



Submission of the Australian Lawyers Alliance

to the

**Education, Tourism, Innovation and Small Business
Committee of the Queensland Parliament**

on the National Injury Insurance Scheme (Queensland) Bill 2016

May 2016

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WHO WE ARE

The ALA is a national association of lawyers, academics and other professionals dedicated to protecting and promoting justice, freedom and the rights of the individual.

We estimate that our 1,500 members represent up to 200,000 people each year in Australia. We promote access to justice and equality before the law for all individuals regardless of their wealth, position, gender, age, race or religious belief.

The ALA started in 1994 as the Australian Plaintiff Lawyers Association, when a small group of personal injury lawyers decided to pool their knowledge and resources to secure better outcomes for their clients – victims of negligence.

The ALA is represented in every state and territory in Australia. More information about us is available on our website.

OUR STANDING TO COMMENT

The ALA is well placed to provide commentary on this Bill.

Members of the ALA regularly advise clients all over the country that have been caused injury or disability by the wrongdoing of another.

Our members advise clients of their rights under current state based and federal schemes, including motor accident legislation, workers compensation schemes and Comcare. Our members also advise in cases of medical negligence, product liability and other areas of tort.

We therefore have expert knowledge of compensation schemes across the country, and of the specific ways in which individuals' rights are violated or supported by different Scheme models.

We are well aware of existing methods of compensation reimbursement across the country, in order for individuals to gain access to care, as they deal with intersecting Schemes.

Our members also often contribute to law reform in a range of host jurisdictions in

relation to compensation, existing schemes and their practical impact on our clients. Many of our members are also legal specialists in their field. We are happy to provide further comment on a range of topics.

INTRODUCTION

The Australian Lawyers Alliance (ALA) welcomes the opportunity to provide a submission to the Education, Tourism, Innovation and Small Business Committee on the Queensland Parliament on the *National Injury Insurance Scheme (Queensland) Bill 2016*.

This is important reform and the Government should be congratulated for delivering a model that preserves existing rights whilst expanding the number of injured Queenslanders who gain necessary care and support. All this, at less than anticipated premium levels. The Government has taken effective action to implement the Newman Government's agreements and we would expect that it would have bipartisan support on that basis.

Inevitably important and complicated reform will include elements that should be carefully examined with reference to experience elsewhere and to ensure that they reflect the Government's stated policy aims. This submission focuses on the details that it is important this committee contemplates in considerable detail. It is in these details that the ongoing fairness, viability and sustainability of the scheme will be secured. Therefore this submission focuses on these particular issues at hand.

SUMMARY OF RECOMMENDATIONS

Appendix A contains a summary of the recommendations contained this document.

As the Committee reviews the Bill, we welcome the opportunity to add our experience and insight as the experts who work in the field every day. We hope our first-hand experience of scheme design, built on a daily basis going back decades can improve and strengthen an already well developed Bill.

MEANING OF TREATMENT, CARE AND SUPPORT NEEDS

Clause 8(g) deals with the exclusions on recovery of aids and appliances that are ordinary personal or household items. The first listed example is air conditioning. That isn't necessarily "ordinary" for everybody, even in Queensland. If a participant is quadriplegic and loses temperature control in the lower body then it becomes essential. Similarly, a quadriplegic might require more expensive computer equipment or an adjustable bed. Another example is someone who is incontinent and soils the sheets nightly, meaning they will use more linen. Extra expenses for ordinary household items are all too common for those with disabilities, and it is most unreasonable to have such an exclusion.

Excessive prescriptiveness, rather than the general touchstone of reasonableness based on individual circumstances, is highly undesirable, and will generate larger numbers of disputes and dissatisfaction with the scheme.

Clause 8 (f) relates to the need for attendant care and support services. The dictionary in schedule 1 defines this as "services to help a person with everyday tasks" with the examples given being "domestic, home maintenance, nursing or personal assistance services". There is no mention of childcare, a quadriplegic or paraplegic of either gender with young children is not only going to need assistance of their own but assistance with looking after the children. This is the same for many people with acquired brain injuries.

The ALA submits that the Act should be explicit that it is intended to cover these needs by having childcare added to the list of examples.

WHEN A CLAIM IS FINALISED

Clause 10 suggests that a claim against an insurer is finalised if the claim has been settled by agreement or final judgement has been given by a Court. Clause 10(b) should be amended to include after the word "claim", "or a Court has sanctioned the settlement of a claim".

PARTICIPANTS IN THE SCHEME

Clause 14(5) can create issues with regards to medical expenses being incurred prior to membership being determined. A foreigner who is billed for public hospital expenses may not be admitted into the scheme for weeks or months during which a significant debt may have accrued.

The informal practice in NSW is that if the person is admitted fairly shortly after the accident the authority will usually pay expenses back to the date of the accident but there is no obligation on them to do so. The ALA submits that the Bill should be amended to cover this circumstance, and ideally participants are admitted to the scheme within (say) three months of accident then all of the bills (ambulance included) back to the date of accident, are to be paid.

RE-ENTRY

Clause 17, inter alia, permits of circumstances where a catastrophically injured participant may:

- a) Choose to accept care and equipment heads of damage in their overall damages claim,
- b) And after no less than 5 years from the receipt of the damages for care and equipment, re-enter the NIIS and receive funded supports.

The circumstances in which a person may be permitted to re-enter the scheme are not stipulated in the Bill, and will be dealt with by regulations the ALA has yet to be consulted on.

The ALA supports, in principle, the agency being permitted to accept applications to re-enter the scheme, under the guiding criteria that such re-entry should not offend the “no double dipping” principle, and that the regulations must be clear as to what circumstances will allow such a re-entry. Appeal mechanisms in respect of disputed decisions on eligibility to re-enter also need to be fair and reasonable.

FAILURE TO DECIDE APPLICATION

Clause 24 provides that if the agency fails to decide an application to participate in the scheme within the decision-making period, the failure is taken to be a decision by the agency to refuse the application.

In our submission, in the interests of fairness to potential participants, the default position should be reversed, so that if the agency fails to decide the application it is taken to be a decision to accept the person as a participant. The clause as currently drafted would effectively require the injured person to engage legal representatives to assist in obtaining a reversal of the refusal in a situation where it is the agency who has not made the decision in a timely way. It is our submission that this would not be fair to seriously injured potential participants who may still be coming to terms with a serious injury and the multiple implications of this. Additionally, a potential participant may not be aware that a decision was due within the decision-making period and that the burden is then on them to obtain reversal of the default refusal and this may further disadvantage vulnerable potential participants.

Similar considerations apply to clause 32 regarding a failure to decide a service request in the decision-making period, clause 39 regarding a failure to decide a payment request in the decision-making period and clause 48 regarding a failure to make a review decision in the decision-making period. It is our submission that the default position should also be reversed in respect of those decisions. The position in respect of clause 48 is particularly concerning as the effect is that a person previously accepted as a participant can be removed from the scheme simply due to the failure of the agency to perform a review. The position should be that a person remains a participant until the review is undertaken and a decision that the person is no longer eligible is made.

PREPARING SUPPORT PLANS

Clauses 26(3) and (4) and 27(3) and (4) allows the agency to amend a support plan (presumably to take account of changed circumstances) but states that it must still be consistent with previous decisions. That is neither necessary nor desirable; support plans should, simply, take account of current circumstances, even if those are substantially different to earlier circumstances.

DECIDING PAYMENT REQUEST

Clause 37(3) allows the agency to approve a payment request even though the treatment, care or support is not an “approved service” as defined. The ALA commends that flexibility.

However, the Act does not allow, by reason of clause 37(6), the agency using clause 37(3) to approve an “excluded” form of treatment, care or support. Clause 9(1)(d) provides that “excluded” supports include those “....provided as part of a medical trial or on another experimental basis.”

In our submission, this is too restrictive. Notwithstanding that the medical or rehabilitative efficacy of a particular mode of support may not be entrenched in medical literature, there may be compelling evidence of the efficacy of a particular form of care, treatment or support in classes of participants. The multi-jurisdictional recent permitted use of medicinal cannabis is one example.

Accordingly, Clause 9(1)(d) should be deleted.

PRICE SETTING

Clause 37(5) permits the agency to set prices for services by regulation, and then refuse to pay the costs of the care, treatment or equipment to the extent that the cost exceeds the regulated sum.

Under the NDIS, the NDIA is seeking to be a price-setter for the market for provision of disability services. This, in tandem with an almost complete absence of effective workforce infrastructure planning by the Productivity Commission and Federal NDIA, means that increasing pressures on existing support services will be very seriously exacerbated from 1 July 2016, when both:

- a) Full rollout of NDIS commences, and
- b) NIIS participants commence to enter this Queensland scheme.

NIIS participants will compete with NDIS participants for scarce services. This problem will occur throughout Queensland, but be particularly acute in rural and regional areas.

A blanket, Queensland-wide approach to price-setting by the agency, will lead to one or more of:

- i. Providers refusing to accept the price set by the agency and the injured person and their family then being left with either no services or being forced to supplement the agency's payment with their own funds (if they have such funds),
- ii. Where no services are provided, the health and safety of the participants will be imperilled,
- iii. Providers using unskilled, unqualified or otherwise unsuitable sources of labour to meet the agency-set price. This also poses risks to the health and safety of participants,
- iv. Increased disputes about refusal to fund services based upon regulated pricing structures.

The rigidity of the current suggested approach is fundamentally inconsistent with the overarching objective of provision of necessary and reasonable treatment, care and supports for participants.

Moreover, it is also inconsistent with the current approach adopted with respect to rehabilitation under the *Motor Accident Insurance Act*, where, reasonableness is the sole touchstone for eligibility to receive rehabilitation services.

In our submission, the Act ought to enshrine the reality that market differentials do, and will continue to exist with respect to various forms of treatment care and supports.

The availability and cost of care and supports for a person living in some areas of Queensland will differ, and this will continue. In a practical sense, precisely what occurs now ought to continue: a case manager investigates the availability, quality and cost of care and supports from suitably qualified providers in the geographic vicinity of the participant; and the agency is then obliged to meet the reasonable costs thereof.

CONTRIBUTION BY AGENCY – PRESERVATION NOTICE

Clause 41 deals with the giving by a participant of a preservation notice. Subsection (5) of that clause requires the agency to apply for sanctioning of a preservation notice if the participant is a person under a legal disability.

The ALA endorses the ongoing need for protection of people under a legal disability. Likewise, the ALA supports court sanction of participants' final decision to "opt out" where that person is under a legal disability. Court sanctions are of long standing in personal injury claims.

We emphasise that existing Trustee and court sanction arrangements (which operate together, not separately) have worked very effectively to protect those under a legal disability. Any suggestion that such arrangements are deficient would be misguided and have no evidentiary basis.

We also recognise that there will be a small number of people for whom legal capacity may not be in issue, but for whom the receipt of lump sum funds may pose risks. The sanction process for the opt-out permits consideration of such cases.

However, we consider that requiring court sanction at such an early stage, where the participant is simply preserving their right to “opt out”, as opposed to making a final decision, is premature and not an appropriate use of the court’s time given that the participant may not eventually elect to continue with that “opt out”. The preservation notice is required to be given at a fairly early stage, when the court would not be in a position to judge whether it is appropriate for the person to “opt out” or give a preservation notice.

There is no point putting the agency, scheme and participant to the time and expense of such an application, if it is not clear that the participant will actually accept those heads of damage. That proposition accords broadly with the structure of Clause 44 of the Bill

It is our submission that the requirement for the agency to obtain a sanction should be at the point that the final decision is made to “opt out” under clause 44.

CONTRIBUTION BY AGENCY – CONTRIBUTORY NEGLIGENCE – POLICY OBJECTIVES NOT MET

The ALA concurs with and supports the statement made in the Explanatory Notes to the Bill, which state:

“The purpose of this Bill is to ensure that certain people who suffer particular serious personal injuries as a result of a motor vehicle accident in Queensland, receive necessary and reasonable treatment, care and support, regardless of fault.” [Our emphasis.]

The “opt-out” provisions in the Bill are based on the policy position adopted by the government that participants who can demonstrate fault, must have the choice to receive care and equipment damages as a component of their damages settlement.

Clauses 42 and 149 (at proposed s52C) effectively means that if contributory negligence is conceded, or judged by a Court to be 25% or more; the agency is not liable to contribute: the opt-out is not possible. This, in turn, means:

1. Those who can prove fault, but have a contributory negligence concession or judgement of less than 25% can receive damages for care and supports, but are treated worse than a person who may have been 100% at fault for their own injury, and
2. Those who concede or have adjudged a contributory negligence percentage of 25% or greater lose the choice to opt out, with all of the dignity, housing and self-determination ramifications the ALA, QLS and other stakeholders have previously ventilated via the Committee process.

These consequences:

1. Are unfair,
2. Represent a fundamental departure from the overarching policy position that those catastrophically injured ought not to have their treatment, care and supports reduced on account of fault (whether part fault or full fault). It is implicit in all that has occurred on this policy initiative, that there is a community recognition that those who are catastrophically injured ought to have full and fair coverage for those heads of damage, “regardless of fault”,
3. Would have the effect of forcing greater numbers into a long-tail scheme, when the financial dangers of such schemes are writ large.

To maximise fairness and choice, and to align the Bill with the policy objectives referred to above, contributory negligence reductions ought only apply to non-care heads of damage. That is, no contributory negligence reductions be permitted (including under the Civil Liability Act) for care and equipment heads of damage for the catastrophically injured. That is the legislative situation in Western Australia, the other jurisdiction which has legislated opt-out arrangements.

Accordingly, in the ALA’s submission, Clause 42(2)(a) should be deleted entirely.

It should be replaced with:

“(2) No insurer nor any Court shall reduce care and equipment heads of damage on account of any contributory negligence (including pursuant to the Civil Liability Act). For the avoidance of doubt, a participant shall be entitled to receive treatment care and support damages, not reduced on account of contributory negligence. The parties to the damages claim may agree, and a Court may decide to apply contributory negligence reductions to other heads of damages.”

Clause 149, where it introduces a new s52C into the Civil Liability Act (at line 26, page 94), should be deleted in its entirety, for the same reasons. It should be replaced with:

“52C Damages if insurance agency is liable to contribute

“No insurer nor any Court shall reduce care and equipment heads of damage on account of any contributory negligence (including pursuant to the Civil Liability Act). For the avoidance of doubt, a participant shall be entitled to receive full damages for treatment care and supports heads of damages, not reduced on account of contributory negligence. The parties to the damages claim may agree, and a Court may decide to apply contributory negligence reductions to other heads of damages.”

APPLICANTS TO COURT FOR ORDER – ADDITIONAL COURT FILTER

Clause 43 permits the agency to ask a Court to preclude any participants who can prove fault, from receiving treatment, care and support heads of damage in a lump sum, as they can now.

The ALA support, in principle, the policy position of an additional filter, beyond existing and well-functioning Trustee arrangements. The majority of participants will be a person under a disability by reason of age or cognitive impairment.

The existence and utility of current Trustee arrangements should be expressly mentioned.

We therefore submit that Clause 43(2) be amended to add “(b) *the court must consider whether the participant is a person under a legal disability, and the existence of private and public trustee arrangements; and* “

The timing for an agency’s application pursuant to clause 43(1) is critical. The court will need to consider in such applications a range of factors similar to those considered in applications to sanction common law damages settlements under current arrangements. In practice, a s.43 application can only be properly considered towards the end of matters, after stabilisation; and when all medical evidence and Trustees’ financial management arrangements can be stated with clarity.

The ALA therefore submits that Clause 43 have an additional subsection as follows: “*the Court may determine an application pursuant to this section concurrently with deciding any sanction of a settlement for a person under a disability.*”

The final issue with respect to clause 43 is costs. The process is as observed above, broadly analogous to existing sanction arrangements. Detailed material will need to be prepared, analysed and counsel usually briefed. Clause 43 lacks any provisions entitling the participant to costs for their involvement in the application.

It should have such provisions, for all participants, irrespective of the ultimate ruling by the Court upon the application by the agency.

Accordingly, the ALA submits that clause 43 have added to it *“the participant shall be entitled to legal costs of responding to the application, regardless of the determination made by the court.”*

ADVANCE OF TREATMENT CARE AND SUPPORT DAMAGES – TIMING ISSUES

Clause 44 requires a participant to provide notification to the agency, of an election to accept an amount awarded or agreed for treatment care and support within an “acceptance period” of 14 days after settlement, sanction or expiry of the appeal period (28 days) against the judgement ends. The ALA considers that in the interests of fairness and choice to the potential participant, an appropriate time frame should be extended to 60 days from the date of settlement, sanction or expiry of the appeal period.

Given the uncertainty of trial (and for that matter settlement negotiations) the participant should not be placed in a position of unnecessary time pressure to make an election that will have profound long term ramifications for participants.

After settlement or judgement, the potential participant and usually their family, will require a reasonable period to make an informed decision (choice) about the participant’s long term treatment, care and support needs. This will require collaboration with experts including accountants, financial planners and trustee companies. These experts will need to undertake necessary actuarial calculations. Legal advice based upon the updated financial material will need to be refined and updated following receipt of the external experts’ material. Participants and their families will then need a reasonable period to consider that advice and provide instructions to their legal representatives.

Accordingly the ALA recommends the participant should be provided sufficient time to gather the necessary information and the period should be extended to 60 days post settlement, sanction or expiry of the appeal period.

Further to ensure clarity around clause 44 (8) (c) the ALA recommends that the legislation state “ that the period for providing notification pursuant to clause 44(2) is stayed whilst the appeal is pending settlement or determination by the Court”.

PARTICIPANTS ABSENT FROM AUSTRALIA

Section 52(1) allows the agency to suspend the participant's participation in the scheme if they leave Australia. Given the number of tourists and longer-term residents who are not Australian citizens we have in Queensland, we query the rationale for rights being suspended when the person leaves Queensland.

If a Queensland resident has been catastrophically injured and goes back to live with family in, for example the UK or Canada; the policy rationale for suspending benefits is lost on us. We accept that such a move of geography, usually to be closer to family supports, could generate the need for an adjusted support plan. The NSW scheme pays participants wherever they are in the world, and Queensland risks allegations of an excessively insular approach unless change is effected.

REVIEWS

Chapter 6 deals with Reviews, a fundamental liberty to guard against error. The ALA supports the existence of a Review process.

Clause 107 sets out the process for lodging an internal review process, and requires the application be provided to any affected person. We encourage an amendment that provides a deadline for doing this to ensure this is done in a timely manner, to ensure the principles of natural justice are adhered to.

Clause 108 allows the agency to request information from the applicant or any other affected persons, however doesn't specify a time frame for cooperation or any impact of failure to cooperate. The provision of this additional information is crucial in determining the date the agency's internal review decision is due. Clause 109(6)(a) specifies that the agency has a period of 28 days to make their decision after the receipt of this additional information. The ALA is concerned that the lack of time frames around the provision of additional information could result in tardiness in providing further information leading directly into delays in the agency providing their decision. Any such delays are likely to be detrimental to an injured person's recovery due to a lack of access to funded treatment. This is an important amendment to allow the agency to serve its purpose.

The internal review process outlined in Chapter 1, Part 6, fails to allow an aggrieved person, often the injured person a right of appearance. A face to face discussion which affords the person and their family the opportunity to be 'heard' and play an active role in resolving a dispute is crucial. The imposition of a decision by the agency that impacts their day to day existence, without an appearance before the decision maker (regardless of the ability to provide written submissions) will result in a lack of confidence in the scheme, and increase the likelihood of disputes being elevated beyond this stage.

The ALA encourages an amendment to allow this to occur.

Clause 110 sets out the requirements for the agency to give an internal review decision and states that if the agency doesn't give the decision as required, the original decision is taken to have been confirmed. Clause 111 then allows the injured person to request the decision notice. What is lacking is an obligation on the agency, in circumstances where they don't provide the decision as required, to notify the applicant of the failure to make a decision and their external review rights. A failure to provide a decision notice as required allows the external review process to be accessed, and with that requires the referral request for review to be lodged within 28 days. The injured person and their family are unlikely to be in a position whereby they are educated on their rights, and hence could miss this crucial deadline for which there is no time limit extension provision. An amendment stating the agency is to inform the applicant of their review rights in this situation will avoid this from occurring.

Part 2 deals with External review. The ALA supports the general structure of an independent review process as detailed.

Clause 112 refers to the circumstances in which an internal review decision involves a decision on a medical matter. Clause 112(1)(a) provides that one of the decisions is "whether a motor accident is the medical cause of a serious personal injury". We submit that provision should be changed to read "whether an injury sustained in a motor accident is a medical cause of a serious personal injury". Note the use of the word "the" before the word "medical" in section 112(1)(a) would be inconsistent with common law notions of causation.

In relation to clause 114, which deals with the constitution of the tribunal we would encourage the tribunal to be flexible with a variety of medical experts across a number of disciplines available to sit on the tribunal depending on the nature of the injured person's condition and the precise matter in dispute. This is particularly important for disputes relating to care and support where we consider there is an important role for an occupational therapist to play who is skilled considering a holistic approach in identifying and reducing barriers to independence. In our members' extensive experience, specialist medical doctors usually consider issues through the narrow prism of their own specialist discipline, and lack the broader experience to address what are commonly multi-disciplinary rehabilitation issues. In our submission, that reality should be recognised by the Act and regulations requiring at least one member to be a qualified occupational therapist.

Clause 123 states that the medical tribunal is final. The ALA considers that the right to pursue an application under the *Judicial Review Act* is a fundamental right that must be afforded here. This is essential to ensuring the medical tribunal administers its in power within its legal limits. Without this it has unfettered discretion to decide medical matters without ensuring the principles of procedural fairness and natural justice are adhered to. An amendment to include access to judicial review would

ensure the provision is consistent with the medical assessment tribunals operating under the *Workers' Compensation and Rehabilitation Act 2003*.

In addition, the ALA considers that it is necessary to allow a further reference to the tribunal on fresh medical evidence if it arises within 12 months of the original medical tribunal decision. Again, this is consistent with section 512 of the *Workers' Compensation and Rehabilitation Act 2003* and ensures the appropriate 'checks and balances' of the medical tribunal.

Clause 127 details who can apply for review by QCAT and refers to the QCAT Act regarding the process and time for applying. Section 33 of the QCAT Act provides a 28 day period from the relevant date to apply for review. For the purpose of this Bill, this is, for a non-medical matter, 28 days from the issue of the internal review decision. In relation to a medical matter, the relevant date for review to QCAT is 28 days from the medical tribunal decision, as opposed to the agency's internal review decision following the tribunal decision. This is a clear inconsistency and places an expectation on the aggrieved party to lodge a review potentially prior to the receipt of the internal review decision (which is the decision being externally reviewed) and prior to being informed by the agency of their external review rights and relevant time frames. The ALA proposes an amendment to ensure the timeframe for review to QCAT is consistent for both medical and non-medical matters.

AMENDMENT OF MAIA (NOTICE OF ACCIDENT CLAIM)

Clause 156 of the Bill incorrectly notes the section of the Motor Accident Insurance Act 1994 to be amended as s 37(1)(c). It should be s 37(1)(b). The clause should therefore be amended so that the reference to "Section 37(1)(c)" be amended to refer to "Section 37(1)(b)".

CONCLUSION

The Government and this committee should be congratulated for the comprehensive way they engaged around the broad policy settings that this bill reflects. This approach ensured the best possible outcome for Queenslanders injured in motor vehicle accident. The task before the committee is to ensure that these principles are applied in the detailed operation of the reform.

As we have set out, the ALA has particular concerns about a number of elements of the Bill before the committee. The amendments we propose in response have been set out in Appendix A below. These changes will further enhance the important reform the Government is engaged in.

Rod Hodgson
Queensland President and National Director
4 May 2016

APPENDIX A

This is a brief synopsis of the paraphrased changes submitted for by the ALA. Reference should be made to the body of the submission for more detail as to both content and rationales.

1. Remove exclusion upon air-conditioning being recoverable. Clause 8
2. Make specific reference to child care as a component of attendant care. Clause 8, and definitions section
3. Amend clause 10 to add reference to Court sanction.
4. Clarify coverage for foreigners under clause 14(5).
5. Re-entry provisions to be considered further upon review of regulations. Clause 17.
6. Reverse the current proposed position in Clause 24, so that the agency's failure to decide an application to participate does not prejudice an intending participant.
7. Reverse the current proposed positions in clauses 32 and 48, on the same basis as stated in 6, above.
8. Amend the interaction between clauses 26 and 27 to permit an updated support plan to not be consistent with an earlier support plan.
9. Remove from the definitions section supports "provided as part of a medical trial or on other experimental basis".
10. Amend s37(5) to require that the agency be liable for the cost of supports on a reasonableness basis (consistent with the current approach under the CTP legislation), notwithstanding that the cost thereof may exceed a price set by regulation.
11. Amend Clause 41 to move the requirement for the agency to obtain a sanction to the point at which the final decision is made to "opt out" under clause 44.
12. Delete contributory negligence provisions and replace them with arrangements which allow contributory negligence reductions only on damages other than treatment care and equipment. Clauses 42 and 52.

13. Add to clause 43 to enshrine existing Trustee arrangements.
14. Add to Clause 42 to allow Courts to determine applications as late as concurrently with a court sanction.
15. Amend Clause 44 to provide realistic timeframes for election to take effect.
16. Amend Clause 52 to remove the prohibition on coverage for participants who leave the jurisdiction.
17. Add a requirement that the agency be given a deadline in respect of Clause 107 reviews.
18. Add a requirement that timeframes be stipulated in respect of the provision of information under Clauses 108 and 109
19. Permit participants' right to be heard in the internal review process in Chapter 1, Part 6.
20. Amend Clauses 110 and 111 to require the agency to notify of any failure by the agency to make a decision. Amend these provisions to require the agency to notify of appeal rights.
21. Amend Clause 114 to expressly provide for an occupational therapist to be part of a medical tribunal
22. Include rights under the *Judicial Review Act* in Clause 123. (align with Workcover legislation.)
23. Amend Clause 144 to permit the medical tribunal to receive a further reference upon fresh medical evidence, within 12 months of the earlier determination. (Align with Workcover legislation.)
24. Amend Clause 127 to align QCAT review timeframes for both medical and non-medical matters.
25. Correct typographical referencing error to s.37 of Motor Accident Insurance Act.