EDUCATION, EMPLOYMENT AND TRAINING COMMITTEE

Members present:

Ms KE Richards MP (Chair)
Mr J Lister MP (via teleconference)
Mr MA Boothman MP (via teleconference)
Mr N Dametto MP (via teleconference)
Mr DJ Brown MP
Mr JA Sullivan MP

Staff present:

Mr R Hansen (Committee Secretary)
Ms R Duncan (Assistant Committee Secretary)

PUBLIC HEARING—INQUIRY INTO THE WORKERS' COMPENSATION AND REHABILITATION AND OTHER LEGISLATION AMENDMENT BILL 2020

TRANSCRIPT OF PROCEEDINGS

WEDNESDAY, 16 DECEMBER 2020

Brisbane

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The committee met at 2.00 pm.

CHAIR: Good afternoon. I declare open this public hearing for the committee's inquiry into the Workers' Compensation and Rehabilitation and Other Legislation Amendment Bill 2020. My name is Kim Richards, the member for Redlands and chair of the Education, Employment and Training Committee. I acknowledge that we are meeting on the custodial land of the oldest living civilisation in the world and I pay my respects to both the Jagera and Turrbal people and their elders past, present and emerging. With me here today from the committee are: Jim Sullivan, the member for Stafford, and Don Brown, the member for Capalaba, who is substituting today for the member for Rockhampton, Barry O'Rourke. On the phone we have James Lister, the member for Southern Downs and our deputy chair; Mark Boothman, the member for Theodore; and Nick Dametto, the member for Hinchinbrook.

On 26 November 2020 the Minister for Education, Minister for Industrial Relations and Minister for Racing, the Hon. Grace Grace, introduced the Workers' Compensation and Rehabilitation and Other Legislation Amendment Bill 2020 to the parliament. The parliament subsequently referred the bill to this committee for examination, with a reporting date of 12 February 2021. The bill proposes to introduce presumptive workers compensation for first responders and other eligible employees in Queensland who are diagnosed with post-traumatic stress disorder, known as PTSD. This is an important bill for protecting the interests of first responders. We note the findings of Beyond Blue's 2018 report that first responders have substantially higher rates of psychological distress and mental health conditions and claim rates for mental health conditions or psychological injuries that are 10 times higher than the Australian workforce.

The purpose of today's hearing is to hear evidence from stakeholders who made submissions as part of the committee's inquiry. The committee's proceedings are proceedings of the Queensland parliament and are subject to its standing rules and orders. In this regard I remind members of the public that, under the standing orders, the public may be admitted to, or excluded from, the hearing at the discretion of the committee. Only the committee and invited witnesses may participate in these proceedings. Witnesses are not required to give evidence under oath, but I remind everyone that intentionally misleading the committee is a serious offence. The proceedings are being recorded by Hansard and broadcast live on the parliament's website. Media may be present and will be subject to my direction as chair. The media rules endorsed by the committee are available from the committee staff if required. All those present today should note it is possible you may be filmed or photographed by the media and images of you may appear on the parliament's website or social media pages. I ask everyone present to turn mobile phones off or to silent mode. The program for today has been published on the committee's webpage and hard copies are available from committee staff.

TOSH, Mr Nate, Industrial Officer, United Firefighters Union Queensland

CHAIR: Good afternoon. Would you like to make an opening statement?

Mr Tosh: Thank you, Chair, and good afternoon committee members. On behalf of the UFUQ I thank you for providing us with an opportunity to speak today. About five years ago the UFUQ participated in a similar process for a bill that proposed the introduction of presumption of injury claims for firefighters who are diagnosed with one of 12 cancers. That is now law thanks to the Palaszczuk government. This was a massive win for firefighters and is rightly celebrated by our members. I could tell many stories about members who have greatly benefited from these laws—firefighters who have been diagnosed with a terrible disease because of the job they do who thankfully do not have to navigate an overwhelming and lengthy claims determination process at a time when they are battling for their lives. This is exactly what these laws set out to do, but that is not always how it plays out. We provided an example of this in our submission of 7 December 2020.

Despite having served more than 10 years as a professional firefighter, WorkCover Queensland determined that a UFUQ member did not qualify for a presumption of injury claim for breast cancer because she was on a period of paid maternity, annual and then long service leave for just over 13 months to give birth and care for her child. They told us that because she was absent from her service for more than 12 months it could not be included in the calculation of years of service.

Because of this interpretation our member was subject to a complex claim determination process that required her to submit to an independent medical examination and obtain relevant evidence to demonstrate that her employment was a significant contributing factor to her diagnosis. She spent four months, with the help of the UFUQ, piecing together every bit of evidence she could obtain about her specific circumstances, particularly her workplace exposure. The onus was on our member to do the legwork, but all of this was unnecessary. She was on paid and authorised leave. The act does not explicitly address the issue of leave, but we do not believe it was the intention of parliament to exclude it. To do so disadvantaged our member and will disadvantage any other firefighter who finds themselves in her circumstances. Our member satisfied the requirements of section 32E(2) of the act because we do not believe it to be reasonably necessary for a firefighter to attend fires whilst on a period of paid and authorised leave. For these reasons we seek the committee's consideration of the amendment to section 36E(2) of the act as proposed in our submission.

We also seek the committee's consideration of the amendments to schedule 4A of the act to expand the number of scheduled diseases to include asbestos related diseases, skin cancer, lung cancer and liver cancer. This would follow the Northern Territory's lead and would align with jurisdictions in the US and Canada. The addition of these diseases is underpinned by scientific evidence as relied upon in those jurisdictions as well as evidence detailed in Safe Work Australia's *Deemed diseases in Australia* report from August 2015. Our legislation in Queensland does not have a prescribed review period like Western Australia or South Australia. Given the committee is considering a bill about the amendment of the Workers' Compensation and Rehabilitation Act, we believe now is an opportune time for review.

As with the presumption of injury laws already in the act, our members would greatly benefit from the proposed amendments relating to post-traumatic stress injury. It is our members' job to protect life and property, and every single day they go to work they could encounter a traumatic event. They see things every day that any one of us would struggle with. When you are at your worst, our members are at their best. But we all have our limit, and it can be overwhelming to navigate the workers compensation system with so much to come to terms with. The bill makes claiming workers compensation less daunting and timelier, and it helps reduce stigma by reinforcing the causal relationship between our members' employment and traumatic psychological injuries like PTSI. For these reasons we speak in support of this bill, but we believe it would benefit from a few amendments.

We have set those out in our submission of 24 September 2020 and note that our comrades from the United Workers Union, the Queensland Council of Unions and Together Queensland provide support for our suggested amendments, including: the first responders and eligible employees schedules being included in the act rather than regulation; rebuttal only being permitted when demonstrable and reasonable evidence can be provided; the inclusion of all trauma related psychological injury; and the inclusion of diagnosis by a psychologist. I will speak further to the last two.

PTSI is not the only trauma related psychological injury our members are diagnosed with as a result of what they see and do in the course of their employment. They are commonly diagnosed with other trauma related psychological injuries such as acute stress disorder or adjustment disorder. The same barriers to accessing compensation exist for these injuries and the process is just as daunting. We believe the scope of this bill should include all psychological injuries that have been diagnosed as work related as a result of exposure to a traumatic event or cumulative traumatic events. As a minimum, we believe it would be reasonable to extend this to other relevant psychological injuries listed in the DSM-5 chapter relating to trauma and stressor related disorders. This includes acute stress disorder and adjustment disorder.

Many of our members begin their treatment and are diagnosed by a psychologist free of charge via the fire and rescue service's employee assistance program. A requirement for our members to then be referred to a psychiatrist and wait for an appointment to be eligible for a presumption of injury claim is unnecessarily prohibitive and time consuming. We know that our members in most circumstances will wait until they have been diagnosed by a psychiatrist before they lodge a claim, because they do not trust the system. This will prevent them from receiving early intervention. The up-front cost associated with being diagnosed by a psychiatrist also puts up a paywall for presumption of injury claims. The alternative is to proceed to lodge a claim without the diagnosis of a psychiatrist and most likely be directed to attend an independent medical examination. This is not too dissimilar to the current process and essentially makes the presumption of injury framework redundant. We encourage the committee to consider the approach to presumptive legislation taken by the Canadian provinces of Alberta, Manitoba, New Brunswick, Ontario, Saskatchewan, Yukon and Nova Scotia and include diagnosis by a clinical psychologist in the bill.

CHAIR: Thank you, Mr Tosh. Deputy Chair, would you like to take the first question?

Mr LISTER: Not at this stage, thank you, Chair, but thank you very much for your appearance today.

Mr SULLIVAN: I should note that the timing is fantastic. I was out at the Chermside station just yesterday with some of your members training on some of the wreckage they deal with every day, so your words ring true. You went through a specific example of that 12-month issue for one of your members, in that case breast cancer. Can I just clarify your submission? Does it go to whether your workers—or other workers, for that matter—can apply for this type of thing while on leave, or is it more to do with any gap of 12 months active service not counting? Further, your example went to maternity leave, where 12 months maternity leave would be not uncommon. Are there other scenarios where your members may be on leave for that period of time?

Mr Tosh: There would be other scenarios: any form of parental leave, maybe taking time off to care for a sick loved one or whatever it might be. Those periods that they take are accrued and paid and authorised leave. To be honest, this was the first example where it had come about from WorkCover making that determination, because it was the first time it arose where someone in the unfortunate circumstance of being diagnosed with cancer making a presumption of injury claim found themselves in this situation. It goes to section 32E(2) of the act. As it is currently worded, it says that a period of 12 months may only be included if throughout the period the person (a) was employed for the purpose of firefighting—which is clear—and (b) attended fires to the extent reasonably necessary to fulfil the purpose of the person's employment. It was deemed that they did not attend fires during that 13-month period so a 12-month period could not be included, which meant they did not make the 10 years service. We say it is accrued, authorised and paid leave and it clearly was not the intent of the legislation to exclude that, in our view.

Mr BROWN: Thank you for coming in and providing your submission today. Can you give us some examples of the expanded trauma related psychological injuries suffered by your members that you have encountered in your time? I also note your previous employment with the ambulance union. You might have some examples with regard to that.

Mr Tosh: I have experience across both. I used to work for United Voice, which looks after paramedics, obviously, and I am now with the firefighters union. I will speak more to my current experience. I deal a lot with workers compensation claims and injuries, both work related and not work related, that our members contact us with. Frequently we have members who, through trauma related circumstances, are diagnosed with injuries other than PTSI. I mentioned two common ones in my submission: adjustment disorder and acute stress disorder. They are two common ones. We also have circumstances where they might develop anxiety conditions or depression. In all of these circumstances, it is clear from the medical evidence that the doctors are saying that has developed out of the traumatic circumstances they have experienced and witnessed—the things they have seen and done through the course of their employment. We say that if we are looking at amending the bill to address this type of circumstance, particularly presumption of injury claim, which will make it easier and less cumbersome for people to make this type of claim, it should include those types of injuries as well. It is not just isolated to PTSI.

Mr BROWN: Firefighters are increasingly attending traffic accidents. Has your union seen an increase in that area correlated to PTSD and also these other trauma related psychological injuries?

Mr Tosh: It is difficult for me to speak in a fulsome way about that, given I have only been with the firefighters union for about five years. However, I know through stories that I have been told by our state committee of management and some firies who have been around for a very long time that that is very much the case. Once upon a time, firefighters did not do those types of rescue duties and then these things started to get introduced into what they do. Responding, when you might find yourself in the worst situation you have found yourself in your life—a motor accident—and having to do the things they do in rescuing people. It takes its toll on our members.

I have heard stories where it may have been a subsequent event that has filled up our member's cup, but the thing they have remembered through their whole career and the thing they dream about at night and the thing they recall over and over again is the first incident they ever went to. I agree completely with the statement you have just made.

Mr BROWN: Thank you.

Mr BOOTHMAN: You mentioned the eligibility period for PTSD whilst on leave for more than 12 months. What would you like to see, though? What period of time would you like to see? As you said, you would like to see it for more than 12 months, but what period of time as a number?

Mr Tosh: I will just clarify about those submissions. They are about the existing presumption of injury laws in the act.

Mr BOOTHMAN: Yes, I know, but I am just thinking what period of time would suffice. For instance, would it be a few years, or five years? I am just curious.

Mr Tosh: Each of the cancers currently has a qualifying period of service. For instance, breast cancer is 10 years and prostate cancer is 15 years. There are varying. The act details in section 36E(2) how you go about calculating each of those years of service. In our submission on 7 December, we proposed just adding simply in that section—

(2) A period of 12 months may be included only if, throughout the period, the person—

(a) was employed for the purpose of firefighting; and

(b) attended fires to the extent reasonably necessary to fulfil the purpose of the person's employment or was on paid leave.

So a 12-month period if they were on paid leave would not be excluded for counting as years of service.

Mr BOOTHMAN: All right.

CHAIR: So it is more with regard to the calculation of the compensation versus the qualification of the claim itself?

Mr Tosh: Yes. It is not changing the qualifying times; it is about clarifying when you figure out what years are in and what years are out. If they were on paid leave, it would be counted as a year of service essentially.

CHAIR: On page 4 of your submission there are proposed amendments with regard to the wording of 36ED(3), around the coverage of PTSD caused by significant life events that would not ordinarily cause PTSD, such as divorce or the loss of a loved one. Could you give more of an explanation behind that and perhaps a bit more definition about what you would be proposing?

Mr Tosh: I think that was in the United Workers Union submission, but I can talk to that if you like.

CHAIR: Sure.

Mr Tosh: We share the same views as the United Workers Union, and I know that other unions that have made submissions to the committee share the same view. This really goes to the circumstances that will be raised by the employer to try to demonstrate in some way to the insurer that this was not caused by work.

What you will find is that our members who are suffering from PTSI or some other trauma related psychological injury do not just wake up one day and suddenly are suffering from it. They have probably battled with that for some time and not realised, and it has taken them a while to get the treatment they need. In that intervening period, their life has started to maybe spiral out of control—things to do with their personal relationships, or maybe they decide to self-medicate by drinking too much of the bottle and they develop alcohol dependency or whatever it might be. Suddenly, a discussion becomes around that being the primary injury for why they are incapacitated for work—instead of what the real scenario is, that is secondary to their primary injury, which is clearly work related.

CHAIR: Thank you for clarifying that. That is really helpful. There are no further questions so I thank you for your time today. We really appreciate the insights and the feedback you have given us.

PERRY, Professor Chris OAM, President, Australian Medical Association Queensland

CHAIR: I welcome Professor Chris Perry.

Prof. Perry: It is lovely of you and your committee members, both those who are here and those who are not here, to ask the AMA to comment on this legislation. I hope I can provide some insights into this.

CHAIR: Would you like to make a brief opening statement?

Prof. Perry: AMA Queensland thanks the committee and the whole parliamentary process, I suppose, for inviting AMA Queensland to comment on this proposed legislative amendment. We believe that the entire medical profession in Queensland—in fact in Australia—needs support and needs to be able to continue in their work and that psychological injuries which are work related do not get the same response as physical injuries. It is a lot longer to have it accepted.

I note that the list of first responders is quite interesting. I did listen to the firefighters representative who just spoke. We will be getting other people talking. They see some terrible sights of people mangled, dead or not dead, burnt or not, on the roads, in houses and elsewhere. Those patients do not disappear; they go to hospitals where they are seen by young and sometimes not quite so young doctors. I will remind this committee that doctors are the ones who get injured and killed at work more than others do, more than nurses do. In the Italian COVID crisis, according to the *Courier-Mail*, that eminent scientific journal, in April I think, when 100 doctors had died of COVID in Italy, there were 30 nursing deaths. That is about the proportion. There are about 10 times more nurses than doctors, so the chance of dying is about 30 times higher.

It is going to get worse with new legislation coming in to try to restrict addicts from getting drugs. Doctors will have to turn people away at the front door. They do not have security in their private offices. They are facing a $1,360 fine if they prescribe morphine or other drugs to somebody who is shaky, is tattooed or has not been checked out for ailments before they come in to see the doctor.

Doctors do get affected. It says that you are going to include first responders—being ambulance officers, corrective services officers, fire service officers, State Emergency Service officers, rural fire brigade officers, volunteer firefighters, police officers or police recruits. Then when you get down to doctors or nurses, it says it is only in the emergency department, acute care or critical care, whatever that means, or high-dependency care, intensive care.

As you can tell, I have been around awhile. I am a consultant head and neck cancer surgeon at the Children's Hospital and Princess Alexandra Hospital. I have seen some terrible things over the years and I am just an average doctor. Two years ago I was with a priest who was dying who had tried to commit suicide by lying in front of a train. It went over his pelvis, for reasons uncertain, and his intestines were visible. He was alive and talking and he was about to go to sleep in an attempt to save his life because his kidneys, bladder and so on had been pulled out by the train.

I was shown some photographs by a police officer of the post-mortem of a child who was killed I think by his stepfather. I was shown photographs of this young boy who had had a broken nose, amongst other injuries, and there was a three-year-old boy on a pathology table at the John Tonge Centre or something, and the next photograph was of this boy who had been skinned. He had every bit of skin taken off his body. I was shown so I could comment on the bruising pattern. I worked in Africa. I have done post-mortems on people who had been run over by trains and in six pieces. I signed death certificates for four to six people every day in a rural hospital in Africa, and often little children. I have looked after burns and whatever, so I have seen lots of things, but I kept looking at that and thinking about that for years afterwards, actually.

I have had to remove both eyes of a patient with advanced skin cancer growing over their eyes. The patient was blind in one eye and about to go blind in the other eye. This was their only chance of living. The patient had been to psychological training for some time beforehand. I did not and nor did the people involved with me, but this was somebody going to sleep being able to see what was happening. I will not go too much into it but they are fairly horrendous sights.

As a young doctor in a GP practice I looked after tongue cancers in 32-year-olds when Milan Brych and his group were around and using vitamin B17, so-called—cyanide obtained from peach seeds. There was a young man who had come to this general practice at the Gold Coast and he had had 50 millilitres of hot water injected into his tongue. He insisted on it. That was the only way you could dissolve this laetrile stuff to try to get his tongue cancer to go. He would have to sit outside in the open air before he came into the private doctors rooms because he smelt too much. He had a mask over his face so nobody had to see this large, red-brown tongue coming four or five inches out of this 32-year-old's man's mouth.

A few weeks ago I had to deal with a carotid artery blow-out of a 20-year-old whose father I used to play touch football with when I was in primary school. This was her fifth or sixth cancer operation. We had to split her chest to get access to her aorta to get control of the vessels in her neck.

I am just a regular surgeon, a regular doctor. Every doctor has to go through an emergency department, to be a first responder. You have to do that for two or three years as a junior doctor. You do it as a registrar. The orthopaedic people do it—they see someone's hand go through a machine. We see eye injuries. Every doctor sees it. Every doctor sees it in Brisbane. Every doctor gets threats to their life by patients, often without the ability to have screening as we have here.

This morning I talked to the group who look after doctors' mental health. Fiona Hawthorne is the CEO of a doctors wellness group, essentially funded by the AMA. On average per year they see 120 doctors having significant issues but in the COVID year it was 200. Fully one-third are purely work related, stress related conditions. That is about 1½ per week. They are serious issues. Most doctors will not go to that service. Most people do not want PTSD on their medical history. Sometimes we get letters from GPs that mention interesting things that we do not need to know about a patient such as a past history of PTSD or dementia or that they were prescribed Viagra 15 years ago. There are not always filtered. PTSD can be on somebody's record for a long time.

I put it to the committee that there may be a much higher incidence of PTSD than you were talking about. The number of people who put in a claim would probably be fewer than the 70 people this year and the 40 people in an average year who seem to have PTSD or mental health issues associated with work as a doctor that we currently see.

CHAIR: In regard to the PTSD claims pathway, based on what you have said, is it more that there is a stigma attached to PTSD than the pathway itself to achieve a successful PTSD claim through WorkCover that is the impediment, in your mind?

Prof. Perry: It is one of my beefs. I really hate the letters I get that tell me information I do not need to know. Doctors get them all the time. There is obviously still a stigma associated with mental disease. In terms of training pathways, people would probably prefer trainees who 'can cope with the stress' than people who cannot cope with the stress. You do not want a surgeon who, when a carotid artery blows, runs crying from the operating theatre.

There are a lot of issues that people may not claim, but I think people need support. I think it should be recognised by this committee that all of the first responders are going to be looked at by the next group of doctors coming through who are like the rest of the people in this room. They do get flashbacks. Even a crusty person like me seeing a four-year-old—

CHAIR: You have certainly seen some graphic sights, as you have relayed to us. I very much appreciate where you are coming from.

Mr LISTER: Thank you for your vivid accounts of the sorts of things that you see. I had not really considered what doctors go through until you mentioned it. I bring you to the submission that AMAQ made which made reference to the work environment that doctors find themselves in during training. There were some disappointing statistics there about bullying and the effects on the victims and witnesses. Is that something you would say requires a legislative response, perhaps with a bill like this, or is it a cultural issue within Queensland Health?

Prof. Perry: I think it is a cultural issue generally. I was on the council of the Royal Australasian College of Surgeons just after the College of Surgeons put out a survey to surgeons in training. I think 50 per cent or so of training doctors responded to it and 40 per cent said they were victims or had seen bullying, sexual harassment et cetera in the workplace. That got a huge response from the College of Surgeons. In fact, this morning I was talking to people from one of the hospitals being bullied by a fellow worker. We responded by getting involved in the Vanderbilt pathway, the Gerald Hickson pathway, of managing people who are bullying other people. The College of Surgeons went through a lot of soul searching. We have to do courses online and in person.

Bullying surveys were done in the Public Service, the universities and the military. In fact, the College of Surgeons' figures are lower than the other institutions. It is everywhere. We do not like it. Certainly the College of Surgeons has been leading the way on this. We are trying to get the AMA in Queensland to go down that pathway of trying to get doctors to do the courses which the College of Surgeons makes available to other people. Hopefully it is better than it was, but it takes a lot of time to turn around an ocean liner. It ain't just doctors. It ain't just surgeons. It seems to be all over the place. To legislate against it—it is a human behaviour. It takes a while to change it, I imagine.

Mr SULLIVAN: Professor, I do not want to misquote you, but I think you said that this was a high year, with about 70 applications for cover and 30 to 40 in a normal year.

Prof. Perry: No. It is not for cover. These are doctors in training. Medical students may do it, but it is essentially doctors ringing up. It is kind of the Kids Helpline for doctors.

Mr SULLIVAN: They put themselves forward for the assistance package.

Prof. Perry: No. They are looking for advice. Often they are sent to psychiatrists and psychologists who are used to dealing with doctors' issues because they are often a bit different. I am sure the people who look after construction workers will be different to the ones who look after nurses. We arrange for help if they need it. Sometimes it is career advice or health advice. Sometimes people need psychologists. Sometimes people need psychiatrists. Sometimes people need medications. Mostly they need advice. Doctors are not immune to depression. Twenty per cent of Australians pretty much at any one time are taking antidepressants. We were asked to comment on voluntary assisted dying and whether people with a mental illness should be allowed to access it. A lot of people—certainly more than 20 per cent of us at any one time—are on antidepressants at some stage in their life.

Mr SULLIVAN: In terms of those who perhaps later in their careers progress to a WorkCover claim for these types of mental injuries, do you have any intel as to the success rate or otherwise of those who go through that pathway?

Prof. Perry: No. Unfortunately, we have about two or three suicides a year. Doctors in general are about the second worst group for suicides.

Mr SULLIVAN: Is that to do with not only what they go through but also their access to drugs and access to—

Prof. Perry: Yes, it is. In talking to Fiona Hawthorne this morning, about a third of the 200 calls this year are for what they put down as work being the origin, but then there would be substance abuse, regular psychiatric illnesses and marital issues that have impacted on their wellbeing.

Mr BROWN: In what year do medical students get emergency training?

Prof. Perry: In first year. When I went through 40-something years ago, you had to do two months in accident and emergency and one night every week and every fourth weekend. That roster is probably less onerous now. It would be in the order of two months. Doctors are getting through medicine at university at the age of 26½. I got through at the age of 22. For some reason we are making our doctors too old, especially for women in training. It is terrible. It is 6½ years before they get on a training program and it is a five-year training program. They are coming out at the age of 38 or 39, and people ask, 'Why haven't you had children?' 'Why is it so hard for you?' 'Why doesn't the college make it easier for you to have children and study for an exam?' when there is about a 20 per cent pass rate for someone in their late thirties. Sorry, what was the question?

Mr BROWN: You answered it at the start. Obviously you have to do the prerequisite degree normally—

Prof. Perry: Which is crazy.

Mr BROWN: Each of those students has a lot of skin in the game before they get into the emergency department.

Prof. Perry: Yes.

Mr BROWN: It may not be their cup of tea.

Prof. Perry: That is the case for most. There are 2,500 emergency physicians in Queensland and 30,000 doctors.

Mr BROWN: For example, I cannot stand blood but I worked as a pathology scientist. There was not any connection to a human being. I understand that once a student has skin in the game they will just keep on pressing through.

Prof. Perry: Yes.

Mr BROWN: That is why we have the number of doctors with psychological injuries, I suppose.

Prof. Perry: Yes, I know. I was just going to make some flippant comment about falling over at the sight of blood. It has been a classic medical student thing. One of my colleagues contacted me this morning about his wife's illness, and I remember him going head first into a caesarean section involving a lady who died in a motor vehicle accident. They saved the baby at the Gold Coast Hospital in 1976. He fainted at the sight of pulling out a live baby from a dead mother and all the blood. He was very embarrassed about having to be taken out of the theatre with his head covered in blood.

Mr BROWN: That goes to your submission about doctors in training. The injury may occur in their training but it is not until years down the track in their career that—

Prof. Perry: The fact is that most people get used to it. It does not really affect me much now. People do find it hard on occasions throughout their life.

CHAIR: Presumably what you have described as cumulative trauma over a career span applies to most doctors in some way, shape or form.

Prof. Perry: I think so, yes.

Mr BOOTHMAN: In the AMAQ's submission, you speak about the need for policy outlines such as time frames for investigation of claims and assigning case managers. Do you want to elaborate on that? What are your thoughts as to how the process should be carried out?

Prof. Perry: To be honest with you, not really. As an ENT surgeon I do not know an awful lot about that. I do know that people can be affected some way down the track. We do say that the approval can be very slow, very onerous and kind of scary. I am an amateur at this. We have policy people. I do not know, I am sorry. You caught me out.

Mr DAMETTO: In regard to a culture shift within the medical profession over potentially the last 20 years, can you please speak to how this proposed legislation is in line with that culture shift?

Prof. Perry: I suppose the culture shift is to accept that mental illness happens to many people. Often it is transitory event. People do get flashbacks. People do need holidays. People do need to take a break. People sometimes need the support of professionals: psychiatrists, psychologists, social workers. Sometimes they just need to talk to people. It is not a weakness anymore.

The way doctors traditionally were taught was to ask them questions and in some ways to belittle them to make sure they studied enough to come back next time and not be caught out. That really does not happen much these days. It is a bit more subtle. People do fail exams and people do get embarrassed when they do not know the answers, whether they are sneered at publicly or not by the person asking the question. I suppose it is a bit more subtle now. It is there sometimes for a purpose. Not every child player gets a prize. You want to have a surgeon operating on you and your family who knows what they are doing and has been through the hard yards, knows their anatomy textbook backwards and knows the operation and has done it many times and knows the complications that occur, whether they have seen them or not. I am not sure whether you can circumvent the long time or the encouragement to do the work. Not everybody who signs on will get that distance. There is a lot of pressure on people.

CHAIR: Thank you, Professor Perry. That concludes our questions. We are very grateful for the time you have spent with us today sharing your experiences.

Prof. Perry: Thanks very much.

NEWMAN, Mr Chris, Senior Legal Officer, Construction, Forestry, Mining & Energy Union, Mining and Energy Division, Queensland District Branch

SMYTH, Mr Stephen, District President, Construction, Forestry, Mining & Energy Union, Mining and Energy Division, Queensland District Branch

CHAIR: Stephen, would you like to make a brief opening statement on behalf of your union?

Mr Smyth: I certainly will. I will probably hand over to Mr Newman to open up and we will go from there.

Mr Newman: The mining and energy division of the union is broadly supportive of the changes proposed in the amendment bill. What we are here today to discuss with the committee is making a specific legislative change to include statutory officials in the coalmining sector and mining more broadly to ensure that first responders and statutory officials who have the equivalent role of a first responder are adequately covered by the legislation. In our submission we say that regulation 11—I believe it is—sets out the specific number of people who are entitled to the presumption with the last section, section 11, having a broader catch-all position of people in equivalent private sections. We do not believe that is good enough for capturing people in the coalmining industry.

As we have outlined in our submission, coalmining is a dangerous activity that results in numerous fatalities each year due to the remote nature of that work, coalmining being underground or in an open-cut mine. Ordinary first response from medical or firefighting professionals cannot be accessed quickly enough. There is a statutory requirement under the Coal Mining Safety and Health Act for first responders to be coalmining workers, whether they be open-cut examiners, ERZ controllers—or explosive risk controllers—or someone from a mines rescue team who has been given the responsibility of responding to a high-potential incident or serious accident. We do not believe that the act adequately covers that. What we are seeking is that an amendment be made to the regulation to specifically cover those people in these roles to ensure this presumption covers them. That is the summation of why we are here.

Other than that, I say we are broadly supportive of the legislation. I do note the responses made by the department, the regulator, in relation to the submissions. One issue I did want to touch on before we proceed is that the regulator had touched on some of the submissions made by other unions and other interest groups in relation to the diagnosis of a psychiatrist in order for the presumption to go ahead. It was their position that there is adequate support for that to occur and that should be the threshold bar.

Our concern that we raised regarding that submission and belief is that in regional and rural communities that level of support is not there that enables coalmining employees—and employees are the first responders more generally—to get that psychiatric diagnosis in time to lodge the claim or to get that presumption. Specifically in our submissions we referred to a member of ours, Mr Anthony Gordon. Mr Gordon is currently diagnosed with a psychiatric post-traumatic stress disorder as a result of attending as a first responder as an OCE to a fatality at a mine site. Not only did his claim not have the presumption at the time; his claim was knocked back by his employer, which was a self-insurer. The reason his claim was knocked back was that he was unable to get to a psychiatrist to get his own diagnosis in time for the claim to proceed. He was put in by his GP in association with a psychologist that he was seeing at the time as well as a return-to-work rehabilitation coordinator. They all diagnosed him with a post-traumatic stress disorder which was directly associated with the fatality that he had to attend to as a first responder as an OCE. However, his claim was rejected by the self-insurance department. He was unable to lodge a claim or appeal of that in time because he was unable to get access to sufficient psychiatric diagnosis and treatment in time. That is a concern out there for the regions.

It is our submission and belief that if the legislation is to proceed on the current basis, with the psychiatrist diagnosis being the threshold for the presumption, the resources for the regulator need to be improved significantly so that any employees who are seeking to make a claim are able to get resources from the regulator to see a psychiatrist within a sufficient period of time, and that would have to be for them to fly to Brisbane. We put that out as an example of what needs to be done in order for this legislation to work effectively to protect those employees it is designed to protect.

CHAIR: Just touching on the example that you have given, what sort of time frame was it that was the basis for rejection?

Mr Newman: My understanding of it from having discussions with Mr Gordon and his personal injuries solicitor is that by the time he was able to seek a psychiatrist, get an appointment and get a report to sufficiently diagnose him with a post-traumatic stress disorder as a result of his role as a first

responder he was out of time to make an appeal to the regulator and to proceed through that appeal process. His personal injuries solicitor and Mr Gordon have taken their claim straight to the Supreme Court and have subsequently filed an application. The time frames for appeal are approximately 30 days, I believe, off the top of my head.

CHAIR: So we are talking about weeks, not months?

Mr Newman: Yes, but that was on top of before even filing the claim—

CHAIR: The initial?

Mr Newman: Yes. Before even filing the claim he had received treatment from a GP and he had received treatment from a psychologist, but was unable to seek a psychiatrist.

CHAIR: I am trying to get my head around the extent of your membership that would be impacted by this. Do you have any rough numbers in terms of your membership that have sought claim under the existing pathways for PTSD?

Mr Smyth: Of interest, at the moment we have approximately eight members who are seeking that type of assistance due to the Grosvenor Mine explosion. I use that as a live example. Eleven of those gentlemen are on compensation and eight potentially have post-traumatic stress disorder as a result of being a first responder as a coalmine worker to that event. Generally, there have been—and I am aware of numbers in the past, although I do not have them on me now—occasions where people have been in similar situations, or in a similar boat, of having responded to either a tragic or traumatic event and they have had to fight, from our perspective, tooth and nail to have their claim accepted. We look at it in simple terms. The members I represent are miners, fitters and electricians. They go to work to do their job. They do not go to work to actually have to respond, but as a part of their role they do the additional training et cetera to provide that level of service to their workmates. I could not give you an exact number, but I am aware of some numbers out of the Grosvenor explosion as an example.

CHAIR: Thank you. That is helpful.

Mr SULLIVAN: Thank you to both of you for coming today. I should point out that workplace health and safety in your industry was a huge and genuine passion of my predecessor as the member for Stafford and I intend to continue that. Following on from the chair's question in terms of getting our heads around how many we are dealing with, on a worksite what sort of share of your workforce or members—in your case they are probably the same—would fall into the categories that you are seeking to add into this? Is it that almost everybody onsite has to do this extra training?

Mr Smyth: I guess there are a couple of different components. On each mine site there will be what they call emergency response personnel. So in the open cut they call them an ERT, and that can be made up of a percentage of workers whose day-to-day job normally is being a tradesman operating a piece of equipment. Some of the open-cut mines have brought in ex-paramedics and ambulance officers. They come in and they provide a service. It varies.

The reason I say it is a bit different is that in the underground sector it is very similar, mines rescue trained personnel. I guess the Grosvenor explosion I have to use as a live example; the first responders were those guys working there beside them until the emergency response capability got to them, because they are a fair way underground. That is something else that factors in—the actual level of emergency response available for a service. Some of our open-cut mines can be up to 100 kilometres long. Some of our underground mines can be 14 or 15 kilometres in. It can take a period of time. Normally you are relying on the person beside you, but they do have dedicated people. In open-cut mines they are called emergency response people who provide those services, and in the underground sector it is the mines rescue and first responders. I would hazard a guess to say the numbers.

Mr Newman: It would depend on the size of the mine. For instance, underground you would have ERZ controllers. They would be responsible for a certain area of the mine. It is a statutory requirement that they be responsible for that mine. The size of the mine will dictate the amount of ERZ controllers you will have on any given shift. Similarly, with an open cut, you will have an OCE, or an open-cut examiner, and they will be responsible for certain parts of that mine. There is a statutory requirement to have at least three on at any given time.

Mr Smyth: Depending on the size of the mine.

Mr Newman: Depending on the size. That is the statutory requirement for those people. Then you have the mines rescue people underneath it who are performing essentially like-for-like roles in terms of the same duties as a paramedic or a firefighter, depending on the emergency, and they have specific training for that. A certain number have to be onsite at any given time depending on, again, the size of the mine. It can range and vary, which leads into that mines rescue part.

Our concern is that the majority of those people are just ordinary coalminers. Their role is an operator or a mine technician. Their ancillary role is on the mines rescue team. Our concern is that the job that they could be called upon to do that would put them in that first response role is not their primary role. It is not. However, when that role is required, they need to do it. We note the submissions by the regulator. The regulator says that part 11, or the catch-all provision, should cover them.

Our concern is that that is all well and good for the regulator, but you have self-insurers in our industry and I can assure you that a self-insurer will look at that and say, 'Well, that's not a like for like. They are a coalminer.' Then what happens? We have to litigate. We will have to determine what parliament's intent was by that catch-all—whether that person is a coalminer or whether that person was performing ERT first-response roles. We are here today to say that that will be the problem. We can fix it right here and right now by putting a separate section in the regulation that says that someone performing a statutory duty under the Coal Mining Safety and Health Act or associated regulations is a first responder. If that is in there then that covers them.

Mr BROWN: If you become an ambo or a firefighter, you are thinking about a threshold of trauma that you will see day to day at a job, but for a coalminer who has these extra duties put on them after they enter the coalmine, because they have worked up the ranks or have had extra training and so on, their first exposure could lead to an injury; is that correct?

Mr Newman: Yes, exactly right.

Mr BROWN: What is the percentage of self-insurers in the mining game?

Mr Newman: There would be two: Glencore and BHP.

Mr BROWN: And you fight them all the time?

Mr Smyth: Yes.

Mr Newman: We fight them constantly. Whilst there are only two, they control probably over 50 per cent of the coalmines, if not more. The main two operators are Glencore and BHP.

Mr BROWN: Every single injury and every single case is, to the nth degree, fighting them to get—

Mr Newman: That is certainly our perspective.

Mr BROWN: In your experience?

Mr Newman: Every one that I see is one that we fight; otherwise I do not see it.

Mr BROWN: Your submission today just goes to one easy point about opening up a clear definition of a statutory position to have one less fight with the self-insurer?

Mr Newman: Exactly right, with the associated point that I made in my opening submissions about the resourcing issue to enable people in these communities to access a psychiatrist to gain that rebuttal.

Mr BROWN: Thank you for that. It is loud and clear.

Mr DAMETTO: Thank you very much, Mr Smyth and Mr Newman, for giving your testimony this afternoon. I do not have any particular questions; I just wanted to thank you for coming in and addressing the committee this afternoon. We appreciate it.

CHAIR: Thank you very much, Mr Smyth and Mr Newman, for joining us here today. We are really grateful for your time and the experiences that you have shared with the committee.

Proceedings suspended from 3.04 pm to 3.09 pm.

JAMES, Ms Leeha, Member, QLS Accident Compensation and Tort Law Committee, Queensland Law Society

MURPHY, Mr Luke, President, Queensland Law Society

SAMPSON, Ms Kerryn, QLS Policy Solicitor, Queensland Law Society

CHAIR: Good afternoon. Luke, would you like to make a brief opening statement to the committee?

Mr Murphy: Firstly I thank the committee for inviting the society to appear at the public hearing on the Workers' Compensation and Rehabilitation and Other Legislation Amendment Bill 2020. In opening, I would like to respectfully recognise the traditional owners and custodians of the land on which this meeting is taking place—Meanjin—Brisbane. I recognise the country north and south of the Brisbane River as the home of both the Turrbal and Jagera nations and pay deep respects to all elders past, present and emerging.

I am joined today by Leeha James, a member of the Queensland Accident Compensation/Tort Law Committee and a practitioner who has a particular degree of experience within the presumptive legislation area of practice, and also Kerryn Sampson, QLS Senior Policy Solicitor, who provides support to our accident compensation committee.

As stated in the submission from the society, we hold significant reservations about the broad scope of the presumptive legislation. Of particular concern is the reversal of the onus of proof. The onus of proof is, as you would all be aware, a fundamental principle and cornerstone upon which the efficient and effective administration of justice has been founded. It is a legal principle that, in the view of the society, should not be breached without appropriate justification. Our concerns about the legislation reversing the onus are compounded by the breadth of the bill which, in our view, is not yet adequately supported by evidence to justify a presumptive legislation across such a broad range of workers.

I emphasise, though—and we have included this in our submission—that the society agrees, without any reservation whatsoever, that workers with work-caused psychiatric and psychological injuries should and must be entitled to workers compensation and appropriate support. Our concern is that presumptive legislation reverses the onus of proof and such legislation needs to be supported by hard empirical evidence. Broad legislative changes of this nature, we believe, must be carefully considered, particularly so that they do not jeopardise the ongoing viability of what is, in our view, the best, most efficient and most cost-effective workers compensation scheme in Australia. The scheme needs to balance those issues.

As Leeha will expand on, our concern here is the lack of evidence supporting such breadth. That concern is heightened in the context where there has been recent legislative change, in 2019, which promotes earlier access to treatment through the approval process of psychological claims. That legislative change is then coupled with new administrative policies which the WorkCover management have implemented. They are both, at this point in time, at what can only be described as an embryonic stage. We understand that, to the extent that there is evidence of the impact of both of those initiatives, the evidence is positive. The time period being taken to accept claims has been reduced. The benefit of early intervention, whilst claims are still being investigated, is starting to be seen, consistent with what the submissions of the Australian Psychiatric Association and the Australian Medical Association have highlighted as being the best way to address issues—that is, early medical treatment.

The final point I make before I hand over to Leeha is a purely practical one: a number of the submissions make reference to, and understandably so, the need for a high evidentiary onus to be satisfied for the rebuttal presumption to be substantiated. We, however, just have a practical concern about how section 36ED(4) will actually work in the context of subsection (2) of that provision providing the presumption. We flag that as a practical issue that may need to be addressed.

Ms James: My job really is to get into more of the technical detail of the bill and also address some of the concerns that we have across some of the studies that inform this bill. I will start with the breadth and scope because Luke has focused on that quite a lot already.

We have concerns with the breadth and scope in that it has the potential to benefit unintended recipients. Some of that rests in the fact that there is no threshold for entitlement around a qualifying period of exposure or employment. The same way that we have within the presumptive legislation for firefighters with cancer, they have a latency period which is premised on years of service engaged in

a particular type of work activity, which for them is fire extinguishment, whether that is training or live fires. This particular piece of legislation, if it goes through in its current form, has no qualifying period at all. That is not supported by the scientific evidence that has been referred to to inform the bill and to substantiate why this bill is important.

Just by way of example, if we look at the Beyond Blue report *Answering the call* we see that they do quite a heavy analysis of the different types of first responders and emergency services workers. What came out of their studies, though, was that, if we are looking at the main body of first responders who are more probable to have PTSD—we are talking about our police, fire and ambulance officers; those, for want of a better word, traditional first responders; those occupations or in those positions—the empirical evidence was informing them that after 10 years of service is when they saw a significant increase in that diagnosis and in people presenting with those problems, as opposed to workers who were only in those industries or in those occupations for a period of, say, two years.

They attribute some of that to the healthy worker effect. I am not sure if the committee is familiar with the concept of the healthy worker effect for epidemiological studies. It basically just says that people who tend to seek out these types of jobs are generally healthier people anyway than people who, say, do not work. That is probably it in its most simplistic form.

I will give you an example of how this legislation has the potential to work, even though it may not be intended. If we have a police officer who is in the job for six years, he or she is probably going to be able to run an argument under the normal section 32 that there is a claim for acceptance. If you have a police officer who is only in the job for six months, they leave that job and they go and work interstate in a different emergency services job or not in a first responder type job at all, under this legislation as its current stands they will qualify if they get a diagnosis in 20 or 30 years time. It may not be that it is work in that six-month period that is the cause.

That is where our concern comes from in relation to the breadth and scope of the legislation. There is no boundary to it at all. That then enables an opening of the floodgates. It was dealt with within the firefighter presumptive provisions by putting in those latency periods. Those periods are supported by the evidence, the same way that the evidence is pointing to those with PTSD working in the first responder industries being more likely to have the presumptive requirement after 10 years of service.

Just to restate what Luke was saying, the society does not want people who are injured in the course of their employment to not be able to access workers compensation and receive the full benefit of the entitlement that the legislation provides. We would like to bring to your attention that there are concerns around the breadth and scope and that there may be unintended recipients who may or may not have, in the ordinary sense, a causation issue in terms of work being the cause of their PTSD.

If we go back to section 36ED, the presumption of the injury in subsection (1), they just have to have a diagnosis of PTSD. There is no requirement that in that diagnosis there has to be an explanation that it is work caused. That is where, again, there is scope for unintended recipients to get the benefit of that. Unintended recipients cause more pressure on the viability of the scheme. We want to bring that to your attention.

We note also that there is a lot of discussion in the other organisations' submissions around a request to broaden the injury type for psychological injury to include other injuries such as depression, anxiety and substance abuse rather than just PTSD. Our observation is that there is already scope within the scheme for secondary injuries to be accepted once the PTSD is an accepted claim. The insurers, across self-insurers and WorkCover Queensland, already have their systems in place to facilitate that process. It is not uncommon for PTSD to come with other ancillary or secondary diagnoses as well, such as depression and anxiety, but there is already a process there for that. The studies that we are looking at are only really addressing the PTSD. We would ask the committee to consider not broadening the breadth and scope of the bill any further than it already is if it is inclined not to contract. I have heaps more to say, but if you have questions we can go to those.

CHAIR: You were talking about the time frames and claims process. What would the society think is a reasonable time frame? You talked about a police officer who might have been in for six months versus one who has been in for six years and the research saying 10 years or more is where there is greater demand.

Ms James: It is less likely that a first responder only employed in the role for six months is going to have a cumulative effect. They are probably more likely to be able to point to incidents or events that are contributing to or causing the condition that they have been diagnosed with.

I cannot give you an answer as to what a good threshold is. They are not nice things to talk about, particularly if a threshold is arbitrary and unfair. Nonetheless, a threshold is something that I think all presumptive legislation requires because it sets a consistency of practice and application with those who need to be making decisions and implementing the legislation.

That is not to say that somebody who keeps a diary or somebody who sees the same doctor or has a good partner who can recall things cannot put together a chronology in the absence of presumption and have a claim accepted. That is certainly my experience a lot of the time. If you put together the right information before the insurer you still can get over the line with PTSD in first responders and eligible employees without the benefit of a presumptive provision.

Mr Murphy: Could I emphasise one further point. What is certainly underpinning the society's position is that the presumptive legislation is, quite appropriately when supported by empirical evidence, allowing valid and justifiable injured workers to have easier access and a less stressful process. It does not in any way deny access to anyone who can satisfy the legislative obligations for every other worker. In our view, what is of significance in the consideration of this legislation is that the starting point is not that we are denying anyone a right; we are, in appropriately supported circumstances, enabling easier access for some. In those circumstances, where we are not removing a right from someone, we need to ensure that we are not opening up to more than are appropriately entitled to it.

CHAIR: I note in your submission that currently around 80 per cent of claims in this space receive a successful outcome?

Mr Murphy: Eighty to 90 per cent is our understanding from WorkCover.

CHAIR: Do you think this legislation will open the floodgates?

Mr Murphy: There are a couple of concerns in relation to it, subject to one piece of data which I am not, I apologise, appropriately up on but Leeha or Kerryn may be. The concern is that, because of the very nature of the psychological condition and the fact that to have an application accepted you have to go through the process of revisiting the trauma and working through it again, people will avoid that—understandably so. There are then other options that may be available to them where they do not have to do that; namely, income protection, either through private contracts they might have or through their superannuation membership.

One of the concerns is: is there an unknown body of workers who would be able to satisfy the current test but will certainly satisfy a presumptive legislative entitlement who will move? If I were acting for them, I would certainly encourage them to move and leave that income protection there after their statutory compensation has been completed. That is one issue. The other is that you get those who were rejected and decide not to take it on. That may be driven by commercial reasons but it also, given the very nature of the condition, may be driven by 'I just can't face it anymore'. There was some statistical data from British Columbia where—

Ms Sampson: The information that I just handed over is some data that we obtained from WorkSafe in British Columbia, where they introduced quite broad presumptive legislation in 2018. I am happy to provide a copy of that data to the committee.

CHAIR: Would you like to table that?

Mr Murphy: Yes.

CHAIR: Leave is granted for that to be tabled.

Ms Sampson: It shows an increase in the number of claims between the period when the presumptive legislation was introduced and after that period. These are just my notes. If it is okay, I might just table it separately.

Mr Murphy: Can we take that on notice and provide it to you? It is a bit ambiguous in the column structure. That may well be due to the quality of printers. I apologise.

In answer to your question, if I am reading this correctly, the British Columbian presumptive legislation started in 2018. In 2017 there were 1,351 and in 2018 there were 1,516. Then in the year following the introduction of the legislation there were 2,300. That is an increase of 1,000 over a two-year period and an increase of just short of 800 in 12 months.

Mr SULLIVAN: It is a similar issue that I want to deal with. Perhaps we can use the example that Ms James went through of somebody serving six months in the Police Service, going interstate and then having a future claim. In the context where the proposed reversal of onus of proof is

rebuttable, is that not the precise information—and I think you said when you line up a chronology and when you get the information together you get across the line for a decision to be made—that WorkCover or a self-insurer would provide to rebut the presumption?

Ms James: It can be, but as an employer or as an insurer I am not quite sure how they access the personal information of the worker. They are not in a court. They cannot issue subpoenas or notices to produce. They cannot access medical records. The insurer would be able to. I think that comes back to where Luke was referring to section 36ED(4), which is where the rebuttal provision sits. From a practical point of view, we do not know how it works. It is not clear how and when it would be triggered.

If we look at 1(a), which is the first tick box to have a claim accepted under presumption, it is just the diagnosis from a psychiatrist that the worker has PTSD. Nothing more and nothing less is required. If we then go to 1(b) it says 'and at any time before the diagnosis was employed as a first responder or an eligible employee'. Once those two boxes are ticked—1(a) and 1(b)—the insurer can accept under the presumption, which is subsection (2). There is no scope or time or process or mechanism for the rebuttal provisions to kick in.

CHAIR: Deputy Chair, member for Theodore or member for Hinchinbrook, do you have any questions?

Mr LISTER: Nothing from me, Chair. I thank the Queensland Law Society for their continued participation in the processes of committees. It is appreciated.

Mr DAMETTO: Thank you to the Law Society for your submission as well as for coming and addressing the committee at the public hearing today. You raise some good points which I am going to go back and pull apart when deciding where I sit on this legislation.

Mr BOOTHMAN: I have nothing to add.

Mr BROWN: You always back self-interest in life. The QLS's members do a very good job leading their clients through a complex system and spend a lot of hours taking them through this system. With this piece of legislation, will that work go away from QLS and is that why you are against the legislation as proposed?

Mr Murphy: The simple answer is no. You would not have expected me to say yes, obviously. The reason it is no is quite simple. Any aggrieved party has an entitlement to seek a review. Whilst Leeha and I are both plaintiff practitioners who practise in this area, 50 per cent of our committee members are defendant insurer practitioners.

Mr BROWN: But 50 per cent of your clients are not? The majority—

Mr Murphy: We are just plaintiff. There is a significant number of practitioners here in Queensland who act for WorkCover or act for self-insurers and they would be taking them on review. Whilst the presumptive legislation would in fact have the result that the plaintiff solicitor would not seek a review because it is accepted, there is another category of practitioners who would. I make a second point: there is nothing harder in this area of practice than taking a rejected psychological statutory WorkCover claim on review. I am saying that with significant experience in practice. They are extraordinarily difficult and time-consuming review applications to run.

Mr BROWN: And I have been through the process.

Mr Murphy: Member, I do not mean to be lecturing in that way, but it is something that I am passionate about. I have had to say to applicants that I believe they are entitled to it but it is just not commercially viable for them to run it. Fees of over $100,000 will be incurred in having to run a review application, because they will run for a number of weeks. You are never going to get that back. You cannot recover that even if you are successful in the industrial commission, because the costs you recover are restricted to Magistrates Court scale E.

Whilst the conflict of interest is acknowledged and the Law Society will always acknowledge it, there is absolutely no influence of that nature that has in any way impacted the position we have taken. The society's position historically has always been that the reversal of the onus of proof is something that, as the custodians of the law, we will advocate against. That is a non-negotiable position. In these circumstances, the last thing we want to see is something that jeopardises the financial viability, as I have said, of what we believe is the most efficient and effective statutory WorkCover scheme in the whole of Australia.

CHAIR: That concludes our questions. Thank you very much for your time today and for your insight. We are extremely grateful. We have taken on notice a document for tabling in regard to data from British Columbia. We ask for that to be provided by 12 noon on Wednesday, 6 January 2021 so

that we can include it in our deliberations. That concludes our hearing. A transcript of these proceedings will be available on the committee's inquiry webpage as soon as it is available. I declare this public hearing for the committee's inquiry into the Workers' Compensation and Rehabilitation and Other Legislation Bill 2020 closed.

The committee adjourned at 3.37 pm.