into ensuring the wellbeing of injured workers, their families and the community as evidenced above, well beyond pure profit motivation. We want to drive the best possible outcomes for the Victorian scheme under our remit.

Herein we have focussed on your Principal Conclusions. The unique intricacies of each of these very complex claims speaks to an overarching need to view the scheme in its entirety …

Decision making on complex claims

We recognise the tensions inherent in a multi-stakeholder insurance scheme, which requires the balancing of the needs of the customer and employer, requirements of the scheme operator and the claims agent, while ensuring the overall sustainability of the scheme now and into the future.

EML inherited its portfolio from QBE on 1 July 2016 and as part of that transition took on 48% of former QBE personnel. The first year of operations focussed on claims transition and rebuilding consistency and reliability of core claims hygiene. This included making all outstanding payments, particularly in superannuation. A critical part of this process included contacting customers and restoring, where necessary, faith in the process. We also began the first of many and ongoing reviews.

In late 2017 we identified a gap in the capability of our personnel, particularly in the complex claim area. This was slowing the speed of improvement. The EML Victoria General Manager restructured the operations in Q2 2018 to segment and ensure complex claims were placed with case managers with more experience in long tail claims. This commenced in the past 12 months. It shows demonstrated improvement and continues to do so in outcomes in terms of the fairness and reasonableness for all claims experiences.

The challenge for EML has been the volume of complex claims as injured workers have progressed through the relevant claim gateway as we took on the portfolio. Not unexpectedly it took time to identify the areas which required change and a further lead time to implement so as to address decision making quality, without adversely affecting customers. This was managed alongside BAU [business as usual]. We now believe that we have the right competency within this team to better manage complex claims and are well on our way to minimising the risks you have raised in your opinion … In taking on board the feedback you have provided we are also further bolstering line 2 review over these claims to address your concerns raised in … the Draft Report.

We acknowledge that there will be situational elements at play for each claim, which ultimately require a fair and reasonable judgement to be made on the claim continuance or discontinuance and that each scheme has its own nuances, which effect operations. We have also further segmented complex claims into specialist teams to provide the higher level of skill required to manage these claims, and recognise that the dispute resolution process should be a last resort mechanism rather than part of the process. We are investing to improve this.

We are committed to continuing to work with WorkSafe to improve how we manage our complex cases. EML operates a very strong front-end case management model focussed on providing a high level of care to our customers based on a human centred design. Whilst we have not had the opportunity to employ this strategy on the tail portfolio, we will seek to focus on this to assist longer-term claimants to find capacity, return to life and some form of work where this is possible. This is what we do well but due to the contextual matters outlined above have not been able to yet demonstrate within the data window selected for the external review.

EML is an insurance mutual owned by our members (the employers who arrange insurance through us). The EML Board has invested significant mutual funds coming to Victoria as part of our commitment to customer care. This is particularly, but not limited to, our mobile case management service which brings the case manager to the injured worker and their family … We note that the focus of this initiative is on new complex claims where we are experiencing high customer engagement, better supporting people in the early stages of their recovery. We are also proud to have been selected to undertake the Recovery Assistance Pilot program with WorkSafe which you mention in … your Draft Report.

…

Remuneration

The current remuneration model covers around 80-85% of our operating costs. Some of the performance elements of the remuneration model can deliver variations in remuneration which ultimately impacts business sustainability. It is fair to say that there is an expectation in any business that it should be in a position where it covers its operating costs and makes a fair and reasonable margin. No remuneration model can be perfect.

We endorse the recent change that WorkSafe has made to the remuneration model which focusses on return to work, rather than discontinuance of payments. We understand that the model is under constant review and believe that some further refinement may be required to it in order to minimise the stressors in the overall economic model surrounding claim agent operations in Victoria and as identified in your Draft Report.

EML has operated in Australia as a mutual for 109 years. EML seeks to build long-standing relationships with all stakeholders in the markets which we enter with a view to a longer-term sustainability of the operations. From a cultural perspective, we do not believe that it is prudent for a person involved in the management of a claim to understand the financial impact to agent remuneration in cessation of an individual claim.

EML's traditional approach is to take a whole of portfolio view and to employ strategies to improve overall liability management. We are bolstering the separation between front-end case management and the financial monitoring of the business to align to this whole of portfolio approach. We will have further dialogue with WorkSafe on the risks associated with the current remuneration model to achieve this approach and to operate the business sustainably.

…

We further note your comment regard[ing] WorkSafe systems in … your Draft Report. As a specialist personal injury claims manager EML understands the tools and technology requirements to support case managers and authorisation frameworks for claims decision making in addition to payment control functionality. In Victoria claims agents are required to use WorkSafe's technology systems. We note that WorkSafe's vision for 2030 is a new technology platform which is aimed at continuous improvement information technology case management capability. We are looking forward to working with WorkSafe in its future scheme design, in particular the expertise and knowledge that we bring from the work we already undertake within the scheme.

EML is driven to provide the best possible outcomes for customers and employers while marrying the responsibilities of ensuring the scheme is viable and the community has faith in it. We do not take this responsibility lightly. We are constantly innovating, reviewing and expanding our knowledge through research to better understand the needs of those who require workers compensation claims management. This is having real and tangible impact in the Victorian scheme with the unprecedented positive worker satisfaction rating. Every one of these represents a life improved as a result of this service.

Gallagher Bassett

Initial observations

Subject to the challenges to the findings detailed in the two attachments to this letter, I broadly accept the accuracy of the findings of fact contained in the majority of case studies.

However, I am deeply concerned about a number of aspects of the methodology of the investigation which has led to the draft report findings:

- Bias in the selected sample of claims – whilst some classes of claims incorporated random selection, the use of a significant number of disputed decisions and decisions arising from complaints skews the conclusions;
  …
- In a number of instances, the draft report seeks to attribute a claims management failure, evidenced by a single finding of fact, to scheme-wide attitudes and activities when evidence of a systemic failure simply does not exist.
- The report identifies the objectives of the WIRC Act … including the need for the Scheme to "ensure appropriate compensation is paid to injured workers in the most socially and economically appropriate manner" and "to ensure workers compensation costs are contained so as to minimise the burden on Victorian businesses". The report also identifies … the standard for decisions being used across the Scheme (and supported by WorkSafe's audit practice) being a decision made based on the merits of the claim and supported by "reasonable and appropriate" evidence. This has been the standard of audit and guidance to Agents for many years. A move to all decisions being made only if sustainable at Court introduces influences on decisions beyond the facts of the individual claim and the legislation, including other potential societal influences. The potential impact on the sustainability of the Scheme and the longer term viability of the current benefit structure with such a significant shift is not considered by the report and the risks of such a move are not called out for context despite this potentially challenging the overall objectives of the Act itself.

Concluding Comments

The draft report is disappointing in a number of aspects:

I. Firstly, it evidences ongoing inadequate and inappropriate claims management activities at Gallagher Bassett that we have worked hard at eradicating since 2016, and which we continue to address. For example the report highlights a number of decisions relating to the use of return to work non-compliance. However work to improve decision making in this area has continued since the timeframe reviewed by this report with the number of decisions issued in 2019 to date being significantly lower than prior years due to additional review processes being implemented. Thus some of the conclusions reached would appear to be counter to current practice.

II. Secondly, in concluding that the behaviours comprising "unreasonable decision making by agents" amount to a "slipping back to where it began" … and that "it is greater than first realized" … the draft report has:

    - failed to appreciate, beyond a passing reference to "some changes" … the improvements brought about by changes put in place since 2016;
    - improperly assumed that a failure to "stop" unreasonable decision making amounts to a failure to "change agent behaviour" … ;
    - failed to consider whether the evidence is indicative of bad behaviour and poor culture, rather than inadequate training, experience or competence of those managing complex claims. An example is the use of pain specialists …

III. Thirdly, the imperfect path of reasoning and lack of supporting evidence makes the stated link between poor decision making and financial considerations difficult to justify. Specifically, the use of unverified, untested and anonymous opinion evidence as a bridge between findings of inadequate claims management activities in a small number of claims, and a conclusion that agents have a systemic culture of decision making for financial reward, should be undertaken with caution. The report notes that "the investigation found limited or no references to the financial reward and penalty measures on claim files" … and "limited overt evidence of the financial rewards and penalties influencing agent decisions" … and yet based on third party evidence from parties potentially biased towards Agents … concludes the focus on making unsupportable decisions for profit continues. Such a conclusion, in the noted absence of evidence, would seem counter to standard investigative practices. This need for caution before reaching such a significant finding is amplified by the inevitable brand damage that will be suffered by WorkSafe and its agents and their staff. It could also lead to a situation which magnifies the issues faced by the Scheme in attracting and retaining qualified and experienced employees to deliver the desired case management and exacerbate current challenges.

…

Response to the Draft Report

It is necessary to respectfully challenge a number of conclusions contained in the draft report:

…

To attribute the motive of termination of entitlement to agents' activities around the use of surveillance and non-compliance notices … is improper.

The conclusion that outcome of the dispute processes are indicative of poor decision making … ignores the distinction between the basis upon which a decision is originally made (arguable case) and the higher test of "reasonable prospect of success at court" imposed by [the] Ministerial Direction.

The conclusion that agents continue to "focus" on financial outcomes … is based on unsupported evidence from an unidentified former agent employee, and one email out of many hundreds. The extrapolation of this evidence to all agents is simply not appropriate or permissible. The finding that the lack of documentary evidence of this focus is due to an agenda of hiding such evidence is outrageous.

Xchanging

As other reports and audits have found in recent years, the management of complex claims is challenging, whether it be the Commonwealth Government managing complex claims through Centrelink or the National Disability Insurance Scheme, or the States such as New South Wales or Queensland managing claims through their respective workers' compensation schemes.

As a non-insurer specialist claims manager, Xchanging takes its role and responsibilities within the Victorian workers' compensation scheme seriously.

Xchanging has endeavoured to steer a course which meets the legal requirements of the legislation, the contractual requirements of the agent agreement and the procedural requirements of the claims manual while ensuring we meet the needs of the injured workers.

Xchanging believes it is important to put the claims and complaints highlighted in your draft report into perspective. During the 2018/19 financial year Xchanging registered over 6,600 new claims and processed over 627,000 payments amounting to over $350m in weekly compensation and medical and like payments.

The case studies and examples selected as part of the draft report represent 15 cases out of 1,700 long term injured workers and 12,000 active injured worker claims managed by Xchanging, at any point in time.

The draft report focuses on the most complex claims, where agents often manage multiple issues within a challenging context. The application of the law is not always black and white, medical conditions are not always clear, and compliance with legislation or claims policy guidelines does not always align with injured worker expectations or the expectations of their legal advisers.

Xchanging has training, controls and improvement programs in place to ensure we properly manage claims and support injured workers. However, because the claims process relies on judgement, discretion and human input, it is possible for errors to occur. If errors do occur, Xchanging works hard to learn from them and reduce the risk of recurrence.

Having reviewed the cases in the draft report referencing Xchanging, it appears that some perspectives have been taken as fact, as opposed to subjective assertions. Additionally, on some claims, only part of the claims information has been included in the draft report. The subjective assertions and partial case histories do not provide all information relevant to many of the claims.

...

Xchanging continues to support independent reviews of any Xchanging practice or decision and is available to discuss any claim in more detail. Xchanging is also committed to working with WorkSafe on any matter.

...

The management of complex claims requires the balance of many factors. Any system that requires eligibility, discretion and judgement will inevitably produce some workers who are dissatisfied with their outcomes. The existence of complaints should not lead to an automatic assumption of fault or the improper conduct of the Agent's handling of the claim and Xchanging requests the relevant feedback of Xchanging's response be taken into consideration.

One of the objectives of the legislation is facilitating return to work. To meet this objective, Agents must pose questions to independent medical examiners (IMEs) and others about the capacity of injured workers to engage in work or work-related activities.

Despite the limited number of workers and the lack of input from Xchanging, the draft report makes findings of unreasonable and unjust conduct against Xchanging even before Xchanging's response has been received. The draft report, and the opinions, has been distributed to others within the industry before Xchanging has had an opportunity to respond.

Appendix 3: Minister's response to the recommendations

Hon Jill Hennessy MP

Attorney-General
Minister for Workplace Safety

Level 26, 121 Exhibition Street
Melbourne Victoria 3000
Telephone: (03) 8684 1111
DX: 210077

Ms Deborah Glass
Victorian Ombudsman
570 Bourke Street
Melbourne VIC 3000
DX210174 MELBOURNE

Via email: [redacted]

Dear Ombudsman

I write in response to draft recommendations formally provided to my office on 8 November 2019 in relation to your follow up own motion investigation into the management of complex workers compensation claims and WorkSafe oversight.

I am disturbed by the findings of your investigation and share your concern that currently the workers compensation scheme is failing too many injured workers with complex claims.

This must be addressed. I am committed to reform and indicate that the Government accepts both recommendations directed to it in full.

Specifically, the Government will commission an independent review of the current agent model. It is timely to consider the model in advance of the conclusion of existing contractual arrangements in 2021. It is essential that the scheme administers appropriate compensation to injured workers in the most socially and economically appropriate manner, as expeditiously as possible, in line with its legislated objective.

The Government also accepts your recommendation regarding the introduction of a new binding dispute resolution process. In August this year, I announced that the Department of Justice and Community Safety would undertake consultation regarding the introduction of arbitration powers for the Accident Compensation Conciliation Service. That work is ongoing.

As Minister for Workplace Safety, I additionally welcome your recommendations directed at WorkSafe. I am committed to ensuring these recommendations and those contained in your 2016 investigation report are fully implemented.

As you may be aware, the Andrews Labor Government committed during the 2018 election to monitor the implementation of your 2016 investigation report's recommendations. I have established a Monitoring and Oversight Committee that brings together key stakeholders to provide direct and independent advice to me about the implementation of recommendations.

This Committee is comprised of employer groups, unions, legal representatives and medical sector representatives. The Committee met for the first time in October. It is my intention that the Committee will now also be tasked with monitoring the implementation of recommendations from this follow up investigation.

VICTORIA

Thank you for your consideration of these issues and for providing me the opportunity to respond to your recommendations.

Yours sincerely

Hon Jill Hennessy MP
Attorney-General
Minister for Workplace Safety

18 / 11 /2019

Appendix 4: WorkSafe's response to the recommendations

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www.worksafe.vic.gov.au

Ms D Glass
Victorian Ombudsman
Level 1, North Tower
439 Collins Street
Melbourne VIC 3000

12 November 2019

Dear Ms Glass

Follow up own motion investigation into management of workers compensation claims and WorkSafe oversight

Thank you for the opportunity to respond to your draft recommendations arising out of your follow up investigation into management of workers' compensation claims and WorkSafe oversight.

WorkSafe would like to take this opportunity to thank you and your office for your very comprehensive investigation and your engagement with WorkSafe throughout the process.

Our people are highly committed to reducing the frequency and severity of workplace injuries, demonstrating empathy to the needs and circumstances of both injured workers and employers and improving outcomes for injured workers.

Accordingly, WorkSafe accepts your recommendations.

Continuous Improvement

The recommendations and feedback arising from your investigation are welcomed by WorkSafe and represent an important opportunity to continue to improve services to injured workers and our oversight of Agent decision-making. We take these recommendations extremely seriously and we look forward to working as an organisation to respond to and address the issues identified by your investigation.

WorkSafe has made strenuous efforts, within the existing claims management model for complex claims, to focus on continuous improvement of its management of complex claims, including implementing in full the recommendations made in your 2016 report.

WorkSafe's long-term strategy is premised on the changing nature of work and workplaces in Victoria, while also addressing the immediate challenges you have outlined in your Report. The strategy envisages a wholesale transformation of the way in which WorkSafe operates and delivers services to the community, including significant changes to the service delivery model for complex claims.

WorkSafe acknowledges that, while it has implemented a number of improvements, including an increase in the number and frequency of reviews of Agent decision-making, there is further opportunity to strengthen and coordinate our oversight and regulatory activities. WorkSafe also acknowledges that there is scope to integrate and centralise its complaint management and oversight function to capture all aspects of a complaint, including in relation to claims management and Independent Medical Examiner (IME) performance.

Your recommendations to WorkSafe

We reiterate our acceptance of your recommendations pertaining to WorkSafe, and note those made to Government.

In particular, WorkSafe accepts recommendation 4, and will immediately review and amend the business rules and protocols that define the quality decision-making audit, strengthening its oversight.

Management of complex claims requires ongoing assessment of complex and sometimes conflicting information, and consideration of new and emerging evidence over time. Audits will necessarily take account of this in assessing the reasonableness of an agent's decision based on the evidence available at the time of making the decision.

WorkSafe welcomes recommendation 3 and proposes to expand the scope of the independent review function to provide independent oversight of complex claims decisions, including those in relation to cessation of weekly payment entitlements.

Moreover, in addition to establishing a centralised process for all complaints, WorkSafe will continue to enhance its ethical decision-making framework and is introducing new capabilities to enable trends to be monitored and root cause analyses to be undertaken.

Please do not hesitate to contact me on telephone [redacted] should you have any queries or wish to discuss these matters further.

Yours sincerely

Colin Radford
Chief Executive

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2019

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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

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
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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

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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

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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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