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ACES
Aged Care Employers Self-Insurance

Submission to the Queensland Parliament Finance and Administration Inquiry

Into

Operation of Queensland's Workers' Compensation Scheme

Submission by ACES employers:-
RSL Care Limited
The TriCare group of companies
Sundale Garden Village, Nambour

17 August, 2012

Introduction

Aged Care Employers Self-Insurance (ACES) holds a Classification Group self-insurance licence as mandated by the provisions of the Workers' Compensation and Rehabilitation Act. The Classification Group relates to the WorkCover Industry Classification 'Aged Care Residential Services'.

The initial ACES licence as a self-insurer was approved from 1 January, 2005 and comprised at that time RSL Care and eight companies within the TriCare group. From 1 July, 2011, Sundale Garden Village joined ACES.

There are 5,014 employees covered for workers' compensation purposes under the ACES scheme.

RSL Care

RSL Care is a not-for-profit organization that has been providing accommodation and care since 1936 to the ex-service community. RSL Care today has developed into one of the largest providers of aged care services in Queensland with a range of community-based services, hostels, nursing homes, secure dementia units and retirement villages providing both rental and equity units.

In 2012 RSL Care has three core businesses:

- Community Care
- Residential Aged Care
- Retirement Villages Living

The geographic area covered includes regional areas and surrounds on the eastern seaboard of Queensland, Longreach, the hinterland in the southeast of the State, northern NSW, parts of Sydney, the Hunter and Macquarie regions of NSW.

RSL Care employs 3,218 people in Queensland.

TriCare

TriCare is an organisation that provides care, accommodation and services to the frail aged in Queensland. TriCare is a 44-year-old privately owned company and is one of the largest private aged care providers in the State.

In 2012 TriCare has three core businesses:

- Residential Aged Care
- Retirement Villages Living
- NutriFresh – a company that manufactures and provides quality assured food services to the health and aged care industries.

The geographic area covered includes southeast Queensland regional areas and surrounds, extending north to Bundaberg, northern NSW and Melbourne.

- Sixteen residential aged care nursing centres and hostels located throughout the southeast of Queensland.
- Seven retirement villages, including five in Queensland.

TriCare employs 1,337 people in Queensland.

Sundale Garden Village Nambour

Sundale is a community-based not-for-profit organisation that has been involved in the age services industry since 1963, and celebrates its 50th anniversary in 2013. The organisation was born out of the enthusiasm and single minded commitment of the Apex Club of Nambour, which with the help of the Sunshine Coast community had, by 1963, raised the funds to commence building a much needed facility.

In 2012, Sundale's service scope includes -

- Eight residential aged care services covering low and high care with a specific emphasis on memory care and support;
- Four retirement communities;
- Rehabilitation services through Sundale's day service centre;
- The provision of in-home care to Sundale's clients;
- Childcare service both as long-day care and outside school hours care; and
- The provision of rental housing with a leaning towards affordable housing.

Sundale's geographic coverage currently focuses on the Sunshine Coast and Kilcoy. Sundale is in the process of development in other regional areas of Queensland.

Sundale employs 459 people in Queensland.

The ACES Experience with Self-Insurance

Prior to commencing ACES self-insurance on 1 January, 2005, RSL Care and TriCare were insured for their respective workers' compensation liabilities with WorkCover.

Each of these employers had experienced a recurring problem with effective control of injuries risk at their facilities through incapacity to properly integrate management of all injury risk issues. In this context, effective injury risk management refers to integrated management of workplace health and safety standards, injuries, compensation, rehabilitation and related human resource issues.

Since becoming self-insured from 1 January, 2005, ACES participants have –

- at a management level, developed a detailed understanding of the risk / cost relationship associated with workplace injuries; and
- as a consequence, progressively developed injury risk management systems and procedures to a level that are well understood and applied at the many ACES aged care facilities.

Self-insurance has created other opportunities of mutual benefit to ACES employers and employees.

- Workers' compensation benefits payments are now made as an integral part of Payroll systems. This has reduced payments to the one process, direct credited to employee bank accounts.
- Payments are made quickly after claim acceptance; thereby delivering better outcomes for injured workers.
- Workers' compensation claim processes have been simplified and made less bureaucratic. The ability for direct two way communications between ACES claims management personnel and injured employees is very advantageous.

  Claim processes through WorkCover or external insurers are inherently more complex, bureaucratic and slower due to –

  - the necessity for involvement of three parties (WorkCover, employer and employee);
  - the requirement for three way communication between parties that often results in differing views regarding claims and rehabilitation management plans and outcomes.

  The examples at Attachment 1 provide summaries of claims that demonstrate the flexibility available to self-insurers and the consequent ability to decide and manage claims more efficiently.
- Initiation of rehabilitation and return to work programmes occurs in a much quicker timeframe than can be delivered through WorkCover.
- Cost savings from self-insurance provides employer incentives to focus on the control of risks and return to work of injured employees.

The stability and substantial reduction in injury costs that have been achieved has allowed greater investment in aged care facilities and services.

This ACES submission will focus on some key elements of the current workers' compensation scheme that have been identified as worthy of consideration in better achieving the objectives at Section 5(4) and Section 5(5) of the Workers' Compensation and Rehabilitation Act (WCRA).

Self-Insurance

Issue 1 - Eligibility Criteria

Recommendation

It is recommended that the current 2,000 Full Time Equivalents policy restriction be removed to nil minimum employees similar to Victoria, WA, SA, NT, and Tasmania. Alternatively, if it was decided to amend this policy restriction, then it is made consistent with NSW (500 full time or part time employees).

A study of the eligibility criteria applying to self-insurance across Australian jurisdictions reveals that –

- Prudential supervisory criteria are similar across jurisdictions and for all intents and purposes achieve identical outcomes.
- Self-insurer financial performance requirements are similar. Employer financial strength measured through analysis of financial accounts is similar. Actuarial analysis and provisioning requirements are similar. Some differences exist in levels applicable to Bank Guarantees and reinsurance.
- The current supervisory and financial performance standards applied to self-insurance licences by Australian State regulators are of a high standard, resulting in very low risk of self-insurer defaults. In particular, the level of Bank Guarantees being required by regulators provide a high level of surety that estimated claims liabilities can be met.

Self-insured employers and regulators understand and accept the supervisory and financial performance standards being applied.

When self-insurance of workers compensation liabilities was first introduced to Queensland following the Kennedy Inquiry in 1996, this legislative provision was set at 500 FTEs and mirrored the Victorian legislation at that time. Victoria has since repealed this requirement, preferring instead to rely on financial strength of companies and other self-insurance viability safeguards.

In 1999 Queensland legislative change increased the entry criteria for those businesses wishing to self-insure their workers' compensation liabilities from 500 full time equivalent (FTE) employees to 2,000 FTE employees. It should be noted that this is not a restriction that exists in the legislation of other major Australian jurisdictions [1]. This arduous and arbitrary restriction appears designed –

- to prevent reasonable competition within the Queensland Workers' Compensation Scheme;
- to prevent larger employers with the financial and management capacity, from managing their own workers compensation claims as an integral part of their injury risk management processes; and
- to maintain WorkCover Queensland as a large bureaucracy that inherently is unable to provide employers the opportunity to efficiently manage injury risk issues at workplaces.

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- Victoria requires no specific numbers – must meet Prudential Requirements.
- NSW requires > 500 workers (full or part time – not FTE based) – must meet Prudential Requirements.
- SA legislation requires no specific numbers (SA policy position is 200 employees) – must meet Prudential Requirements.
- WA requires no specific numbers – must meet Prudential Requirements.
- NT requires no specific numbers – must meet Prudential Requirements.
- Tasmania requires no specific numbers – must meet Prudential Requirements.
- Queensland requires minimum of 2,000 FTE's – must meet Prudential Requirements.

This table shows that Queensland's Eligibility Criteria is not reasonable when compared to other Australian States and Territories and forms a severe deterrent on companies becoming self-insured.

While WorkCover underwriting of workers' compensation may be appropriate for the majority of Queensland employers, it is inefficient and unjust to deny large, eligible employers the choice to self-insure. In the 15 years since self-insurance of workers' compensation was introduced to Queensland, the claims administration and rehabilitation outcomes for injured workers in self-insured businesses have been excellent.

It is understood that a reason offered for maintaining the increased 2,000 FTEs requirement is a concern regarding insurance pools viability within the Queensland WorkCover scheme. This has been the subjective response from a number of people. **However, no objective analysis has been made available verifying this concern.**

- It is understood that, during the Kennedy Inquiry, the viability of the WorkCover scheme was tested to understand the impact of self-insurance with larger employers opting to become self-insured.
- Given that the risk profile for larger employers insured with WorkCover is no better (and in some cases worse) than the risk profile for smaller employers, this viability testing apparently identified minimal adverse impact and for most insurance pools an improved position. Such an outcome is understandable since it is a fallacy to assume that larger employers have lower injury cost risk than smaller employers. The more unionised nature of larger employers can often mean higher frequency claiming behavior and costs than for smaller employers.

It is important that the current 2,000 FTEs policy restriction be amended or removed to achieve the WCRA's objective of flexible insurance arrangements and balanced outcomes. This would also improve competition within the overall workers' compensation scheme and allow greater opportunity for larger eligible employers to more effectively control injury risks at workplaces.

Issue 2 - Licencing Criteria

Recommendation

It is recommended that –

The current legislative requirement that self-insurers undertake costly external Workplace Health & Safety (WHS) audits, not imposed on all other Queensland employers, be repealed. Alternatively, such audits be required at initial Licence application and at some set timeframe thereafter (e.g. at five yearly intervals) if a self-insurer has demonstrated satisfactory compliance at the prior audit.

Greater flexibility around the duration of a self-insurance Licences be introduced to remove costly and often unnecessary Licence renewal processes; whilst ensuring self-insurance scheme integrity through use of Q-COMP's oversight powers. Unnecessary 'red tape' needs removal.

There are two other Self-insurance Licencing criteria that need reconsideration and legislative reform. These are.

- A prerequisite for employers to become a self-insurer is to undergo costly external Workplace Health & Safety (WHS) audits at Licence renewal when this is a requirement not imposed upon all other Queensland employers holding WorkCover policies.

  Self-insurers are already required to satisfy all current WHS legislation and WHS Queensland inspections and targeted audits continue to apply to self-insurers; the same as all other Queensland employers holding WorkCover policies. The result is there is a much higher WHS benchmark for self-insurers compared to WorkCover underwritten employers. WHS compliance costs are, therefore, much higher for self-insurers.

  This additional Licencing requirement for self-insurers to undertake costly external WHS audits was introduced in 1999 and viewed by many as a self-insurance hurdle and designed to reduce the incentive for eligible employers to self-insure. It is highly questionable that these external WHS audits produce any improvement in WHS and risk reduction outcomes. The audits are essentially an exercise in having correct documentation and do not critically review injury outcomes and add value to employer WHS risk reduction practices and procedures.

- Current self-insurance Licence durations are restricted to a maximum four years with reduced durations for those self-insurers with less than high level exemplary performance. Q-COMP has in place a range of self-insurance performance measurement criteria and have powers to intervene if diminished performance is suspected.

  Given the legislative oversight powers that do and should exist, there is a case for a self-insurance Licence to be enduring or for longer periods, unless determined otherwise by the Authority based upon some concern about self-insurer performance and/or continuing non-compliance by the self-insurer. WorkCover underwritten employers are covered on an enduring basis unless policies are cancelled.

  In summary, there needs to be greater flexibility around the duration of a self-insurance Licence to remove costly and often unnecessary Licence renewal processes; whilst ensuring self-insurance scheme integrity through use of Q-COMP's oversight powers. Unnecessary 'red tape' needs removal.

Statutory Claims

As a general comment, ACES is supportive of most WCRA provisions relating to statutory claims entitlements, rehabilitation and return to work provisions and claims management rules applying to statutory claims. This is despite difficulties associated with the management of non-work related pre-existing or congenital conditions that are often attributable to work injury events, exaggerated injuries and fraudulent claims that are experienced from time to time.

There are some claims management issues that need to be highlighted to the Inquiry and that are causing decision making delays and claims management inefficiencies.

Issue 3 - Medical Assessment Tribunals (MAT)

Recommendation

It is recommended that MATs' referral processes be reviewed to determine if appointment processes can be better arranged and timeframes can be shortened.

Often, when statutory claims are lodged, questions arise regarding the accuracy of the GP's injury diagnosis and the claims management requirements on the claim. The insurer sometimes requires an independent medical examination (IME) to be undertaken by an appropriate medical specialist to confirm and/or advise an alternative diagnosis and treatment. In some cases, the treating GP will have referred the worker to a medical specialist.

In some circumstances differences of opinion between medical professionals arise that cannot be resolved. Occasionally the treating GP will not agree with the diagnosis and injury management recommended by medical specialists. Often the differences of opinion arise from the extent to which a condition is work related against the background of a significant pre-existing condition.

The insurer has little option but to refer the case to the Medical Assessment Tribunals for decision.

This has led to an increasing number of claims being referred to the MATS which are struggling to hear and decide referrals in a timely manner. The result is delays of up to 6 – 8 weeks for MAT appointments, delays in claims management timeframes and consequent unnecessary costs.

The management of the MATs warrants review to look at ways in which appointment processes can be better arranged and timeframes can be shortened.

Issue 4 - Journey Claims

Recommendation

It is recommended that Journey Claims as defined in the WCRA be removed as workers' compensation insurable events where there is no substantial connection between the worker's employment and the incident out of which the injury arose.

Data published by Q-COMP identifies that –

- approximately 6% of all statutory claims are 'Journey to Work' claims;
- <1% of all statutory claims are 'Journey from Work' claims;
- approximately 7% of all statutory claims costs arise from journey claims; after recoveries.

The significant disparity between 'Journey to Work' claims numbers versus 'Journey from Work' claims numbers is an interesting finding and raises an issue of significant concern. That is, the problem of non work related injuries incurred away from work that are attributable to the journey next morning to work; in un-witnessed circumstances. The 'Journey to Work' represents the first opportunity for an employee to claim a private injury as a workplace injury; the statistics tend to support claims management experience that this occurs on a regular basis.

It is sometimes asserted that journey claims often result because workers are tired after a day's work. The Q-COMP statistics do not support this argument.

Hence, a reasonable assumption can be made that approximately 7% of all statutory claims costs arise from journey claims for which no other party, other than the worker, is 'at fault' or the injuries relate to non work related events.

The WCRA at Section 35(2) mandates that for journey claims 'employment need not be a significant contributing factor to the injury'. This provision essentially removes any nexus between work and an alleged journey injury. As a consequence, the provision is quite unjust from an employer's perspective.

A legitimate question arises regarding why these journey claim costs are imposed on employers in circumstances where employers have no management control or ability to control the risks associated with worker travel to and from work. In all other life circumstances people assume personal responsibility for the risks associated with travel from one location to another. Journey claims should be treated no differently.

Moreover, journey claims can be insurable events in circumstances where others are 'at fault'; for example, motor vehicle Compulsory Third Party and public liability claims.

It is noteworthy that many other Australian jurisdictions have addressed access to journey claims and have chosen, on balance, to curtail or remove the ability to lodge journey claims.

This is a workers' compensation cost impost that warrants consideration for reform. Removing Journey Claims would remove costs from the workers' compensation system and eliminate a cost impost on employers over which they have no control.

Issue 5 - Common Law Claims

Recommendation

It is recommended that the Government consider the introduction of legislation that –

(1) *Removes the incentive for common law claims to be lodged for* injuries that are largely degenerative and non work related or have questionable work related components. *Example, a minimum 5% measured against the American Medical Assessment Guides;*

(2) *Introduces greater disciplines in the management and processing of common law claims that prevents manipulation of pleadings.*

The Queensland workers' compensation scheme is structured to provide a full range of statutory benefits for up to two years for all injured workers (up to five years for seriously injured workers) and to further compensate those work related injuries involving employer negligence through common law access. While the basic structure of this Queensland scheme needs to be retained, legislative amendment is required to redress some emerging common law practices causing adverse impacts on the scheme.

Over the past two to three decades increasing cost and long tail liability pressures have emerged from the unlimited nature of common law claims and claiming behaviour that tends to under-compensate more seriously injured workers and over-compensate for injuries that are largely degenerative and non work related or have questionable work related components. Reference here is made to -

- A growing proportion of speculative common law claims, often encouraged by lawyer advertising;
- The developing incidence of secondary psychiatric overlay of physical primary injury in common law claims;
- A significant proportion of common law claims where the level of work related impairment (WRI) is 0% or very low levels of WRI;
- Some common law claims where the extent of work related events are questionable;
- Greater legal advocacy within the statutory claims process by solicitors that impedes worker incentive to rehabilitate and return to work when a potential common law claim is in prospect. Inability to return to work is apparently argued as a means of maximising common law settlements, a practice that is counter-productive to the rehabilitation objectives of the WCRA; and
- The high proportion of costs of legal, medico-legal and investigative services.

It was once the case that common law claims were lodged only in circumstances of more serious injuries where an employer was clearly negligent. Courts required that liability (employer negligence) be properly tested. Workers with 0% WRI or lower level WRI were meant to be compensated in the 'no fault' statutory workers' compensation scheme.

However, common law claiming culture has now altered significantly. The test of liability has been eroded by precedents to the point that it is extremely difficult to defend common law claims on liability. Employers are held accountable to workplace standards that are often difficult to achieve at a practical level.

As a consequence, a greater proportion of common law claims with 0% WRI or lower level WRI are being lodged. The risk of plaintiffs not being successful on "liability" is so low that such claims are now encouraged.

A typical example of an actual claim against an ACES member, that involves a number of the elements described above, is summarised below and outlined in more detail at Attachment 2. In this particular common law claim -

- The Plaintiff has changed pleadings four times during the currency of the claim. The most recent change of pleadings has resulted from an Ergonomist and Safety Consultant's report that embellishes the event as originally described by the Plaintiff on ten separate occasions over the many months since the alleged incident was reported and a statutory claim was lodged.
- It is a claim of very doubtful veracity. The treating specialist medical evidence has found it difficult to diagnose a work related injury supportive of the claim. He reported –
    - "There is no evidence that the claimant has suffered a degree of permanent impairment;
    - I have been unable to make a diagnosis to account for the claimant's ongoing symptoms. Any restrictions are based on her symptom report and as such no formal restrictions could be prescribed;
    - I cannot account for the severity of the claimant's symptoms or their duration."
- Work related impairment (WRI) on this claim has been assessed by an independent Medical Specialist at 0% and confirmed by the treating Medical Specialist in a report that was withheld by the Plaintiff's solicitors since it was not supportive of the Plaintiff's case.

The particular circumstances of this alleged injury are so minor that the claim should never have been permitted by legislation to proceed to a common law claim.

This type of 0% WRI claim is by no means an isolated one within the Queensland common law system of compensation. It is a common occurrence as identified by Q-COMP statistics.

It goes without saying that there will be fierce resistance from certain interests to any change to the access regime involving common law claims. Both plaintiff and defendant Solicitors and Barristers derive substantial fees in common law procedures. The arguments will suggest that any change will be detrimental to the rights and welfare of workers. However, it must be recognised that these arguments will mainly arise from the legal profession who have vested commercial interests in maintaining current and higher income levels from the existing structure of the scheme.

It is not the intention of this submission to argue a position that denies common law access in cases of employer negligence and genuine significant disability.

However, to not introduce reasonable legislative change to common law claims access will continue and leave unaddressed the clearly emerging imbalances and financial strains being imposed on the Queensland workers' compensation scheme.

Employer Costs

Over the past three years, there has been an unwillingness to deal with cost pressures and imbalances in the Queensland worker' compensation scheme arising from, predominantly, common law claims costs. In addition, a Government decision to unwind some of the 1996 legislative initiatives has contributed to these cost pressures and imbalances.

The result has been a significant increase in the cost burden imposed on Queensland employers through WorkCover premiums and self-insured costs.

For the Aged Care industry, there has been a sustained, year on year, increase in the relevant WorkCover Industry Classification premium rate as summarised in the following table.

A 95% increase since 2007/2008
A 40% increase over the past 3 years.

2007/2008	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013
1.760%	1.874%	2.016%	2.456%	2.918%	3.436%

Significant rises in workers' compensation and other regulatory costs do impact the viability of Queensland businesses and the consequent capacity of businesses to grow and employ Queenslanders.

Attachment 1

Following are two TriCare self-insured claims where the treating doctor faxed medical certificates, application documentation and tax invoices to WorkCover and WorkCover then set up new claims in their system applying the claims to incorrect policies. The injured workers knew that TriCare's nursing homes are self-insured and they had already correctly lodged Applications for Compensation with ACES.

Example 1

- TriCare employee suffers an injury on 23 March 2012 and lodges an Application for Compensation with ACES on 28 March 2012. The claim is accepted and paid by ACES on 2 April 2012. Due to the quick decision on the claim, there was no interruption to the worker's normal pay cycle and therefore the worker was not inconvenienced.
- Treating doctor incorrectly faxes claim forms, tax invoice and medical certificate to WorkCover on 2 April 2012. Treating doctor faxes a further medical certificate to WorkCover on 12 April 2012. On 19 April 2012 (17 calendar days after they received the initial documents), WorkCover sends an email to TriCare advising that TriCare's employee has recently lodged an Application for Compensation with WorkCover and asking TriCare to contact them as soon as possible to help WorkCover make a timely decision on the claim. On 20 April 2012, ACES advises WorkCover to cancel their claim, which they do.

Example 2

- TriCare employee suffers an injury that had occurred over a period of time and lodges an Application for Compensation with ACES on 3 April 2012. The claim is accepted and paid by ACES on 5 April 2012. Due to the quick decision on the claim, there was no interruption to the worker's normal pay cycle and therefore the worker was not inconvenienced.
- Treating doctor incorrectly faxes claim forms, tax invoice and medical certificate to WorkCover on 2 April 2012. Treating doctor faxes further medical certificates and tax invoices to WorkCover on 14 April 2012. On 16 April 2012 (14 calendar days after they received the initial documents), WorkCover sends an email to TriCare advising that TriCare's employee has recently lodged an Application for Compensation with WorkCover and asking TriCare to contact them as soon as possible to help WorkCover make a timely decision on the claim. On 16 April 2012, ACES advises WorkCover to cancel their claim, which they do.

These are just two of a number of claims that have been observed as demonstrating the capacity of self-insurers to manage claims more efficiently and quickly.

Attachment 2

CLAIM SUMMARY

Statutory Claim	
Date of Event	**Event**
1/11/2007	Application for Compensation (Statutory Benefits) lodged for injury to right thumb and right wrist area sustained on 28/10/2007 when lifting a resident's head to put a pillow under the head. Statutory claim was accepted and paid. The injury occurred approximately 15 minutes after the claimant commenced a shift following two rostered days off work.
6/12/2007	Independent Orthopaedic Surgeon advises the diagnosis is mild tenosynovitis of the extensor tendons to the index long and ring fingers as well as the abductor pollicis longus and extensor pollicis brevis tendons of the right hand. The surgeon was doubtful that the injury occurred as a consequence of the mechanism described by the claimant. The Surgeon believed that the prognosis for a complete recovery was good and that the claimant would be able to return to her normal duties.
7/1/2008	Statutory Claim was ceased due to the medical evidence that the claimant was fit to return to normal duties as a Personal Carer.
31/1/2008	The claimant requested a review of the decision by Q-COMP
31/3/2008	Q-COMP confirms ACES's decision to terminate the claimant's entitlement to compensation.
16/5/2008	Letter received from claimant's solicitors requesting that the claimant's injury be assessed to decide if the injury has resulted in a degree of permanent impairment
7/6/2008	Independent medical practitioner advises the claimant has suffered a 0% Permanent Impairment and that the claimant's presentation at examination was consistent with over presentation and concomitant Abnormal Illness Behaviour.
11/11/2008	Claimant phoned Facility Manager and advised that she is not available for work (the Facility Manager had previously attempted on a number of occasions to contact the claimant about returning to work). The Manager advised the claimant that if she doesn't intend to return to work, she needs to provide her resignation in writing as she hasn't worked for the previous six months. The claimant advised that she will discuss with her lawyer and then get back to the Manager. However the Manager never heard from the claimant again.
Despite the fact that the claimant's position with the Nursing Centre was kept open for her, the claimant never returned to work. In May 2008, the claimant and her husband purchased a Carvery business and the claimant and her husband have continued to operate that business until the present day.	
Common Law Damages Claim	
22/12/2008	Claimant's solicitors disclose three compensation estimates from Centrelink , which advise that the claimant's solicitors had sought details of likely refunds to Centrelink should the common law damages settlement amount be $50,000, $60,000 or $70,000.

16/1/2009	Surveillance film of the claimant shows her working in the Carvery, preparing food, serving customers, making coffee, picking up items from the floor, carrying plates, clearing tables, stocking the fridge and carrying empty boxes.
16/6/2009	Notice of Claim received from claimant's solicitors. The total amount of damages sought by the claimant in the NOC was $206,735.74
27/8/2009	Claimant's solicitors advise TriCare's solicitors, in response to the request for a copy of a treating Orthopaedic Surgeon's report, (the claimant had been under the care of this Orthopaedic Surgeon) that they have still not received the report about their client's injuries and therefore are not able to provide the report to TriCare's solicitors at this stage. The claimant's solicitors also advise that they have followed up the Doctor's surgery on several occasions requesting the report and that TriCare's solicitors will receive it when they have it.
11/9/2009	Compulsory Conference – claim did not settle – final written offers: Claimant $180,000, TriCare nil
10/11/2009	TriCare is served with a District Court Plaint claiming $250,000 plus interest plus costs.
6/1/2010	Claimant's solicitors advise that they have not received the report from the Orthopaedic Surgeon to date.
3/2/2010	Claimant's solicitors provide a report dated 23/10/2009 from an Ergonomist and Safety Consultant. This Consultant based his report on an interview with the claimant (He never visited the Nursing Facility). Previously the claimant and the witness to the injury had always advised that the claimant had only lifted the resident's **head** to put a pillow under the head. However for the first time, the Consultant alleges in his report that the claimant lifted both the **head and shoulders** of the resident.
3/2/2010	TriCare's solicitors advise that they have written to the claimant's solicitors on numerous occasions requesting a copy of a report from the Orthopaedic Surgeon who had treated the claimant, which the claimant's solicitors had requested. Even as late as 14 January 2010, the claimant's solicitors had advised that the report had not been received. However TriCare's solicitors had obtained a copy of the report direct from the treating Orthopaedic Surgeon, which showed that the Surgeon sent the report to the claimant's solicitors on 10 August 2009. The report was not favourable to the claimant. The Surgeon advises in his report that: • There is no evidence that the claimant has suffered a degree of permanent impairment; • I have been unable to make a diagnosis to account for the claimant's ongoing symptoms. Any restrictions are based on her symptom report and as such no formal restrictions could be prescribed; • I cannot account for the severity of the claimant's symptoms or their duration TriCare's solicitors also advise that the report was not disclosed by the claimant's solicitors prior to the Compulsory Conference. Also not disclosed prior to the Conference, was a further letter from the Orthopaedic Surgeon

	to the claimant's solicitors dated 9/9/2009. The medical report and the further letter from the Surgeon were also not included in the Claimant's List of Documents dated 11/11/2009 or 13/1/2010 or in the Claimant's Statement of Loss and Damage dated 16/11/2009.
13/4/2010	TriCare lodges a complaint with the Legal Services Commission about the claimant's solicitors failing to disclose the Orthopaedic Surgeons' report. However TriCare's solicitors advise that the complaint will not make any difference to the management of the claim and it's probably unlikely to make any significant difference to the Claimant's solicitor. It was noted on TriCare's file at the time that although the Legal Services Commission was set up by Government, it is closely associated with the Qld Law society and is run by lawyers.
20/04/2010	TriCare's Counsel confirms TriCare's solicitors view that TriCare has good prospects of defending the claim.
12/5/2010	Legal Services Commission advise they have referred TriCare's complaint to the Qld Law Society for investigation.
30/6/2010	TriCare offers to settle the claim on the basis that the matter is withdrawn and that each party bears their own costs however no response was received from the claimant.
1/7/ 2010	Solicitors Professional Standards (Qld Law Society) advises that the claimant's solicitor has advised them that he originally held the incorrect view that the medical report dated 10 August 2009 was a draft and was unsigned and as such, it did not require to be disclosed and he had no intention of misleading TriCare's solicitors.
17/8/2010	Legal Services Commission advises that they are satisfied that the Qld Law Society (QLS)has properly investigated TriCare's complaint and they agree with the QLS's recommendation that the Commission takes no further action in regard to the complaint. The Legal Services Commission also advised that it is in the public interest not to do so rather than there is no reasonable likelihood of a finding. It is clear that the report should have been disclosed. The claimant's solicitor now acknowledges this and has indicated that he will not make a similar mistake in the future.
30/03/2011	TriCare's solicitors advise they have not heard from the claimant' solicitors for some time.
2/09/2011	TriCare's solicitors write to the claimant's solicitors advising their client has not taken a step to substantially progress the matter since the claimant delivered a Reply, to TriCare's amended Defence, on 20/9/2010 (nearly 12 months previously).
5/10/2011	Surveillance film of the claimant over a 4 day period, shows her serving customers , preparing food , carrying items, chatting with customers, clearing tables, wiping down benches, driving and alighting a vehicle.
2/11/2011	Report received from a Consultant Physician in Occupational and Environment Medicine (This Physician had been engaged by TriCare's solicitors). The physician believes the description of injury in the Claimant's Statement of Claim has been copied from the Claimant's Ergonomist and Safety Consultant's report. The Physician also comments on the fact that the Consultant ignored the Claimant's previous descriptions of the incident.

9/11/2011	TriCare again offers to settle the claim on the basis that the matter is withdrawn and that each party bears their own costs however no response was received from the claimant.
5/11/2011	TriCare's solicitors advise the claimant's solicitors that TriCare is unable to progress the matter until their client provides a Further Amended Statement of Claim, which complies with the Uniform Civil Procedure Rules.
8/12/2011	Claimant's Updated Statement of Loss and Damage received. Claimant claims the Carvery business has not been able to return a profit and as such the Claimant has not received a regular wage or salary from the business and has in fact received what is in effect a nil income from the business as confirmed by her tax returns.
18/1/2012	Bank statement received from the claimant's personal accounts and an investment loan account she holds with her husband. These statements indicate that contrary to the sworn allegations made in the Claimant's Notice of Claim for Damages and the allegations that she provided in her two Statements of Loss and Damage, the Claimant has received an income from various sources since she left TriCare. The Claimant's income tax returns indicate that she has not received an income from the business however it would appear she has received income in cash, some of which has been put in her bank account. TriCare' solicitors therefore sought clarification of the deposits from the claimant's solicitors but clarification is not provided.
7/2/2012	Claimant's solicitors request copies of TriCare's documents relating to staffing levels, duty rosters and staffing protocols/policies for the months of September, October and November 2007, which were not relevant to any of the Claimant's allegations in her pleadings.
28/3/2012	The claimant's solicitors request particulars relating to allegations first made 2.5 years previously. TriCare's solicitors responded that ,if the claimant genuinely believed that TriCare's Defence was not adequately particularised, why had she waited to now to request particulars.
17/4/2012	Q-COMP had received advice from Counsel and they advised that they shared TriCare's suspicions about income that is apparently shown in the claimant's bank accounts as it appears more likely that some of the withdrawals from the business account related to personal expenditure and would therefore be categorised as income. Q-COMP also said that it stretches credulity to suggest that the claimant alone, or she and her partner, continued to operate the business if the financial situation was so dire but they needed the primary documents upon which the claimant's tax returns were completed. TriCare's solicitors had been attempting to obtain these documents from the claimant for some time without success.
1/6/2012	TriCare' solicitors bring an Application to the Court to compel the claimant to provide the financial documents that have been requested.
21/6/2012	TriCare's solicitors advise the claimant's solicitors as follows: 'Your client has stated or sworn that she lifted the resident's head in her Notice of Claim for Damages, in the Incident Report, her Application for Compensation, in the records of a Physiotherapist, on four separate occasions to four different Doctors including the treating Orthopaedic

	Surgeon. This is a total of over 10 times that your client has reported that she lifted the resident's head only. We have also disclosed a statement from the witness to the incident who advises the claimant only lifted the resident's head. The first time that your client stated that she lifted the resident's head and shoulders was after she consulted the Ergonomist and Safety Consultant. TriCare's solicitors also advise that TriCare again offers to settle the claim on the basis that the matter is withdrawn and that each party bears their own costs however no response was received from the claimant.
26/6/2012	Claimant's solicitors bring a Cross Application to the Court requesting disclosure of documents relating to staffing levels and other information.
28/6/2012	TriCare's solicitors write to the claimant's solicitors advising: 'We have previously denied your client's requests for the disclosure sought on the basis that they are not relevant to the facts in issue in the proceedings. On 5 June 2012, almost 5 years after the incident and more than 2.5 years after first commencing proceedings, your client has delivered another amended pleading. This pleading alleges inter alia, that TriCare failed to provide at least 4 personal carers, failing to replace an absent worker and failed to provide a third worker to manoeuvre the resident'. Due to the claimant's another amended pleading, TriCare had to engage Counsel to settle the Fourth Amended Defence .
4/7/2012	TriCare's solicitors advise that both Applications to the Court were resolved in an unsealed Consent Order. The claimant is required to provide the financial documents that have been requested and TriCare is to provide the documents relating to staffing levels, which the claimant has requested.
	In TriCare's solicitors view, the main reason why the claimant's solicitors kept changing their pleadings and requesting further documents was to considerably increase TriCare's costs and then, they thought TriCare would make a commercial decision to settle the claim by paying damages.
	TriCare's total legal costs to date, including Counsels' fees and outlays is $47,901.01.
	Once all documents are provided in accordance with the Court Orders, the matter will probably go to trial unless the claimant abandons her claim.

ACES
Aged Care Employers Self-Insurance

Supplement to the ACES 17 August, 2012 Submission

to

The Queensland Parliament Finance and Administration Inquiry

Into

Operation of Queensland's Workers' Compensation Scheme

Submission by ACES employers:-
RSL Care Limited
The TriCare group of companies
Sundale Garden Village, Nambour

3 September, 2012

Issue 5 - Common Law Claims

At Page 11 of the 17 August, 2012 ACES Submission to the Queensland Parliament Finance and Administration Inquiry into Operation of Queensland's Workers' Compensation Scheme, the following reference was made.

"However, common law claiming culture has now altered significantly. The test of liability has been eroded by precedents to the point that it is extremely difficult to defend common law claims on liability. Employers are held accountable to workplace standards that are often difficult to achieve at a practical level."

The cases found at -

http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/qld/QCA/2011/253.html?stem=0&synonyms=0&query=tabcorp%20holdings%20ltd

http://archive.sclqld.org.au/qjudgment/2012/QDC12-148.pdf

are examples of the difficulty being experienced in the defence of common law claims on the basis of liability. The precedents established by these typical cases are having significant impacts on the preparedness to defend common law claims and, as a consequence, the rising number and costs of common law claims.

- Defendants are being forced to make commercial decisions to settle common law claims in circumstances where the claims should be defended on liability.
- The "fault" based nature of common law has been eroded to such an extent that the common law system operates, in practice, more like "no fault".
- The workplace safety and training standards advocated by these case precedents are costly and impracticable to achieve in a commercial, competitive workplace environment.
- If a greater number of workers chose to lodge common law claims, the Queensland Workers' Compensation scheme would not cope. This is the risk facing the scheme. The only control at present is that many workers, who would likely be successful, choose not to lodge common law claims.