



Annual Report

2010-2011

Office of the

WORKCOVER OMBUDSMAN

South Australia

**ANNUAL REPORT
2010 – 2011**



Letter to the Honourable Minister for Workers Rehabilitation

The Honourable, John Snelling, MP
Minister for Workers Rehabilitation
Parliament House
Adelaide

It is my duty and privilege to submit the South Australian WorkCover Ombudsman's Annual Report for 2010/2011 to the Minister as required, pursuant to subsection (1) of section 99L of the *Worker's Rehabilitation and Compensation Act, 1986*.

Mr W I Lines
WorkCover Ombudsman
September 2011

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Introduction

The Office of the WorkCover Ombudsman is established pursuant to Part 6D of the *Workers Rehabilitation and Compensation Act 1986* and commenced operation on 1 July 2008.

The Office was created following the Clayton Walsh Report of December 2007 which recommended that the Office be established for the purpose of discharging a complaints investigation role in relation to the operation of the WorkCover scheme as well as reporting on any systemic issues that lie behind patterns concerning individual complaints (Recommendation 65).

The Report also recommended that the Office have a role in monitoring the nature and quality of decision making in relation to key impact areas within the scheme such as the proposed 130 week review and termination of payments (Recommendation 26).

The Minister for Industrial Relations appointed Wayne Lines as the acting WorkCover Ombudsman effective from 1 July 2008. In June 2009, he was appointed as the inaugural WorkCover Ombudsman for a period of 5 years commencing from 1 July 2009.

On 23 June 2011 the administration of the *Workers Rehabilitation and Compensation Act 1986* was committed to the Minister for Workers Rehabilitation.

Mr W I Lines
WorkCover Ombudsman

What does the WorkCover Ombudsman do?

The functions and powers of the WorkCover Ombudsman are set out in sections 36(15) and 99D to 99G of the *Workers Rehabilitation and Compensation Act 1986* (the Act) and give the WorkCover Ombudsman a range of roles that are designed to support the fair and effective operation of the Act. These roles may be described as:

- Identifying and reviewing issues arising out of the operation of the Act and making recommendations for improvement.
- Receiving and investigating complaints about the administration of the Act, including complaints about the rehabilitation and return to work of injured workers, and endeavouring to resolve those complaints.
- Encouraging and assisting WorkCover and employers to establish their own complaint-handling processes and procedures.
- Reviewing decisions to cease weekly payments to injured workers and suspending those decisions whenever they are not reasonably open.

The WorkCover Ombudsman has the powers necessary for the carrying out of these functions and can require a person to provide information in writing, produce documents or attend in person to answer questions.

Section 99H of the Act provides that the WorkCover Ombudsman must carry out his functions and powers independently, impartially and in the public interest.

Jurisdiction

It is clear from subsection 99D(1) of the Act that the WorkCover Ombudsman's functions and powers are confined to the operation and administration of the Act. The WorkCover Ombudsman has no power to investigate any issues related to the operation of the *WorkCover Corporation Act 1994* or the *Fair Work Act 1994*, although workers compensation issues sometimes overlap with the provisions of these Acts.

The WorkCover Ombudsman has no jurisdiction to investigate matters that are, or are capable of being, the subject of proceedings in the Workers Compensation Tribunal under Parts 6, 6A and 6B of the Act or before Medical Panels SA under Part 6C of the Act or before the Levy Review Panel under Part 5 of the Act. In addition, the WorkCover Ombudsman may not investigate a matter that has become the subject of legal proceedings.

The WorkCover Ombudsman may investigate complaints about Rehabilitation and Return to Work Plans even though disputes about Plans may be heard by the Workers Compensation Tribunal under section 28B of the Act (which comes within Part 3 of the Act). Provided no legal proceedings have actually been commenced in connection with the dispute, the WorkCover Ombudsman may still be involved in helping to resolve disagreements about Rehabilitation and Return to Work Plans.

The WorkCover Ombudsman may perform the functions under 99D(1) of the Act on his own initiative, at the request of the Minister for Industrial Relations, or on receipt of a complaint by an interested person.

However, the WorkCover Ombudsman has a wide discretion to refuse to investigate a matter if of the opinion that:

- The matter raised is trivial
- The complaint is frivolous, vexatious or not made in good faith
- The complainant has insufficient personal interest in the matter
- The complainant has failed, without good reason, to take reasonable steps to resolve the matter through another complaint-handling process
- The investigation is unnecessary or unjustifiable
- The matter of the complaint should be dealt with under another Act or by another person or body
- There is some other reasonable cause for discontinuing the investigation.

Referral and Advisory Service

Consistent with the role of supporting the fair and effective operation of the Act, the Office provides assistance to many people who contact us. It is often possible to give people some guidance about the issues they raise or provide them with information about the scheme and the effect of legislative changes to the Act on entitlements and obligations. If their enquiry is about a matter outside jurisdiction we refer them to another appropriate source of assistance.

Provision of Training and Education

By invitation, the WorkCover Ombudsman has presented seminars and workshops to a variety of organisations and small groups. The presentations are an opportunity to increase awareness of the operation of the Office and the process of investigating complaints. They are also a means of educating compensating authorities and rehabilitation providers about some of the issues affecting the scheme and how they may improve their service delivery.

Review of the Year's Work

2010/2011 is the third year of operation of the Office. There were 1606 enquiries in the 2010/11 period compared to 1558 in the previous year (see Appendix Part One). The Office website also attracted an average of 798 visitors per month.

The Office received 165 complaints, up from 100 in the previous year. Injured workers or their representatives lodged 146 of these. The remainder were lodged by or on behalf of employers and service providers.

In the 2010/11 year, 17 complaints were assessed as being beyond jurisdiction, 31 were assessed as not requiring an investigation and 6 were withdrawn. Another 88 were resolved after investigation. I issued 38 recommendations in response to complaints investigated. As at 30 June 2011, 24 complaints were at various stages of consideration.

A total of 93 decisions to cease weekly payments were reviewed, down from 193 in 2009/10. 13 were suspended on the basis that the decision was not reasonably open. The suspension rate was 14%; about the same as the previous year.

In September 2010, the Office implemented a new case management system to improve the process of managing and reporting on information and documentation collected and generated while investigating complaints and responding to enquiries.

I addressed a variety of forums to explain the function and procedures of the Office. These included:

- Australian Institute of Administrative Law (SA Chapter)
- Self-Insurers of South Australia General Meeting
- Both Sides of the Fence Workers Compensation Seminar
- DeakinPrime Summit Conference
- Crown Solicitor's Office Civil Litigation Intra Office CLE
- Public Sector Workforce Relations IM Managers' Group
- De Poi Consulting Staff Training Session
- Institute of Private Practising Psychologists General Meeting
- Australian Rehabilitation Providers Association General Meeting
- Beckmann and Associates Staff Training Session
- 2 Employers Mutual New Case Manager Program Training Sessions

In addition, I presented a seminar on the topic of "changing the return to work culture in the work place" at a WorkCoverSA Rehabilitation and Return to Work Coordinator Training Session and addressed two WorkCoverSA Principal Engagement Sessions on the topic of significant Workers Compensation Tribunal decisions.

During the year, I provided written submissions to:

- WorkCoverSA and Employers Mutual Joint Task Group on Work Capacity Reviews
- WorkCoverSA Scheme Performance and Contract Management on Rehabilitation Program and RRTW Plan Templates
- WorkCoverSA Vocational Rehabilitation Unit on draft Guidelines for workplace rehabilitation providers on worker training

- WorkCoverSA on WorkCoverSA's engagement guidelines
- Minister for Industrial Relations on the *Workers Rehabilitation and Compensation (Dispute Resolution) Amendment Bill 2010*
- Medical Panels SA on Medical Panel Process and Function
- *Workers Rehabilitation and Compensation (Scheme Review) Amendment Act 2008* Review Team

Pursuant to section 99J of the Act, the Office is funded by the Compensation Fund. A statement of the Office's expenditure is provided in Appendix Part One.

Review of Decisions to Cease Payments

Introduction

The *Workers Rehabilitation and Compensation (Scheme Review) Amendment Act 2008* amended Section 36 of the *Workers Rehabilitation and Compensation Act 1986* so that the operation of a decision to discontinue or reduce weekly payments is not affected by the injured worker lodging a notice of dispute in the Tribunal. The WorkCover Ombudsman is empowered by section 36(15) to review decisions to discontinue weekly payments and suspend the operation of those decisions where it appears to him that the decision was not reasonably open. In the event that the decision is suspended, the worker is entitled to a continuation of their weekly payments while the dispute is proceeding in the Tribunal, otherwise the decision takes effect. This amendment to the Act took effect from 1 July 2008.

A worker may apply to me for a review of a decision if the following preconditions are met:

1. The decision is a decision to discontinue his or her weekly payments under section 36(1) of the Act; not a reduction of weekly payments under section 36(2) of the Act or a rejection of a claim for weekly payments under section 53 of the Act or a suspension of weekly payments under sections 38(6) or 98G(5) of the Act;
2. The worker has received notice of the decision to discontinue weekly payments;
3. The worker has lodged a notice of dispute against the decision at the Workers Compensation Tribunal.

An application for a review is made informally by sending me a copy of the notice of the decision and the notice of dispute filed at the Tribunal with a written request that I undertake a review. I then give the decision maker 7 calendar days to provide me with copies of the documents relevant to the decision and in most cases I am able to complete my review with 14 days of receiving the application.

The table below provides the statistics for applications received by me in the 2010/2011 year.

Table 1. Section 36(15) Applications: 1 July 2010 to 30 June 2011

Decisions by:	Suspended	Application Withdrawn	No Jurisdiction	Not Suspended	Total	Suspension Rate
EML (Registered Employers)	6	2	4	57	69	9.5%
Self-insured Employers	7	4	3	23	37	23.3%
Total	13	6	7	80	106	14%

Table 2 compares the results of reviews under section 36(15) of the Act for the 3 financial years since 1 July 2008.

Table 2. Comparison of Suspension Rates

Decision by:	Suspended			Not Suspended			Total Decisions Reviewed			Suspension Rate		
	2008/09	2009/10	2010/11	2008/09	2009/10	2010/11	2008/09	2009/10	2010/11	2008/09	2009/10	2010/11
EML (Registered Employers)	40	9	6	54	127	57	94	136	63	42%	6.6%	9.5%
Self-Insured Employers	13	19	7	30	38	23	43	57	30	30%	33.3%	23.3%
Total	53	28	13	84	165	80	137	193	93	39%	14.5%	14%

Suspension Rates

This 2010/11 year the suspension rate was almost the same as for 2009/10. I consider 14% to be an acceptable level. Employers Mutual's suspension rate is under 10% as it was the previous year. The suspension rate for self-insured employers improved from 33.3% in 2009/10 to 23.3% for 2010/11. Even so, there is still room for further improvement.

There has been a significant decrease in the number of disputed decisions reviewed by me. Whereas in 2009/10 I reviewed 193 decisions, in 2010/11 I reviewed only 93 decisions. From information received from the Workers Compensation Tribunal, I can report that the number of decisions reviewed by me represents about 8% of section 36 decisions disputed in the Tribunal over the same period. This is down from 16% in the 2009/10 year.

The main reasons for this decrease are firstly, compensating authorities have improved their decision making in this area resulting in a reduction of disputes and, secondly, representatives of workers are more familiar with how difficult it is to demonstrate that the decisions are not reasonably open and are, therefore, not referring as many decisions to me for review.

Work Capacity Reviews

Sections 35B and 35C of the Act came into effect from 1 April 2009. These provisions were introduced by the *Workers Rehabilitation and Compensation (Scheme Review) Amendment Act 2008* and govern the process for determining whether a worker's weekly payments may be discontinued after 130 weeks of entitlements.

If a work capacity review results in a decision to cease the worker's weekly payments, I have jurisdiction to review the decision under section 36(15) of the Act because the ground for the decision is prescribed by subsection 36(1)(i) which allows payments to be discontinued where "*the worker's entitlement to weekly payments*

ceases because of the occurrence of some other event or the making of some other decision or determination that, under another provision of this Act, brings the entitlement to weekly payments to an end or the discontinuance of weekly payments is otherwise authorised or required under another provision of this Act'. Section 35B of the Act is one such provision that brings the entitlement to weekly payments to an end if certain criteria are met but the actual decision to discontinue payments is made pursuant to subsection 36(1)(i) of the Act.

The following Table 3 summarises my review of decisions to stop payments as a result of a section 35B work capacity review in the 2010/11 year:

Table 3. Review of Section 35B Decisions

Decisions by:	Suspended	Not Suspended	Total	Suspension Rate
EML (Registered Employers)	1	37	38	2.6%
Self-insured Employers	0	3	3	0%
Total	1	40	41	2.4%

These figures are a subset of the statistics presented in Table 1 above. They demonstrate that Employers Mutual is conducting many more work capacity reviews than self-insured employers and that the documentation supporting Employers Mutual's decisions has been of a reasonably good standard as it was in the 2009/10 year. All but one of their decisions have satisfied the test of being reasonably open.

There have been a number of disputes in the Tribunal that have raised technical arguments about the interpretation of section 35B of the Act. One of these was referred to the Supreme Court on appeal from the Full Tribunal. The Supreme Court's decision was delivered on 20 July 2011. In the meantime, about 160 disputes have been held up in the Tribunal awaiting the outcome of the Supreme Court appeal. Now that the Supreme Court's decision is known, it is hoped that the Tribunal will be able to process these disputes on their merits. It is therefore probable that over the next 12 months we will have a better idea about whether the evidence obtained by Employers Mutual to support their decisions is sufficient.

Submission to the Review of the Impact of the Amendment Act 2008

The review of the impact of the 2008 amendments was undertaken in the first half of 2011 as required by the *Workers Rehabilitation and Compensation (Scheme Review) Amendment Act 2008*. The Review's report was completed in May 2011 and tabled in Parliament on 23 June 2011.

I provided written submissions to the Review. A copy of my submissions is provided in Annexure Part Two. My submissions referred to most of the 2008 amendments. In relation to sections 35B, 35C and 36, I submitted that:

- Section 35B(1) be amended so that it clarifies the need for the compensating authority to make an assessment of the worker's work capacity prior to any discontinuance of payments after 130 weeks of entitlements;
- Section 35B be amended so that an assessment under section 35B(1) is required to be undertaken in the context of and in accordance with the procedure of a section 38 review of a worker's work capacity;
- Provided a section 35B assessment follows the procedure in section 38, the provisions of section 35B(4), (5), (6), (7) and (8) giving a worker 13 weeks notice of a discontinuance if the worker was totally incapacitated at the end of 130 weeks of entitlements should be deleted;
- Section 35C requires substantial redrafting to simplify it and make it fairer;
- Section 36(15) be amended to (a) allow the WorkCover Ombudsman to review all section 36 decisions whether they result in a discontinuance or reduction of weekly payments, and (b) increase the WorkCover Ombudsman's discretion to suspend decisions in cases where the decision is not compelling or fails to comply with the Act or Regulations or is otherwise unsound.

The Review referred to these submissions with approval and I urge the Minister to take action to put them into effect.

Complaint Investigations

Introduction

The WorkCover Ombudsman may receive complaints from anyone who thinks they have been treated unfairly in relation to the operation of the *Workers Rehabilitation and Compensation Act 1986*. A complainant may be an injured worker, an employer, a health provider, an individual or an organization, a private business or government agency.

In accordance with Section 99D(4) of the Act, the Office established a scheme for receiving and dealing with complaints. The scheme is represented by a flow chart that has been posted on the Office website (see Appendix Part Three).

Procedure

When a complaint is received, I assess whether the subject matter of the complaint is within my jurisdiction and, if it is, whether in the exercise of my discretion I ought to investigate it. As much as possible, I encourage complainants to take up their complaint directly with the organisation against which the complaint is directed if they have not already. I usually require this to be done before I agree to undertake an investigation.

If I determine that I have jurisdiction to investigate and that in my discretion an investigation should be undertaken, my investigation officers will write to the person or organization complained against (the respondent) seeking an explanation, from their point of view, of what has occurred and whether they agree with any aspect of the complaint. After receiving the report, I decide whether further investigation is required or if I require more information from the complainant. I also consider whether the matter may be resolved by a conciliation conference or by way of issuing formal recommendations.

With the implementation of the new case management system, it has been possible to include in the category of complaints those enquiries that have required my Office to engage in an informal investigation with a respondent. Most of these informal investigations are conducted by email and telephone and do not involve the respondent in preparing a formal report. This has led to many complaints being resolved quickly as the response provided by the respondent has given an adequate explanation of the situation that gave rise to the complaint or has advised on appropriate action has been taken to address the problem.

Investigations and Recommendations

In the 2010/11 year my Office received 165 complaints on a range of issues. 58 out of 165 or 35% of complaints received relate to delays by case managers to approve or process payments or make decisions or reply to enquiries. Not all delays complained about are unreasonable, but often the situation has been exacerbated by the case manager failing to keep a claimant informed of their progress. The importance of case managers processing payments promptly and communicating effectively with a claimant whenever there is a delay cannot be overstated.

Only 22 of the 165 complaints or 13% related to concerns about rehabilitation. Considering the importance of rehabilitation and the fact that a rehabilitation consultant's relationship with an injured worker frequently extends to periods of 12 months or more, this number of complaints is quite low.

Significantly, the main subject of concern in connection with rehabilitation is compliance with section 58B of the Act: the obligation of an employer to provide suitable employment to the work injured. In 2009/2010, I made a series of recommendations to improve Employers Mutual's procedure for deciding whether to detach a worker from the pre-injury employer, which would exempt the employer from section 58B. While their procedure was revised in accordance with my recommendations it was never fully implemented and has since been revised again. If the new procedure is in fact put into operation, it should result in fewer complaints.

Some of the section 58B complaints I received were not about Employers Mutual's decision to detach a worker but WorkCoverSA's Return to Work Inspectorate's investigation of alleged breaches of section 58B. A key part of the problem has been that the Inspectorate has not properly informed people of the extent of their investigation or explained the basis of their conclusions. As a result of these complaints to my Office, the Inspectorate has undertaken a review of their procedures with a view to improving the level of communication to interested parties. An improvement to their procedures that incorporates appropriate reporting to those affected by their investigations should result in reduced complaints to my Office.

Complaints about referrals to independent medical examiners and to Medical Panels SA featured more prominently this year. Media coverage of a Supreme Court case that involved a consideration of the function and validity of Medical Panels SA may have had some influence on this. However, the complaints did bring to my attention that case managers were operating without any proper guidelines as to when and how to refer a matter to Medical Panels SA. This led to some referrals being inappropriate or unnecessary and in some cases the process leading to the referral was flawed.

I am hopeful that recommendations I have made to compensating authorities both formally and informally will see an improvement in the standard of referrals to both independent medical examiners and Medical Panels SA.

The table below sets out the number of complaints received in the 2010/2011 year according to complaint subject. Complaints relating to delays by case managers are highlighted in blue.

Table 4: Complaints Received 2010/2011

Complaints about:	Registered Employers Scheme	WorkCoverSA	Self-Insured Scheme	Total
COMMUNICATION				
Behaviour / conduct of case manager	7	0	3	10
Inaccurate information	3	1	0	4
Lack of information	7	0	1	8
Response not timely	10	0	1	11
DETERMINATION				
Delay by Case Manager	7	0	0	7
Interim payments	1	0	0	1
Investigation of claim	1	0	1	2
Procedural Fairness	1	0	0	1
Section 32	0	0	2	2

Complaints about:	Registered Employers Scheme	WorkCoverSA	Self-Insured Scheme	Total
Section 43	1	0	0	1
Request for advance surgery / medical treatment	1	0	0	1
Use of IME / Medical Panel	11	0	2	13
GENERAL				
Compensation entitlement	1	0	0	1
IME / MEDICAL PANELS				
Behaviour / conduct of IME	1	0	0	1
Report not provided	0	0	1	1
Support person not allowed to attend	1	0	1	2
INCOME MAINTENANCE				
AWE calculation	1	0	1	2
Back pay	4	0	1	5
Incorrect amount paid	1	0	1	2
Incorrect tax deducted	3	0	0	3
Leave entitlements	0	0	1	1
Not paid / delays	16	0	0	16
Overpayment / recovery by compensating authority	1	0	0	1
Reimbursement to employer	3	0	0	3
LEVIES/FINES				
Review process	0	2	0	2
MISCELLANEOUS				
Case Manager misconduct / behaviour	1	0	0	1
Compliance with WCT Orders	0	0	2	2
Section 43 payment delayed	2	0	0	2
Section 107B	0	1	0	1
Self Insured evaluations	0	1	0	1
PROVISIONAL LIABILITY				
Amount paid	2	0	0	2
Not approved within required time	2	0	0	2
Reasonable excuse	5	0	3	8
REDEMPTION				
No offer	4	0	0	4
Payment delayed	3	0	3	6
REHABILITATION				
Compliance with Section 58B	6	4	6	16
Content of RRTW/RP	1	0	0	1
No rehabilitation provided	3	0	0	3
Provider behaviour / conduct	1	0	0	1
Retraining declined / not offered	1	0	0	1
SECTION 32 EXPENSES				
Delay in approving payment	7	0	3	10
Documentation lost by compensating authority	1	0	0	1
Worker not reimbursed within timeframe	1	0	1	2
TOTAL	122	9	34	165

Resolution of Complaints

By 30 June 2011, I had issued 38 recommendations on 20 separate complaints. These recommendations have been collated in chronological order and annexed to this report in Appendix Part Three. The focus of all recommendations is to help improve the delivery of claims and rehabilitation services to injured workers and the delivery of services generally to all stakeholders. For this reason recommendations must be realistic and achievable. It is pleasing to note that although my recommendations are not enforceable by recourse to litigation, compensating authorities have accepted nearly all of the recommendations issued in the 2010/2011 year, although several relating to changes to policies are still to be implemented.

168 complaints were finalised this year. 166 (99%) of these were completed within 12 months of receiving them. Some of these were complaints that had been received the previous year and the investigation had carried over into the 2010/11 year.

46% of complaints received were finalised after the respondent provided me with a response to the complaint. Although, the Act empowers me to hold conciliation conferences between parties I have not employed this dispute resolution method this year as I have found that obtaining written responses from a respondent that are timely and thorough is the most effective tool for complaint resolution in the majority of cases.

Six of the 20 cases that were resolved by a notice of recommendation concerned provisional liability. Provisional liability allows for the commencement of weekly payments after initial notification of a disability prior to the claim being determined by the compensating authority. It is covered by Division 7A of the Act and came into operation on 1 January 2009. The intention of provisional liability is that an injured worker is paid their normal income for up to 13 weeks on the basis of preliminary information while the claim is being investigated. Provisional Payment Guidelines published by the Minister in the Government Gazette prescribe 4 "reasonable excuses" that may be relied upon by compensating authorities for refusing to commence provisional weekly payments within 7 days of an initial notification of a disability. The complaints received by me relate to the failure of compensating authorities to approve provisional liability within 7 days or the validity of the reasonable excuse relied upon to refuse provisional liability.

As for 2009/2010, my investigation of these complaints has revealed that some case managers do not have a good understanding of the provisional liability provisions and their procedures and policies relating to this area need improvement. My recommendations have been directed towards that.

While, provisional liability has not given rise to too many complaints to my Office in 2010/11, it remains my view that the reasonable excuses are complicated and difficult to apply. I repeat the view expressed in last year's annual report that the provisional liability regime would be more effective if the reasonable excuses were reduced from 4 to 1. The one excuse that is worth retaining is that it is unlikely that the injured person is a worker under the Act. The others ought to be dispensed with.

Table 5: Outcomes of Completed Complaints 2010/2011

	Completed Within 12 months	Completed after 12 or more months	Total
Notice of Resolution	14	1	15
Notice of Recommendation	19	1	20
Resolved after response from respondent	77	0	77
No jurisdiction	18	0	18
Investigation declined	32	0	32
Complaint withdrawn	6	0	6
Total	166	2	168

Code of Claimant Rights

Section 123B was inserted into the Act in 2008 and provides that the Governor may, by regulation made on the recommendation of the Minister, prescribe a code to be known as the *Code of Claimants' Rights*. The intention of this amendment was to provide injured workers with another layer of assurance that they will be dealt with reasonably by a compensating authority. Such a code would define the expectations placed on WorkCover and self-insured employers and enable injured workers to raise objections if, in their view, expectations are not met. It is an important component of the package of amendments introduced in 2008. However, at the time of completing this report, a code is yet to be promulgated.

In my submission to the Review of the Impact of the Amendment Act 2008 (see Appendix Part Two), I expressed the view that a code should be in place to standardise the quality of service injured workers can expect to receive from compensating authorities and to make compensating authorities more accountable to the public. This view is supported by the types of complaints and enquiries my Office receives on a daily basis.

I understand that a draft Code that had been the subject of considerable consultation was presented to a former Minister in late 2009. According to the report of the Review of the Impact of the Amendment Act 2008, there is perceived to be a legal impediment to the proclamation of a code as a Regulation under the Act and the Review recommended an early resolution of the impediment so that a code could be put into operation.

I support that recommendation and request that the Minister take action to progress the finalisation of the Code of Claimants' Rights.

Review of Internal Complaint Handling Processes

Introduction

Under section 99D(1)(d) of the Act, the WorkCover Ombudsman has the specific function of encouraging and assisting WorkCoverSA and employers to establish their own complaint handling processes and procedures with a view to improving the effectiveness of the Act. This function is consistent with the WorkCover Ombudsman's discretion under section 99D(5) of the Act to refuse to investigate a complaint if the complainant has failed, without good reason, to take reasonable steps to resolve the matter through another established complaint-handling process. In my view, I should only exercise the discretion on this ground if I have confidence in the internal complaint-handling processes of the organisation that is the subject of complaint. I, therefore, have an interest in ensuring that WorkCoverSA and self-insured employers have effective internal complaint handling processes.

WorkCoverSA and Employers Mutual Ltd

In 2011, WorkCoverSA and Employers Mutual Ltd commenced a revision of their respective complaint handling procedures with a view to entering a memorandum of understanding. I have asked to see the memorandum once it is completed so that I may satisfy myself that it will be effective.

Self-insured Employers

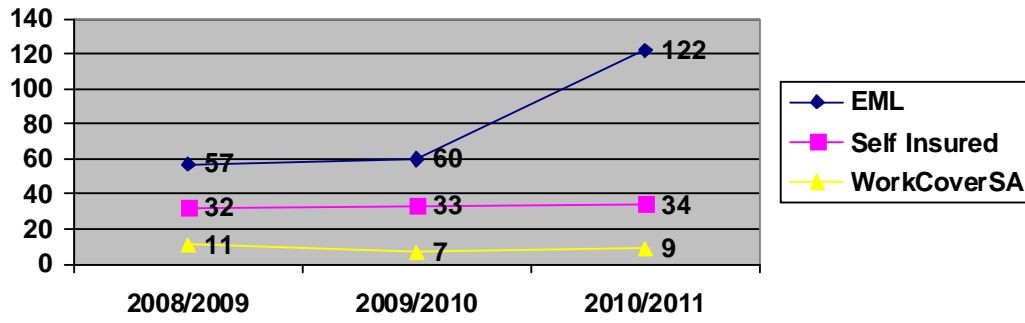
In 2009/10, the Office completed a review of the internal complaint handling processes of all 69 private self-insured employers and all 12 crown agencies that provide a workers' compensation claims management service. As a result of my review all self-insured employers should have an effective internal complaint handling process in place.

As reported in the section on complaints investigations, the implementation of the new case management system has resulted in a broadening of the definition of complaints so that those enquiries that have required my Office to engage in an informal investigation with a respondent are now included in the complaints data. Most of these informal investigations are conducted by email and telephone and do not involve the respondent in preparing a formal report.

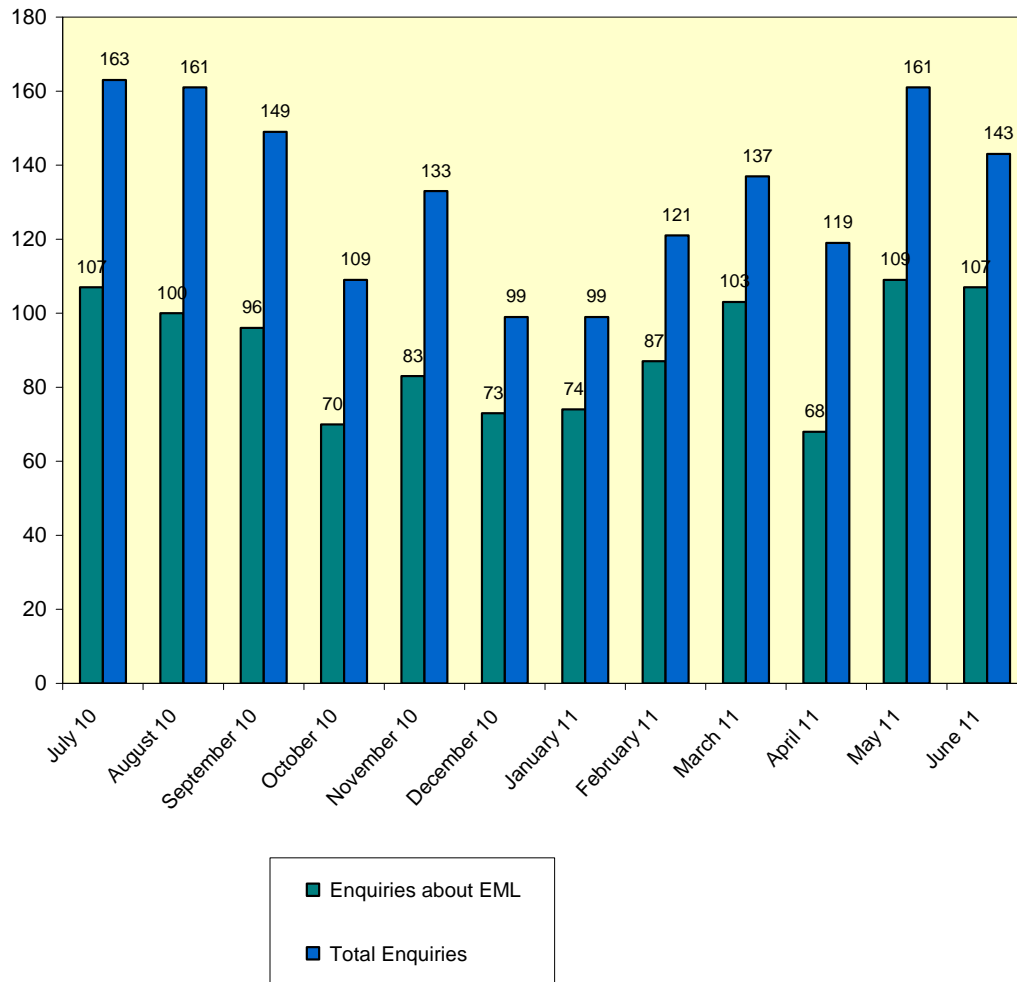
It is worth noting that while this expanded definition of complaint has led to an increase in the number of approaches to my Office being categorised as complaints, the number of complaints about self-insured employers since the end of the 2008/09 year has not changed (see Chart 1 below). This suggests two possibilities to me. The first is that the management of claims by self-insured employers has been of a consistent quality in the three years since my office commenced operations so that the incidence of complaint has been kept to the same level. The second is that their complaint handling processes have been effective in dealing internally with the less serious complaints so that my office has not had to deal with them.

Given this experience, I have decided to defer undertaking another review of all self-insured employer internal complaint handling processes until the 2012/13 year.

Chart 1: Complaint Investigations



General Enquiries 2010/2011



Office Expenditure

Salaries and Oncosts	\$527,703
Motor Vehicles and FBT	30,915
Supplies and Services	165,224
Depreciation and Amortisation	-
Total	\$723,842

WorkCover Ombudsman's Submissions to the Workers Rehabilitation and Compensation (Scheme Review) Amendment Act 2008 Review Team

Introduction

Schedule 2 of the *Workers Rehabilitation and Compensation (Scheme Review) Amendment Act 2008* ("the Amendment Act") requires the Minister for Industrial Relations to appoint an independent person to review the impact of the Amendment Act on the work injured, on levies paid by employers and on the sufficiency of the Compensation Fund to meet liabilities. In accordance with Schedule 2, the Minister appointed Mr Bill Cossey AM and Mr Chris Latham ("the Review Team") to undertake the review commencing on 24 January 2011.

My Office presents submissions to the Review Team on the following topics:

1. Amendments to section 4 – Average Weekly Earnings
2. Amendments to section 35, and insertion of sections 35A, 35B, 35C – Entitlement to weekly payments
3. Amendments to section 36 – Discontinuance of Weekly Payments
4. Amendments to section 43 and insertion of sections 43A and 43B – Lump Sum Compensation
5. Part 4, Division 7A – Provisional weekly payments
6. Part 6C – Medical Panels
7. Part 6D – WorkCover Ombudsman
8. Section 123B – Code of Claimant's Rights

1. Amendments to section 4 – Average Weekly Earnings

The amendment to section 4 has been generally well accepted by injured workers. The requirement that average weekly payments be calculated on a purely historical basis (subsection 4(1)) rather than on an assessment of what the worker may have earned if he/she had not been injured has given more certainty and less cause for disagreement. The inclusion of overtime in the calculation (subsection 4(12)) has also received a favourable reception.

The one area of concern is the discretionary nature of subsection 4(6) which allows the compensating authority to calculate average weekly earnings by reference to the earnings of a comparable employee in certain circumstances. The reluctance by Employers Mutual Limited (EML) to apply this subsection in some obvious cases was disappointing. The Workers Compensation Tribunal has now judicially determined some disputes relating to this subsection in favour of injured workers¹. This may help to resolve the problem. Nevertheless consideration should be given to making

¹ *Rennie v WorkCover/EML Ltd (Extrastaff Pty Ltd)* [2009] SAWCT 42; *Frape v WorkCover/Employers Mutual Limited (DP World Adelaide Pty Ltd)* [2009] SAWCT 39

this alternative method of calculating average weekly earnings mandatory if a fair average cannot be achieved by the historical approach.

2. Amendments to section 35, and insertion of sections 35A, 35B, 35C – Entitlement to weekly payments

The provisions of section 35 and 35A have not caused too many difficulties. However, the definitions of the first, second and third entitlement periods (subsection 35(8)) allow the calculation of each period to include any week in which the worker has an entitlement to a payment of weekly payments. This has meant that even if a worker has received weekly payments for a few hours off work in a week, that week has been included in the entitlement period. Many workers have been taken by surprise by this. I question whether this was the Parliamentary intention and submit that it would be fairer if for the first 2 entitlement periods the periods were calculated according to whether the worker had received the equivalent of 13 weeks of average weekly payments. This would increase the incentive to a worker to return to work at least on a part time or reduced hours basis as it would extend the overall period for which they will be paid at the 100% or 90% level of average weekly payments.

Sections 35B and 35C have resulted in changes to entitlements and procedures and had a major impact on injured workers. Unfortunately, these sections are unnecessarily complicated and obscure. Due to their ambiguous terms, use of double negatives, many references to other sections and uncertain relationship to sections 38 and 36 of the Act, I expect that many challenges will be mounted in the Tribunal and Supreme Court on grounds of statutory construction. In my view, it has to be considered whether the cost of litigation that will surround these provisions and the consequential delays this will cause to case management will outweigh their perceived benefit to the Scheme.

While I do not advocate for the complete dismantling of the procedure created by sections 35B and 35C, I do submit that the following changes need to be considered:

- Subsection 35B(1) contains a double negative and is convoluted. Its wording creates uncertainty as to whether an assessment of work capacity must be undertaken before weekly payments cease at the end of the third entitlement period. The phrase “likely to continue indefinitely to have no current work capacity” is clumsy and vague. Subsection 35B(1) should be amended to read: “A worker’s entitlement to weekly payments ceases at the end of the third entitlement period. However, the Corporation cannot discontinue a worker’s weekly payments at the end of the third entitlement period unless it has assessed the worker as (a) having a current work capacity or (b) likely to have a work capacity within 3 months of the assessment.”
- It should be expressly stated that an assessment under section 35B must be undertaken in the context of and in accordance with the procedure of a section 38 review. This will afford workers with fair notice of the assessment and allow them to provide relevant information to the compensating authority before a decision is made to discontinue their payments².
- Subsections 35B(4), (5), (6), (7) and (8) should be deleted. Having a separate process and notice period for workers who are in receipt of weekly payments on the basis of total incapacity when they reach the end of their

² See *Davey v WorkCover Corporation (Construction Industry Training Board)* [2011] SAWCT 1 for Full Tribunal’s view on the importance of procedural fairness to section 35B assessments.

third entitlement period is unnecessarily complicated³. The relationship of subsection 35B(6) to section 36 is unclear in light of subsection 36(3a)(bb)⁴. Provided that the section 35B assessment follows the procedure under section 38, workers will have sufficient warning of the decision that is likely to be made whether or not they have gainful employment at the time the process is commenced.

- Section 35C is a mess. Besides having several vague and ambiguous terms, it has managed to create a mind twisting tangle of concepts. The intention is to provide an exception to section 35B(1) so that workers who have reached the end of their third entitlement period will continue to receive their weekly payments if they are gainfully employed and working to their maximum capacity. It takes several readings to discover what it is trying to achieve. It is in desperate need of redrafting before it consumes an inordinate amount of the time and resources of injured workers, compensating authorities, Medical Panels and courts. I also question why the exception to section 35B(1) created by section 35C is only considered if a worker makes an application to a compensating authority. Why not require the compensating authority to consider whether the worker is working to his/her full capacity at the time of making the assessment under section 35B(1)?

3. Amendments to section 36 – Discontinuance of Weekly Payments

The amendments to section 36 effect significant changes to the Scheme and have had a substantial impact on injured workers. The amendments are working reasonably well in the sense that they are intelligible and functional. However, the change to subsection 36(4) removing the automatic continuation of weekly payments upon lodgement of a dispute against the section 36 decision has caused financial hardship and anguish to many injured workers. The government is under pressure to ameliorate the affects of the change.

One response is to “fast track” the dispute resolution process so that a determination of the correctness of the section 36 decision is made within weeks rather than months. The problem with this is that for the merits of a section 36 decision to be properly assessed there needs to be a hearing of evidence and submissions made on behalf of the protagonists. This will ordinarily take more than a few weeks to arrange if it is done fairly and thoroughly. In particular, workers will not be in a position to present their cases within a few weeks of receiving notice of the decision. A fast tracked process is more likely to be detrimental to the interests of injured workers than helpful.

In November 2010, the Minister for Industrial Relations introduced the *Workers Rehabilitation and Compensation (Dispute Resolution) Amendment Bill 2010* which has the aim of expediting the dispute resolution process for section 36 disputes. In my submission to the Minister in relation to the Bill I have asked the Minister to defer the progress of the Bill until completion of your review. I have also pointed out that the procedure proposed by the Bill is impractical and unworkable. In my view, the better approach to the issue is to focus on improving the standard of decision making by compensating authorities. If section 36 decisions are of a high quality and, therefore, likely to be upheld by the Tribunal, it will be better for workers to have to adjust to the loss of weekly payments soon after the decision is made than to be

³ See for example, *Creek v WorkCover Corporation (Glenn Industries Pty Ltd)* [2011] SAWCT 3

⁴ See comment by DP McCouaig in *Taylor v WorkCover Corporation/Employers Mutual Ltd (Burnside War Memorial Hospital Inc)* [2011] SAWCT 2 at para 21.

faced with having to repay the total of weekly payments received while the dispute is proceeding in the Tribunal.

As reported in both of my annual reports to date, the threshold for a compensating authority to avoid a suspension of a decision by the WorkCover Ombudsman under section 36(15) is quite low. Provided the decision is “reasonably open”, I have no discretion to suspend the decision. This means that decisions that are of a poor quality may still avoid being suspended by me because they meet the test of being reasonably open. In my view, the standard of decisions needs to be quite high if they are to take effect while a dispute proceeds in the Tribunal.

To this end I have recommended to the Minister that he consider amending:
(a) Regulation 35 of the *Workers Rehabilitation and Compensation Regulations 2010* (“the Regulations”) to require that decisions contain an outline of the evidence, facts and law on which the Corporation is relying to discontinue or reduce the weekly payments, and
(b) Section 36(15)(b) of the Act to allow the WorkCover Ombudsman to suspend the decision “if it appears to the WorkCover Ombudsman that the decision is not compelling or fails to comply with the Act or Regulations or is otherwise unsound.”

Another issue relating to the amendments to section 36 is that the WorkCover Ombudsman’s review function created with the introduction of sections 36(15), (16) and (17) of the Act is exclusive of decisions to reduce weekly payments. Since commencing the review function on 1 July 2008 I have reviewed approximately 10% of section 36 disputes lodged with the Tribunal over that period. Part of the reason for the low percentage of disputed decisions coming to me for review is that my power of review is confined to decisions to discontinue weekly payments only. I cannot review decisions to reduce weekly payments. I do not know why the review power has been limited in this way. Given that many reductions to weekly payments pursuant to section 36(2) of the Act are substantial and have a significant impact on workers’ entitlements, the limitation on my review power seems unfair and illogical. In my submission, section 36(15) should be amended to allow the review function to cover all section 36 decisions, whether they result in a discontinuance of weekly payments or a reduction in weekly payments.

4. Amendments to section 43 and insertion of sections 43A and 43B – Lump Sum Compensation

My office has not received much feedback on the operation of these amendments. People I have spoken to regarding their entitlements to a lump sum are accepting of the 5% threshold (section 43(4)). I have not received any negative feedback about the quantum of lump sum compensation payable for particular percentage impairments.

However, I am surprised by the level of variation between medical practitioners in their assessments of percentage impairment. I believe there is more disputation over section 43 entitlements than was anticipated when the amendments were conceived. I believe part of the problem is that Schedule 4 of the Regulations prescribes a higher dollar amount for every one percentage point from 5% and above. In the higher ranges, an increase of 1% permanent impairment can result in several more thousand dollars. The variation of expert assessments would matter less if the lump sum was the same over a range of percentage impairments. For example, currently the difference between having a 6% impairment rather than a 9% impairment is

approximately \$4,500, but if the one lump sum figure of say, \$15,000, applied to all impairments between 5% and 10% it would not matter if a person was assessed as having a 6% or 9% impairment. I believe consideration should be given to amending Schedule 4 to set lump sums for a range of percentage impairments instead of for each percentage point.

5. Part 4, Division 7A – Provisional weekly payments

The concept of providing an injured worker with up to 13 weeks of weekly payments while the claim is being investigated and determined has merit. It has benefited injured workers by reducing their levels of financial hardship and anxiety while they await the determination of their claim. The payment of provisional payments also adds incentive to compensating authorities to be prompt with their determination of claims.

My office has investigated a number of complaints from injured workers about compensating authorities refusing to commence provisional weekly payments. It appears to me that the Provisional Liability Guidelines are causing some problems. In particular, the reasonable excuses in paragraph 2.1 of the Guidelines are complicated and require the decision maker to discharge a higher onus of proof than if the claim itself was rejected. In most of the cases I have investigated, it is evident that the decision maker has not understood the reasonable excuse criteria and has wrongly applied a reasonable excuse for refusing to commence provisional weekly payments. Some compensating authorities appear to be distracted by the availability of reasonable excuses and spend a lot of effort in trying to establish a reasonable excuse to refuse provisional weekly payments instead of focussing on investigating and determining the claim.

In my 2009/2010 Annual Report (at page 10), I have stated that the problem could best be addressed by dispensing with the reasonable excuses except for the one relating to whether the injured person is a worker under the Act. I still believe that would be worth implementing.

6. Part 6C – Medical Panels

There is considerable opposition by injured workers and their representatives to the concept and function of Medical Panels. Much of the opposition is due to the fact that Medical Opinions are final and conclusive on medical questions (section 98H(4)) and Medical Panel assessments of workers take place without the presence of advocates. The constitutionality of Medical Panels will be determined by the Supreme and High Courts in due course and it is, therefore, unnecessary for me to comment on this issue.

However, a range of other criticisms have come to my attention and warrant my comment. These relate primarily to the way in which case managers have gone about the process of referring an injured worker to Medical Panels. I specify some of the criticisms that have been reported to me as follows:

- The case manager failed to give the worker any explanation for the referral.
- The referral by the case manager was premature and based on inadequate information.
- The referral by the case manager was unnecessary because medical evidence had already been obtained and is uncontroversial.

- The case manager designated some medical practitioners as having a conflict of interest without providing reasons.
- The questions on a referral were inappropriate or invalid.
 - E.g. Questions about the compensability of an accepted disability or about the reasonableness of medical treatment when the compensating authority has already paid the accounts for the treatment;
 - E.g. Questions that require Medical Panels to assess the worker's credibility.
- The compensating authority made the referral without attempting to agree facts.
- The referral contained a multitude of questions, e.g. 60 or more questions in the one referral. The referral sought to cover all possible issues relating to the claim rather than those that actually require a resolution.
- The worker was subjected to 2 referrals to Medical Panels in the one month and had to attend assessments by 2 separate panels.
- The worker received no forewarning of the referral by the case manager.
- Referral documentation submitted by compensating authorities omitted highly relevant documents such as recent medical reports.
- Compensating authorities submitted documents to Medical Panels which are prejudicial and irrelevant.
 - E.g. Reports by investigators summarising surveillance film.
- Fees charged by representatives of workers for preparing submissions to Medical Panels are not recoverable when there is no current dispute in the Tribunal.

In my view, many of these criticisms would have been avoided if compensating authorities had a fully developed set of internal guidelines for determining when and how referrals will be made. I am unsure about how many of the self-insured employers currently have guidelines for Medical Panel referrals. I know that Crown agencies and Employers Mutual Limited have developed theirs in the last few months. It is too early to say how effective these are.

If compensating authorities continue to refer injured workers to Medical Panels without proper care or consideration, the Minister may have to issue guidelines that apply to the procedures of Medical Panels under section 98B(5) of the Act and have the effect of controlling the way in which referrals are made to them. The Minister's guidelines may be able to stipulate such matters as to how frequently a worker may be referred, what attempts a compensating authority must make to agree facts with the worker and what documents should be included with or omitted from a referral.

The question about recovery of representation costs associated with Medical Panel referrals is an important one. A Medical Panel opinion will often be conclusive of a worker's entitlements under the Act. It is therefore understandable that injured workers will consult a lawyer to assist with their preparation for a Medical Panel assessment. Workers will often need advice on the possible ramifications of a Medical Panel opinion and on what information should be submitted to a Panel. In particular, they may need the help of a lawyer to ensure that all relevant documents are collated and provided to the Panel. If the referral is by a compensating authority prior to there being any dispute in the Tribunal, there is no prescribed representation fee that is payable by the compensating authority for the service provided by the worker's lawyer. The worker has to pay the entire legal fee themselves. Therefore, a

compensating authority's referral to a Medical Panel can result in financial detriment to a worker.

In contrast, if the referral occurs in the course of dispute proceedings before the Tribunal, workers can recover some costs that will help towards their lawyers' fees that are related to their involvement in assisting workers to prepare for their assessment by the Panel.

In my submission, consideration should be given to amending section 98G of the Act to allow for representation costs incurred in the referral process to be prescribed.

7. Part 6D – WorkCover Ombudsman

As a result of performing the functions of complaint investigation and review of section 36 decisions, I have been able to address some systemic issues which I believe has had a beneficial impact on injured workers generally. However, it may be too early to gauge that benefit at this present time.

Firstly, my review of section 36 decisions has highlighted the need for compensating authorities to exercise more quality control over their decisions to cease weekly payments. In particular, Employers Mutual Limited has improved the standard of documentation in support of their decisions. This is reflected in the suspension rate for their decisions decreasing from 42% in the 2008/2009 year to 6.6% in 2009/2010. The number of decisions Employers Mutual Limited set aside once the decisions were referred to me for review halved over the same period, which also indicates that the decisions are more robust and able to withstand external scrutiny. If this improvement applies to all section 36 decisions whether reviewed by me or not, then workers will have benefited from better decision making.

In the course of investigating a number of complaints about decisions by Employers Mutual Limited to approve a worker's termination of employment by their pre-injury employer, I identified the need for the process to be more transparent and evidence based. Recommendations I made on individual cases have resulted in the whole process being substantially revised so that it includes a meeting of the case manager with both the worker and the employer, a period following the meeting for parties to provide any further information of relevance to the case manager and more detailed correspondence to both the worker and employer setting out the information relied upon and an explanation of how the decision was reached.

Investigation of complaints by injured workers about the way they have been referred to Medical Panels SA has resulted in it becoming apparent that there has been an absence of internal guidelines within self insured employers and Employers Mutual Limited governing the process by which case managers refer workers to Medical Panels. Accordingly, I have alerted compensating authorities via Self Insurers SA, Public Sector Workforce Relations and WorkCoverSA of the need to develop guidelines immediately.

Complaints my Office received about the terms of Rehabilitation and Return to Work Plans indicated to me that inadequate consultation was occurring between rehabilitation consultants and injured workers in the development of their Plans. My recommendations included amendments to WorkCoverSA's Injury and Case Management Manual that would strengthen the requirement for consultation with workers and their treating doctors in the preparation of a Plan. In addition, I had

input into the revision of the standard form Rehabilitation and Return to Work Plan and Rehabilitation Program completed in December 2010. These revised forms and the guidelines attached to them emphasise the requirement of consultation.

I have also made recommendations to WorkCoverSA about their process for exercising investigation powers under section 110 of the Act and publicising convictions for fraud so that the privacy of injured workers is not unnecessarily or inappropriately infringed.

In addition, I have exercised my function of encouraging WorkCoverSA and employers to establish internal complaint handling processes (section 99D(1)(d) of the Act) to review the processes of all 69 private and 12 crown self insured employers. As a result of my review, a number of employers that did not have a process in place now do and several others whose processes were inadequate now have improved ones.

I advise that my Office has been adequately funded and staffed for the work it has needed to undertake so far. Currently, there are 3 full time staff besides myself and for each of the last 2 years we have been dealing with about 2000 approaches for assistance across the full range of my functions. Although, section 99D(2) of the Act allows me to investigate or review an issue arising out of the operation of the Act on my own initiative, I have only been able to do this in an informal, low profile way on a few matters. If my jurisdiction were to expand or if I were to instigate public inquiries into systemic issues relating to the operation of the scheme, the resourcing of the Office would need to be reviewed.

Generally, I am satisfied with the extent of the powers to perform the WorkCover Ombudsman's functions. The level of co-operation I receive from compensating authorities is very good and for the most part my recommendations are accepted and implemented. Sometimes, though, the implementation can take a very long time and my Office has to engage in some persistent follow-up to ensure the implementation occurs. It may be worthwhile amending the Act to empower the WorkCover Ombudsman to give directions concerning the implementation of recommendations made pursuant to the exercise of functions under section 99D of the Act and specifying that the failure to comply with a direction is a breach of the Act.

8. Section 123B – Code of Claimant's Rights

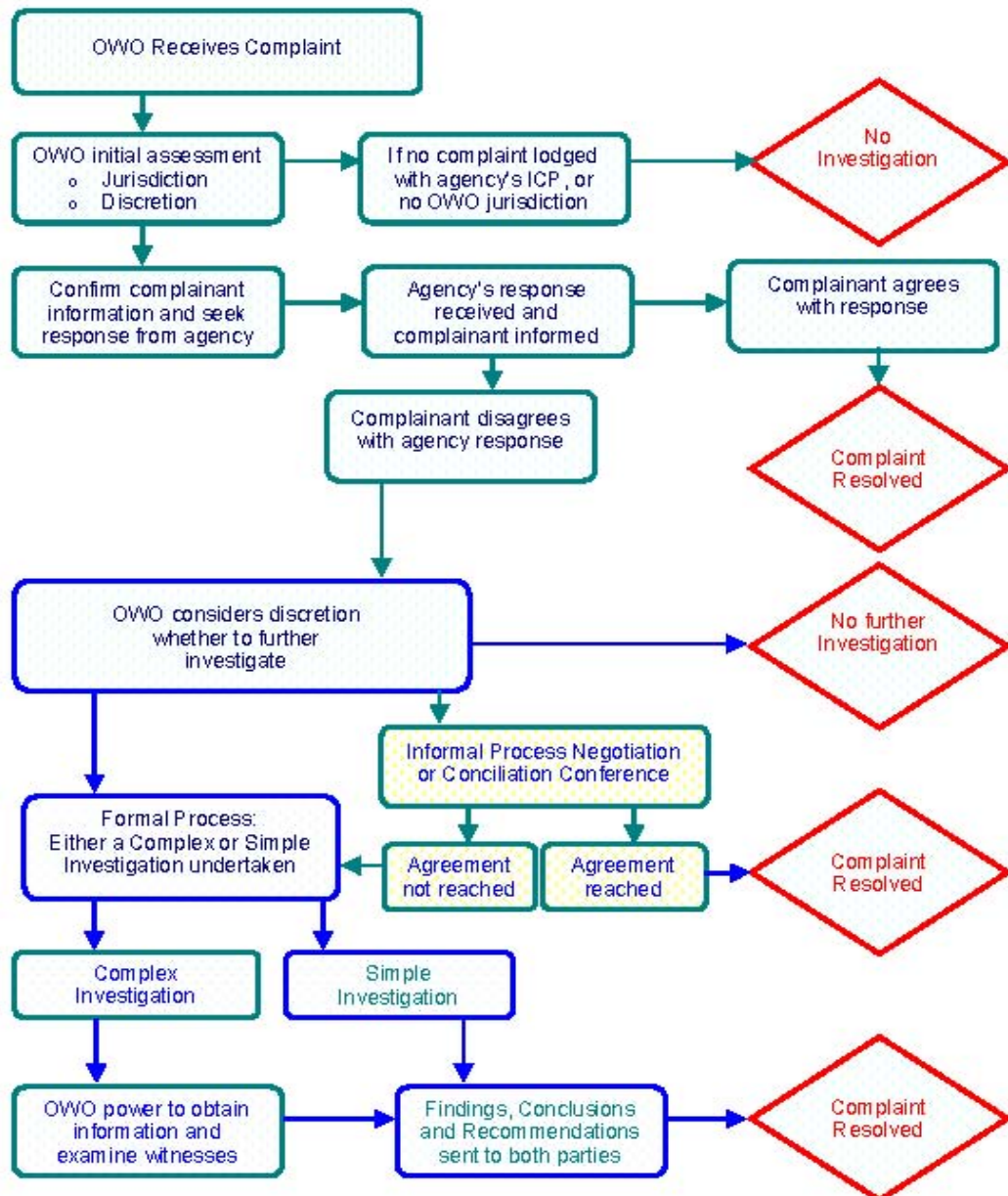
No Code of Claimant's Rights has been issued under this section of the Act. In my view, a Code should be in place to standardise the quality of service injured workers can expect to receive from compensating authorities and to make compensating authorities more accountable to the public. I provided feedback to WorkCoverSA on a draft Code of Claimant's Rights in February 2009, and I understand that the Workers Rehabilitation and Compensation Advisory Committee presented the former Minister with recommendations regarding the Code in late 2009. It appears no progress has been made since then. I do not know the reason for the delay. The Review Team should insist on a Code being issued by the end of 2011.

I welcome any questions the Review Team may have in regard to these submissions and acknowledge that my submissions will be made publicly available at the conclusion of the review.

Wayne Lines
WorkCover Ombudsman

February 2011

Complaint Resolution Process



Recommendations Issued 2010-2011

7 July 2010 – Provisional Liability – EML

Complaint:

1. *The worker's solicitor states that a claim for compensation was served on EML under cover letter dated 29 March 2010 supported by a Prescribed Medical Certificate dated 27 March 2010. However, by letter dated 21 April 2010, EML determined not to accept the claim on a provisional basis by applying a reasonable excuse pursuant to section 50B of the Workers Rehabilitation and Compensation Act 1986 ("the Act") and paragraph 2.1.1 of the Provisional Payment Guidelines. EML's decision indicated that the worker's claim for "ring finger fracture, ring & 3^d fingers laceration – left" sustained on 8 May 2009 had already been determined on 7 July 2009. In regard to the decision, the solicitor alleges that:*
 - a. *EML failed to comply with the Act and the Provisional Payment Guidelines by not providing the worker notice, in writing, of its decision within 7 days;*
 - b. *The decision to not commence provisional weekly payments to the worker on the basis that the claim for compensation has already been determined is not reasonable. Whilst the claim lodged in May 2009 was originally accepted and determined to be compensable, this cannot constitute a reasonable excuse where the compensability of a claim has already been determined but the issue in reality relates to whether the worker suffers an ongoing incapacity as a result of such accepted disability; and*
 - c. *This is particularly so because the original determination dated 7 July 2009 accepting the claim for a closed period indicated to the worker that, "if you wish to claim for a subsequent period of incapacity you may do so by submitting a further Prescribed Medical Certificate".*

The WorkCover Ombudsman recommended that:

1. WorkCoverSA amend Chapter 4 of the Injury and Case Management Manual to ensure it reflects:
 - that an *initial notification* means the first notification of a disability as defined in paragraph 1.1 of the *Provisional Payment Guidelines*;
 - the need for a Case Manager to assess, and if necessary, contact the injured worker to determine whether the information received in a claim form (or other manner) is in fact an *initial notification* (the first notification of a disability) or whether the claim for compensation is for a new period of incapacity by reason of a disability previously suffered by the worker; and
 - if the Case Manager determines that the information received is in fact a claim for compensation for a new period of incapacity by reason of a disability previously suffered by the worker rather than an *initial notification*, the Case Manager should immediately write to the injured worker advising that a claim for compensation for a new period of incapacity does not constitute an *initial notification* pursuant to section

50A of the Act and the *Provisional Payment Guidelines* and that a determination has or will be made as quickly as possible by the Case Manager pursuant to section 53 of the Act.

12 July 2010 – Entitlements – EML

Complaint:

1. *The worker's complaint relates to a dispute over interest payable on his income maintenance payments as per Orders sealed by the Workers Compensation Tribunal on 2 September 2009.*
2. *The worker alleges that he received income maintenance payments for the period 17 January 2009 to 9 September 2009 plus interest, on 22 October 2009. However the interest component had only been calculated up until 9 September 2009 rather than up to and including 22 October 2009.*

The WorkCover Ombudsman recommended that:

1. WorkCoverSA issue an instruction to EML (to take effect immediately) requiring that, in circumstances where a weekly payment, or part of a weekly payment, is not paid as and when required to be paid under this Act; or the making of a weekly payment is delayed pending resolution of a dispute under this Act any amount in arrears will be increased by interest at the prescribed rate. Interest must be calculated to the date the worker is paid and that any delay experienced as a result of the claims agent conducting relevant enquiries with Centrelink or the Child Support Agency is not a reason to not pay interest to an injured worker.
2. WorkCover SA amend page 37, Chapter 9 of the Injury and Case Management Manual to reflect the above instructions given to EML.

12 July 2010 – Communication – EML

Complaint:

1. *Mr B runs a VIP lawn-mowing franchise and provides services to injured workers on EML's behalf. He alleges EML did not inform him that an injured worker's eligibility for workers compensation had ceased and that therefore he could not charge EML for further services to that claim.*

The WorkCover Ombudsman recommended that:

1. WorkCoverSA pay Mr B the outstanding sum of \$90.00 for services delivered on 19 June 2009 and 2 July 2009 as per invoice Y94 issued on 3 July 2009.

23 July 2010 – Inappropriate Management of Claim – EML

Complaint:

1. *The worker alleges that his case manager requested a report from his doctor without a signed medical authority; and*
2. *The case manager and her team leader failed to receive the worker's complaint and respond to it appropriately.*
3. *In support of his complaint, the worker advises that:*
 - a. *he required surgery to his right knee on 20 May 2010 and was certified unfit for work until 7 June 2010.*
 - b. *prior to surgery, the case manager phoned him to obtain his authority so that she could obtain a report from his surgeon. The worker told his case*

- manager that he gave her permission to only ask the doctor to advise on the cost of the surgery and nothing else.
- c. after the surgery he received a letter from EML dated 17 May 2010 enclosing copy of a report from the doctor dated 7 May 2010 that not only specified the cost of the surgery but gave opinions on 7 questions. The worker was upset that EML had requested more from the doctor than he had given permission for (and that the doctor had provided the information without his authority).
 - d. he met with the case manager and her team leader at EML's office on 27 May 2010 at 11 am to specifically complain about EML exceeding his permission to obtain information from his doctor and to raise some other grievances. They did not have his claim file with them and would not get it when he asked them to. The team leader would not admit that they had done anything wrong and refused to fetch his claim file so that he could show them that they did not have a signed medical authority from him to obtain a report from his doctor. They insisted that they needed the information to approve his surgery. The meeting was cut short after 30 minutes because the conference room was booked for someone else to use it. The worker felt that they were not interested in his grievances.

The WorkCover Ombudsman recommended that:

1. The case manager prepare and send a letter to the worker with an apology for breaching Chapter 6 (Injury and Case Management) of the WorkCoverSA Injury and Case Management Manual by not obtaining and forwarding a signed medical authority to the doctor when requesting a medical report on 6 May 2010.
2. WorkCoverSA and EML conduct a review of Chapter 14 (Claims Administration) of the WorkCoverSA Injury and Case Management Manual and EML's Complaint Policy to ensure that proper instruction and processes are developed to ensure comprehensive complaint records relating to any expression of dissatisfaction with EML's service are recorded and maintained on SAGE to enable identification of systemic and recurring problems so that recommendations can be made within each organisation to continuously improve the manner in which services are delivered.

16 August 2010 – Inappropriate Management of Claim – EML

Complaint:

1. *The worker alleges that his case manager has managed his claim inappropriately and when he complained about this to EML it was "covered up" and not fully investigated. In particular, the worker alleges that:*
 - a. *The case manager told him a blatant lie*
On or about 12 April 2010 he received a telephone call from Dr C's secretary who advised she had received a letter from EML asking Dr C to examine the worker and provide a comprehensive report back to EML. After the appointment had been made, the worker telephoned his case manager and asked him who had written the letter to the doctor. The case manager replied, "I don't know who sent the letter, I would have to go around the office asking everyone". When asked by the worker, "can you do that", the case manager replied, "Why don't you ring the doctor's rooms and find out who signed the letter". The worker rang the secretary and was advised that the case manager had sent the letter. As a result, the worker telephoned and spoke with the case manager and he admitted

- that he had sent the letter but had not made the appointment. The worker requested a copy of the letter from the case manager but was advised, "no, not now, you can have a copy after you have seen the doctor";*
- b. *The case manager does not follow the WorkCover legislation*
On or about 21 April 2010, the worker spoke to his chiropractor, who advised she had received a request from the case manager to prepare a report but had not received a signed medical release. The worker states he spoke to the chiropractor's secretary and she stated she had telephoned the case manager about the signed medical release, but he said it wasn't necessary. However, after being told insurance companies always send a signed medical release the case manager agreed to send one to her. The worker also alleges that the case manager did not provide a signed medical release with the letter dated 30 March 2010 to Dr C;
- c. *Communication*
Neither the worker nor his solicitor were advised by the case manager that EML had requested Dr C conduct a further examination of him and that the case manager's letter dated 3 May 2010 is untruthful. The worker also states he has been asked to sign a 'draft' medical release form even though EML is able to use photocopies of the one he has already signed;
- d. *Failure by EML to investigate the complaint*
EML has failed to contact the chiropractor's secretary to ask her what the case manager said to her about the medical release form, eg. "it wasn't necessary". Further, EML has failed to contact Dr C's secretary to find out whether the case manager sent a signed medical release form with his letter dated 30 March 2010; and
- e. *Refusal by EML to change Case Manager*
Despite the alleged behaviour of the case manager, EML has refused to allocate a new case manager to the worker's claim.

The WorkCover Ombudsman recommended that:

1. The case manager send a letter of apology to the worker:
 - for requesting a medical report from Dr C on 30 March 2010 and from the chiropractor on 6 April 2010 without a signed medical authority from the worker being attached to the letters of request;
 - for failing to communicate with the worker before the letter was sent to Dr C requesting a report;
 - for failing to check the wording of his letter dated 30 March 2010 to Dr C when speaking to the worker on 12 April 2010; and
 - for failing to communicate clearly to the worker and his solicitor (on 3 May 2010) the fact that he had requested Dr C examine the worker and provide answers to specific questions about his medical condition.

13 September 2010 – Provisional Liability – Central Northern Adelaide Health Service (CNAHS)

Complaint:

1. *The worker states he lodged a claim for "stress/anxiety" as a result of "confusion over secondment-suspended wage, appeal grievance lodged" on 16 June 2010. Upon receipt of the claim, CNAHS determined not to accept the claim on a provisional basis by applying a reasonable excuse under paragraph 2.1.3 of the Provisional Payment Guidelines stating that the worker was "on leave without pay" during the alleged disability. The worker states he was at*

work and that the injury was sustained due to management irregularities and failure to comply with a secondment to the Queen Elizabeth Hospital. He also alleges that the decision not to accept his claim for provisional liability was made without consulting with his managers and medical practitioners.

The WorkCover Ombudsman recommended that:

1. CNAHS commence provisional weekly payments of compensation to the worker from the first date of incapacity, which was 16 June 2010, for a period of up to 13 weeks in accordance with Section 50C of the Act.
2. CNAHS conduct a review of Section 3 of its Injury Management Manual relating to 'Provisional Liability' so that:
 - the Manual reflects the requirements set out in 'Attachment B1 – Supporting Information for Provisional Liability' contained at page 5739 to 5746 of the *South Australian Government Gazette* dated 18 December 2008; and
 - the Manual contains sufficient information for case managers / claims administrators to ensure that, prior to decisions being made under paragraph 2.1.3 of the Provisional Payment Guidelines, all matters, relevant to section 30 and section 30A, are carefully evaluated and investigated so that CNAHS can demonstrate to workers its decisions are evidence based and without bias towards the interests of employers on the one hand, or workers on the other.

26 October 2010 – Entitlements – EML

Complaint:

1. *The worker states that he signed a redemption agreement on 18 June 2009 and as part of the process, EML withheld and forwarded the sum of \$20,012.70 to Medicare. However, the worker advises that Medicare did not refund his money to him until 12 November 2009 on the basis that it was unable to process his payment because it did not receive any further documentation from EML until 16 September 2009. The worker is of the opinion that there was an unreasonable delay by EML in advising Medicare that the claim had been settled and this resulted in him not having access to the \$20,012.70 until 12 November 2009.*

The WorkCover Ombudsman recommended that:

1. The General Manager of EML send a written apology to the worker for failing to send to Medicare Australia the Notice of Judgement or Settlement when required to do so and for any delay caused to him in receiving the full financial benefit of the settlement;
2. In recognition that the Notice of Judgement or Settlement was not sent to Medicare Australia within a reasonable timeframe thereby delaying and preventing the worker from having access to the full financial benefit of the settlement, EML calculate simple interest on the sum of \$20,012.70 at the rate of 9.51% for the period of 72 days and pay the worker this amount;
3. EML develop a checklist that can be attached to the front of the redemption paperwork before it is sent from the Redemption Team to the Case Manager. The checklist should include the date the Notice of Judgement or Settlement was sent to Medicare Australia, the name of the case manager or person

- responsible for doing so, and a requirement that this action is recorded in Curam; and
4. EML amend its 'Section 42 Redemption – Operational Policy' and 'Section 42 Redemption – Overview & Procedures' to include an instruction that the new checklist must be attached to the front of the redemption paperwork before it is sent from the Redemption Team to the Case Manager and that the Case Manager must complete the checklist prior to closing the claim file.

11 October 2010 – Entitlements – EML

Complaint:

1. *Johnston Withers allege that EML have been non-compliant with its statutory obligations in respect to notification to Medicare Australia and a failure by EML to pay redemption costs in a timely fashion.*

The WorkCover Ombudsman recommended that:

1. The General Manager of EML send a written apology to Mr R for failing to pay to Johnston Withers the scheduled costs within a reasonable timeframe and any inconvenience this has caused;
2. EML revise its 'EM Redemption Payment Checklist' and 'Claims Agent and Legal Provider Redemption Agreement / Payment Checklist' documents to ensure they contain sufficient information to ensure that the service providers who have given professional and financial advice to injured workers during settlement negotiations are paid (without the need for a separate invoice) in accordance with the 'Schedule of Costs' at the same time a worker is paid their redemption.
3. EML develop a checklist that can be attached to the front of the redemption paperwork before it is sent from the Redemption Team to the Case Manager. The checklist should include the date the Notice of Judgement or Settlement was sent to Medicare Australia, the name of the case manager or person responsible for doing so, and a requirement that this action is recorded in Curam; and
4. EML amend its 'Section 42 Redemption – Operational Policy' and 'Section 42 Redemption – Overview & Procedures' to include:
 - an instruction that the new checklist must be attached to the front of the redemption paperwork before it is sent from the Redemption Team to the Case Manager and that the Case Manager must complete the checklist prior to closing the claim file; and
 - an instruction that service providers who have given professional and financial advice to injured workers during settlement negotiations are paid their scheduled fees (without the need for a separate invoice) in accordance with the information contained within the redemption documentation.

28 October 2010 – Inappropriate Management of Return to Work – DECS

Complaint:

1. *The worker has previously lodged a complaint with my office; however the worker advised that she continued to have ongoing problems with the management of her claim. In particular, the worker feels there has been a*

break down in the relationship between herself and the Case Manager and Rehabilitation Consultant, her return to work has been delayed and she has now been referred to Medical Panels SA without prior consultation with herself or her treating general practitioner.

The WorkCover Ombudsman recommended that:

1. DECS develop policies and procedures outlining the considerations and procedures for referring injured workers to Medical Panels SA.

1 November 2010 – Case Manager Demeanour – EML

1. *Bourne Lawyers allege that during a conciliation conference held on 20 August 2009 an EML staff member, accused their client of fraud.*
2. *The EML staff member allegedly stated that their client had fraudulently failed to disclose that he had received \$53,000 by way of earned income over and above the income maintenance payments he received from WorkCover SA in the financial year ending 30 June 2007.*
3. *The matter was brought to the attention of EML in an email dated 23 September 2009 and again in a letter dated 25 September 2009, however EML have not responded to the complaint.*

The WorkCover Ombudsman recommended that:

1. EML amend its Complaints Management Procedure and include under the heading of 'Investigate and action' that:
 - "every reasonable effort should be made to investigate all the relevant circumstances and information surrounding the complaint".
 - "to enable the investigator to demonstrate that an objective, impartial and balanced approach has been taken, any person who may be able to provide relevant information that may assist in the resolution of a complaint must be approached for an interview".

15 November 2010 – Communication – AGL

Complaint:

1. *The worker's solicitor alleges that:*
 - a. *After being advised by the worker's solicitor on 8 February 2010 that he was representing the worker and required all communications be sent to him, AGL failed to send a claim determination dated 20 April 2010 to the worker's solicitor;;*
 - b. *On 15 April 2010, the worker's solicitor was advised by Ms K that "we have not received a full version of Dr C's report". However, when asked to provide whatever she had received from Dr C that was not a "full version, Ms K failed to respond; and*
 - c. *It is unclear whether the Code of Conduct for Self Insured Employers allows for claims management responsibilities to be sub-contracted to persons who are not employees of AGL.*

The WorkCover Ombudsman recommended that:

1. AGL instruct Ms K to provide a written apology to the worker's solicitor for:
 - a. failing to ensure that all communications relating to the worker's workers compensation matters were sent to his solicitor as required by his letter of 8 February 2010; and

- b. failing to respond to the worker's solicitor's email of 15 April 2010 within a reasonable timeframe.
2. AGL amend the Torrens Island Power Station, Injury and Claims Management Manual to make it explicitly clear that:
 - a. it will manage workers claims proactively and in a manner that will prevent complaints from occurring;
 - b. the compensating authority will be open, honest, responsive and transparent in all of its dealings with workers and their representatives. This includes, communicating in a friendly, professional and courteous manner and responding to all enquiries within a reasonable timeframe;
 - c. the compensating authority will direct all communications and all relevant documentation to a worker's representative when requested to do so; and
 - d. all emails from a worker or their representative will be responded to within 2 working days.

15 November 2010 – Inappropriate Management of Claim – EML

Complaint:

1. *The worker states that she wrote a letter to her case manager on 16 March 2010 advising that it was her intention to relocate to Brisbane and requested advice about the process she needed to undertake to ensure ongoing income maintenance and medical support. As a result, the case manager wrote to the worker's treating medical experts and received the following reports:*
 - *Report from Dr Michael Notley dated 30 March 2010;*
 - *Report from Dr Gary Clothier dated 12 April 2010; and*
 - *Report from Physiotherapist, Ms Ania Sobieraj dated 26 March 2010.*
2. *The worker believes that EML has been in possession of all relevant facts and information since receipt of the medical reports and that there has been an unreasonable delay by EML in determining whether or not to consent to the move to Brisbane.*

The WorkCover Ombudsman recommended that:

1. EML rely on the medical evidence it has already sought and approve the worker's request to relocate to Brisbane within 14 days.
2. EML conduct a review of the operational procedure for managing a worker's request to move interstate. This operational instruction should include a timeframe for decision making and outline procedures for decision making in the circumstance where a worker is totally and permanently incapacitated for work.

13 December 2010 – Case Manager Misconduct – SAPOL

Complaint:

1. *The worker alleges that South Australia Police (SAPOL) made alterations to his Rehabilitation and Return to Work Plan (for the period 11/08/09 to 11/11/09) after he had signed it and after the Plan had taken effect by including the words "W to attend appt with Medical Panel".*
2. *The worker alleges that during a case conference held on 16 September 2009, the claims manager threatened to refer him to the Medical Panel and discontinue his weekly payments pursuant to section 36 of the Act.*

The WorkCover Ombudsman recommended that:

1. The Manager, Injury Management Unit, issue a written apology to the worker for:
 - amending Rehabilitation and Return to Work Plan No. 5 (for the period 11/08/09 to 11/11/09) after it had taken effect; and
 - breaching the SAPOL 'Dispute Resolution' procedure by failing to acknowledge and investigate the worker's written complaint.
2. The Manager, Injury Management Unit, issue a written instruction to all Claims Managers advising them not to amend RRTW Plans without first consulting with the injured worker.

22 December 2010 – Provisional Liability – EML

Complaint:

1. *Tindall Gask Bentley allege that:*
 - a. *Their client's claim for compensation was lodged with EML on 14 October 2010 (13 weeks and 2 days after the commencement of the incapacity on 12 July 2010) and supported by a Prescribed Medical Certificate dated 12 October 2010.*
 - b. *By letter dated 19 October 2010, EML determined not to commence provisional weekly payments by applying a reasonable excuse pursuant to section 50B of the Workers Rehabilitation and Compensation Act 1986 ("the Act") and the Provisional Payment Guidelines. EML's letter indicated that the worker's claim for "anxiety/depression" was lodged after 13 weeks of the date of the commencement of incapacity.*
 - c. *It was not reasonable for EML to rely upon this "reasonable excuse" in the circumstances of this case.*

The WorkCover Ombudsman recommended that:

1. WorkCoverSA and EML review the standard letters that relate to Chapter 4 of the WorkCoverSA Injury and Case Management Manual (at page 19) and EML's Early Decision Claim Determination Procedure (Step 9) and, if necessary, amend them so that they properly support the requirement that the case manager provide "details of the reasonable excuse, including copies of information, documents, and medical reports that are relevant and were considered in the decision to apply the reasonable excuse".

23 December 2010 – Provisional Liability – UniSA

Complaint:

1. *The worker alleges that the claims manager has applied the reasonable excuse incorrectly by confusing the date of commencement of incapacity (8 September 2010) with the date the injury was first noticed (4 May 2010).*

The WorkCover Ombudsman recommended that:

1. UniSA pay provisional weekly payments of compensation to the worker from the first date of incapacity, which was 8 September 2010 until 29 October 2010, the date that the worker's claim was formally rejected.
2. UniSA conduct a review of its internal procedure and standard letters relating to 'Provisional Liability' so that:
 - the procedure reflects best practice similar to that published by WorkCoverSA; and

- its standard letters support the requirement that the Claims Manager provide “details of the reasonable excuse, including copies of information, documents, and medical reports that are relevant and were considered in making the decision”.

21 February 2011 – Provisional Liability – EML

Complaint:

1. *The worker states that he submitted a claim to EML on or about 8 November 2010 for an injury sustained during his employment with AE. Upon receipt of the claim, EML determined not to accept the claim on a provisional basis by applying a reasonable excuse under paragraph 2.1.2 of the Provisional Payment Guidelines, stating that the worker has been unable to verify that he is a worker within the meaning of the Act.*
2. *The worker advises that he is a casual worker with AE and that he has included all relevant information on the claim form. However, EML have applied the reasonable excuse incorrectly by failing to demonstrate on a reasonable basis (which must be evidenced based), that he is unlikely to be a ‘worker’ under the Act.*

The WorkCover Ombudsman recommended that:

1. WorkCover SA and EML review the prescribed notice (Statement of worker’s rights under the WRCA – section 50D) attached to the standard letters to ensure that it recites the wording set out at page 2972 of the *South Australian Government Gazette* dated 25 June 2009.

11 March 2011 – Medical Panels – EML

Complaint:

1. *The worker was denied the right to have the Certificate of Referral reviewed by his solicitor prior to the referral being made;*
2. *Palios Meegan & Nicholson made lengthy and costly submissions on their client’s behalf to Medical Panels SA in response to EML’s ‘incorrect’ Certificate of Referral and were required to make further submissions in regard to the ‘correct’ Certificate of Referral;*
3. *Palios Meegan & Nicholson had to provide numerous documents to Medical Panels SA which EML failed to include with their Certificate of Referral; and*
4. *The worker has been severely prejudiced in that the legal costs he incurred are as a result of not being afforded procedural fairness and/or natural justice in his ability to seek his entitlements under the Act.*

The WorkCover Ombudsman recommended that:

1. WorkCoverSA develop and include guidelines for EML in its Injury and Case Management Manual for referring workers to Medical Panels SA. The guidelines should specify that before a referral is sent to Medical Panels SA a case manager must:
 - a. advise the worker verbally and in writing the reasons for the referral;
 - b. meet or correspond with the worker or their legal representative to seek to agree on the facts that may be set out in the Certificate of Referral for the benefit of the Medical Panel; and
 - c. consult and confirm with the worker or their representative what documents relating to the medical question(s) will be provided with the Certificate of Referral.

2. By 31 March 2011, EML amend its guidelines for referring workers to Medical Panels SA to ensure the above requirements are included; and
3. EML pay to the worker the sum of \$1209.24 (\$1099.31 plus GST of \$109.93) for legal costs incurred as a result of EML sending an incorrect Certificate of Referral to Medical Panels SA.

18 March 2011 – Provisional Liability – EML

Complaint:

1. *The worker states that EML has applied the reasonable excuse incorrectly by failing to demonstrate on a reasonable basis (which must be evidence based), that he is unlikely to be a ‘worker’ under the Act.*

The WorkCover Ombudsman recommended that:

1. EML commence provisional weekly payments of compensation to the worker from the first date of incapacity, which was 21 January 2011 for a period of up to 13 weeks in accordance with section 50C of the Act; and
2. WorkCoverSA and EML review the standard letters that relate to Chapter 4 of the WorkCoverSA Injury and Case Management Manual (at page 19) and amend them so that they properly support the requirement that the case manager provide “details of the reasonable excuse, including copies of information, documents, and medical reports that are relevant and were considered in the decision to apply the reasonable excuse”.

5 May 2011 – Income Maintenance Not Paid / Delays – EML

Complaint:

1. *The worker advised that he commenced employment on or about 31 January 2011 in a position where he was not earning equal to or greater than his notional weekly earnings from this employment. However upon attending the bank on 9 February 2011, the worker found that no money had been received from EML. The worker contacted EML on or about 9 February 2011 and was advised that because he had earned income from 31 January 2011 EML was unable to process his weekly payment until a payslip had been received. The worker faxed a copy of his payslip to EML on 11 February 2011 for processing but it appears his payment was not processed and at the time of making his complaint, payment had still not been received.*

The WorkCover Ombudsman recommended that:

1. WorkCover SA develop a policy and procedure for inclusion in Chapter 10 of the Injury and Case Management Manual that outlines the steps involved when moving injured workers from direct income maintenance payments to top up payments that is consistent with the law, particularly subsections 36(1), 36(2), 36(3) and 36(3)(a) of the Act. In addition, the policy should require case managers to communicate directly with workers about:
 - the consequences of overpayments being made to the worker (ie. the possibility of recovery action if overpayments occur); and
 - the option of a discontinuance by consent under section 36(1)(a) of the Act to prevent overpayments.

28 June 2011 – Rehabilitation / Compliance with Section 58B – WorkCoverSA

Complaint:

1. *Neither the worker nor his representative, Mr B were advised by WorkCover's Return to Work Inspectorate ("the RTW Inspectorate") on the settlement of the supplementary levy dispute between WorkCover and the worker's former employer or invited to be involved in the settlement process;*
2. *The RTW Inspectorate reached the conclusion that the company had no suitable employment available to offer the worker without any consultation with him;*
3. *Neither Mr B nor the worker have been advised of what investigations the RTW Inspectorate undertook to determine whether section 58B had been breached.*

The WorkCover Ombudsman recommended that:

1. The Manager of the Return to Work Inspectorate issue a written instruction reminding investigating officers of the requirements of its section 58B/C EML referral procedure to (a) seek a worker's feedback whenever they reach the conclusion that the employer has complied with section 58B or C of the Act and (b) provide to the parties a comprehensive report setting out their reasons whenever they determine that a breach of section 58B or C of the Act has occurred;
2. The Return to Work Inspectorate amend its section 58B/C EML referral procedure so that, whatever determination is made as a result of the investigation, the investigating officer is required to provide the parties with a comprehensive report at the completion of an investigation setting out the reasons for the determination.
3. The Return to Work Inspectorate amend its section 67/72 imposition of supplementary levy procedure to (a) provide for the requirement that an interested party be advised of key developments of a supplementary levy dispute or section 58B/C prosecution if they have requested it and (b) include a form that may be completed by an interested party to indicate that they wish to be informed of developments in a supplementary levy dispute or prosecution.