OFFICIAL

South Australian Public Sector Injury Management Standards

13 December 2021

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Government of South Australia

Office of the Commissioner for Public Sector Employment

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Preamble

The South Australian Public Sector Injury Management Standards (IM Standards) seek to:

- ensure all South Australian Public Sector (SAPS) agencies understand their obligations as Crown self-insured employers under the *Return to Work Act 2014* (SA) (RTW Act)
- promote the integration of injury prevention and management into core business.

The IM Standards replace the SAPS Injury Management Practice Notes and the South Australian Public Sector Code of Practice for Self-Insured Employers. They apply to all South Australian Crown self-insured employers.

The SA Public Sector IM Standards outline requirements, policies, and guidelines for the administration of an injury management system across the public sector.

Each Standard should be read in conjunction with the legislation and policy to which it relates, including the Building Safety Excellence Strategy.

Each SAPS IM Standard includes:

- Information on the priorities reflected within the standards and the rationale for their inclusion.
- Core Requirements – the specific legislative and ReturnToWorkSA Crown Audit program minimum requirements which every agency must meet.
- SAPS Policy – specific public sector policy requirements which every agency must meet.
- Hints and Tips which may add insight, or assistance in understanding particular elements or managing particular matters is also provided where useful. These are not mandated and are for assistance only.

This document also contains various appendices (including service standards, forms, self-assessment tools and example questions) to support SAPS agencies in implementing the SAPS IM Standards. An index is also appended which lists key subjects and topics for quick reference to their specific location within the SAPS IM Standards.

Document control

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Introduction

The public sector is the largest and most diverse employer within South Australia and each agency faces a wide range of operational challenges, hazards, and risks.

In the context of their core business, each agency chief executive must develop management systems which examine, select, promote, and implement best practice approaches in both injury prevention and injury management that result in the sustainable reduction in the human and financial costs associated with work related injury.

South Australian public sector agencies are required to establish safety management systems that address the requirements of the Work Health and Safety Act 2012 and ensure that safety is given the highest priority in the work of the public sector. The Building Safety Excellence in the Public Sector Strategy provides the operational framework for agencies to develop and improve safety management systems that enable them to move towards excellence in safety performance. It assists agencies to identify challenges to health and safety and address them before they adversely impact on workers.

Public sector agencies must have a safety management system that clearly designates overall responsibility for injury prevention, recovery and return to work and claims administration to the chief executive of the organisation.

Agency chief executives must establish systems and processes for the administration of return to work claims including documented procedures for claims administration and the recovery and return to work of injured workers.

These Injury Management Standards relate to key claims management processes. They are designed to provide direction and guidance to agency-based injury management practitioners and to be incorporated into agency injury management systems and procedures. Compliance with the standards ensure that agencies meet legislative and ReturnToWorkSA Crown Audit program minimum requirements.

Standard 1 – Resources and performance

SAPS agencies are committed to meeting their legislative obligations and effectively administering their delegations as the Crown self-insured employer. To ensure this, SAPS agencies must provide appropriate human, physical, information and operational resources.

A critical function of SAPS agency executives is to understand and provide the resources required to ensure their agency can meet their legislative and operational requirements. They are supported in this function by advice and information provided by injury management units and key stakeholders.

Resources are not just limited to human, financial and physical resources, but include information, instruction, training, and systems to support injury management core functions, claims administration and return to work services.

STANDARD 1 – ELEMENT 1 – ALLOCATION OF RESOURCES

Core requirements

1.1.A To support effective claims management and return to work processes agencies will have:

- procedures describing the administration of delegations under s134 of the RTW Act including:
  - fundamental rights, principles and obligations under s13 of the RTW Act
  - claims and injury / incident reporting
  - early intervention and return to work processes
  - claim determination
  - ongoing claims' management
  - provision of suitable employment
  - financial benefits
  - serious injury claim determination and management
  - dispute resolution
  - confidentiality
- documentation which describes how the agency will achieve the Service Standard set out in Schedule 5 of the RTW Act.

1.1.B Responsibilities for Injury Management personnel, and where relevant managers, supervisors and workers are documented.

1.1.C Position descriptions for key Claims and Return to Work (RTW) personnel, and where relevant Managers, supervisors and workers are documented.

1.1.D Contingency arrangements for Claims and RTW functions in case of loss of key personnel are documented.

1.1.E Competency and training needs (including professional development) for personnel with responsibilities in claims and injury management are identified, including:

- appointing, training, and maintaining RTW Coordinators
- appointing and maintaining registration with SAET of Reconsideration Officers.

SAPS Policy

1.1.F A documented review is undertaken by the SAPS agency at least once in every three years which considers:

- the agency's risk profile based on:
    - number and type of injuries
    - number and cost of claims
- outcomes from audits and surveys
- the human resources available to administer claims and provide return to work services, including:
    - contingency arrangements in case of loss or absence or conflict of interest
    - competency of injury management personnel
    - training needs of injury management personnel including delegated decision makers
    - the currency and adequacy of role descriptions or responsibility statements of injury management personnel and relevant supervisors
    - access (and history of use) to specialist expertise and external resources such as legal counsel, medical or Return to Work providers
    - compliance with appointment, training and registering requirements
- the physical and/or electronic resources in place to maintain claim information securely
- information, instruction and training provided to roles with responsibilities in recovery and return to work processes.

1.1 Hints and Tips

Are injury and claims management resources adequate?

To identify whether adequate resources are in place, it is important to consider how things are currently operating and where improvements could be made. This requires gathering information, relevant audit reports, monthly and annual claims data, survey outcomes and complaints and considering (but not limited to) the following questions:

- How many claims were made in the last 12 months compared to the previous?
- How many claims are currently open and active?
- Are determinations and decisions being made in a timely manner?
- What sort of claims profile does the agency have, is there a prevalence of psychological injury claims, or high-risk claims?
- What is the demographic, cultural and linguistic profile of the agency? Does the profile suggest a need for information to be translated into other languages or formats? Is the workforce aging and increasing risk of musculoskeletal injury or recovery timeframes?
- Is there machinery of government changes that might impact upon claims portfolios?
- If key personnel were absent how would this impact on claims and return to work activities? How were contingency arrangements used over the last year to cover leave /absence? Were they adequate?
- Is a high level of staff turnover interrupting service delivery?
- Are key personnel with injury management responsibilities appropriately trained? Do they require any professional development?
- Do audits identify claims activities which aren’t being completed on time, or at all?
- Are physical resources adequate to ensure claim confidentiality and security? Is there potential for confidential phone conversations or web-based meetings to be overheard due to open plan office environments/shared workspaces?
- How is confidentiality and privacy managed in working from home environments?
- Have there been breaches of confidentiality in the past year?
- What do surveys tell you about achievement of the SAPS Service Standards?
- Are there significant numbers of disputes? Is this impacting upon available resources?
- How often are external providers being used, and for what purpose and cost?
- Are claims costs increasing? In what way? (e.g., income support, medical services, legal costs)

Document your answers to these questions, or similar and use this to determine your future priorities. Do you require more human resources to undertake work? Could you better utilise external providers? Would training in key functions improve service outcomes? Would reviewing or providing new procedures improve claims management practice?

It is not always going to be possible to get a bigger budget or increase staffing levels, but understanding the impact of resources and their adequacy, documenting this and communicating the outcome to senior executive provides the best opportunity of allowing them to understand whether the agency is able to meet its legislative obligations given the current resources available.

STANDARD 1 – ELEMENT 2 – MEASURING PERFORMANCE

Core requirements

1.2.A Agencies must ensure that requirements and responsibilities for identifying and documenting performance measures are included in the Injury Management or management system.

1.2.B Agencies have identified agency specific Injury Management goals and performance measures.

SAPS Policy

1.2.C Agencies monitor and report against injury management performance.

1.2.D OCPSE monitors and reports upon agency injury management performance

1.2.E Agencies record data in claim files to fulfil RTWSA data requirements for the electronic transfer of data under schedule 3 of the *Return to Work Regulations* (2015). (Self-insurer EDI (Electronic Data Interchange) technical specification)

1.2 Hints and Tips

How to identify appropriate goals for claims and injury management?

For most organisations, the best way to work out what your goals would be for the next year is to look at how you have performed in the previous one. Have audits identified that RTW plans are not being put in place for workers who are likely to be incapacitated for four or more weeks? Have surveys identified workers have not felt supported by their managers in returning to work? Consider also what are the objectives and obligations you may have under the RTW Act - your organisational goals should also enable achievement of these.

It is important to set goals which are achievable / possible but will stretch and improve performance. You also need to identify targets or strategies which will enable you to achieve your goals.

For example, let's say that in reviewing your previous years claims cost you identified that legal costs for disputes were extremely high, and dispute numbers themselves were high. The RTW Act has a primary object of reducing disputation by improving quality decision making and reducing adversarial contests, so as a goal your agency might set "Reduce the number and legal costs of disputes on new claims by 10% as compared to the prior year".

Now you need to work out how you might achieve this. Strategies may include training claims managers in conflict resolution, providing early access to interim medical benefits for claims, reviewing claims determination processes for psychological claims. Set a timeframe for these activities, or targets in terms of the quantity of training provided or audience, then identify how you will regularly monitor, measure and report on progress.

It doesn't matter if one of your strategies or all of them fail, what matters is that you measure against what you are trying to achieve to see if there is any value in continuing your strategies of if you need to try a different approach.

Standard 2 – Reporting and compensability

This standard focuses upon agencies' reporting and determination processes. Priority is placed on early notification and reporting of injury and claims to provide for early intervention and prompt determination.

The first days in the life of a claim, and initial interactions between an injured worker, their manager, claims manager and return to work coordinator can have a dramatic impact upon claim and return to work outcomes. Making sure a worker is treated fairly, with respect, empathy and honesty goes a long way towards reducing risk of future dispute and likelihood of a worker remaining at or making a timely return to work.

STANDARD 2 – ELEMENT 1 – REPORTING

Core requirements

2.1.A Responsibilities and processes in relation to the notification of work injuries are documented, including:

- the preferred method and contact for giving notice
- ensuring the following information about the injury is provided:
  - day, time, date, and place injury occurred
  - the cause of the injury
  - the nature of the injury
- requirement to forward notification of injury to relevant employer if the agency notified is not the current employer
- ensuring that where notice of injury or claim is made to a worker's manager or supervisor it is provided to the relevant injury management unit within 24 hours of receipt.
- ensuring that the claim is made in the appropriate form, within six months from the day on which the entitlement to make a claim arose and supported by an appropriate certificate.

2.1.B A documented process is in place which describes how workers will be informed about how to access support under the RTW Act. *(Schedule 5)*

2.1.C Agencies will use and provide the designated claim form for reporting and recording all claims. *(s30)*

2.1.D Where required, agencies will assist a worker to make a claim. *(Schedule 5)*

2.1.E Workers are provided with information about:

- early intervention and return to work processes (including non-claim programs)
- how to notify a work injury and lodge a claim for financial and/or medical support
- the claims administration process
- requirement to provide a current medical certificate
- injured worker and employer rights and responsibilities
- worker right of choice of medical provider
- process for complaints and disputes, including how to access to State Ombudsman and workers right to seek review of the provision of any service or employer's failure to comply with any requirement of the RTW Act.

SAPS Policy

2.1.F If notice of a work injury is provided verbally by the injured employee, SAPS agencies will request notice be verified in writing e.g., log/record via phone reporting system and agency injury/incident form in accordance with WHS system requirements.

2.1 Hints and Tips

How and what injury management information to provide?

Providing information to workers can occur in different ways, depending on your agency and preferred method of communication. It can be helpful to consider what information needs to be provided to all workers, as compared to what information needs to be provided to an injured worker (at time of injury) or to personnel with ongoing responsibilities in claims or return to work.

In general, all workers should be provided with:

- an understanding of the process of injury notification
- how claims are made (and the role of each agency as a self-insured employer)
- where to find information and claims forms
- any non-claim early intervention programs and their rights to make a claim
- grievance management processes.

Such information should be provided prior to any injury or incident, so might be provided for example at induction, through awareness sessions, and through open access intranet pages.

Information required by injured workers after an incident or injury is more specific and includes rights to access advocacy and support, information about the claims process and their rights and responsibilities, complaints, and dispute management processes, including a worker's right to lodge a complaint through the state ombudsman. Other information to consider providing might include processes for reimbursement of claim related to expenses, some general information about entitlements, the Service Standards and information on advocacy and support services. All of these things, together with claim forms and authorities to exchange medical information can be provided to workers at the time of injury (or initial notification) in a claims information pack. It is always a good idea to record the provision of this pack or information in some way, in case of any future need for record of this.

In order to make sure the agency is able to deliver on the Service Standards, it is important that information provided is appropriate and suitable with consideration of cultural and linguistic needs of the workforce. Other key requirements include that assistance is provided to workers in making a claim and they are advised of their rights to be supported by another person, or be represented by a union, advocate or lawyer. Having a process in place to ask workers about their linguistic or cultural needs and if they require help in completing claim forms or access to support services is the best way to ensure you are able to meet these service standards. This may be part of a new claim or initial early intervention checklist or form which is a good way of recording these requirements, and that they have been considered appropriately.

STANDARD 2 – ELEMENT 2 – COMPENSABILITY

Core requirements

2.2.A Agencies demonstrate evidence-based determination of entitlements and claims which may include:

- any HR/WHS investigations through liaison with relevant team
- having the worker interviewed or asking them to provide a written statement regarding their claim
- contacting supervisor/other relevant person to ascertain the circumstances and obtaining from them written statements
- obtaining reports from treating providers if worker has provided authority
- having the worker independently assessed by an appropriate specialist

2.2.B Agencies should undertake investigations and inquiries as necessary to achieve evidence-based determination of entitlements and claims. *(s31)*

2.2.C Agencies should apply appropriate tests of compensability to the claim including connection to employment, serious and wilful misconduct, and presumptive injuries. *(s7, 8, 9, & Schedule 2)*

2.2.D Claims files are maintained with supporting notes and documents to support evidence-based decisions. *(s31)*

2.2.E Determinations are provided in writing, including relevant information and notices, including review/dispute rights and the dispute resolution process.

2.2.F Claims are determined as expeditiously as practicable, where practicable within 10 business days. *(s31)*

2.2.G If claims are not determined in 10 business days workers are notified in writing of investigations and inquiries being undertaken and their right to seek an expedited decision. *(s31 & 113)*

2.2.H If a claim is not determined in 10 days an offer of interim benefits is made, which may include:

- income support: weekly payments equivalent to the rate at which the injured worker's average weekly earnings (AWE) may be set
- reasonable and necessary medical expenses: payment for 'medical services' (that is, attendance, examination or treatment by a health practitioner (including the obtaining of a certificate or report)); any diagnostic examination or test for the purposes of treatment by a health practitioner; hospitalisation and all associated medical, surgical and nursing services. *(s32)*

2.2.I If interim benefits are offered, injured workers must be advised of the potential for recovery of the amounts paid, if it is determined there was no entitlement. *(s32(3))*

2.2.J Pending claims are reviewed to ensure the determination of the claim is expedited on receipt of additional information. *(s31(4))*

2.2.K Injured workers receive communication of their entitlements under the RTW Act, including calculation of AWE, rate of income support and medical expenses.

2.2.L Weekly payment calculations must:

- factor in any prior redemptions or deeds of release, where applicable
- include or exclude prescribed non-cash benefits as required with consideration to whether the non-cash benefits are retained *(s5(13) & Regulation 9)*
- exclude prescribed allowances *(s5(14))*
- ensure AWE is not more than twice State average or less than the Federal Minimum Wage. *(s5(15)(c))*

2.2.M Where determinations are made which are unfavourable to the worker, these are communicated face to face or by personal contact (such as phone) before written notification is sent.

SAPS Policy

2.2.N For the purposes of measuring determination timeframes day zero, or date received, is the day a claim is received by the injury management unit.

2.2.O A claim for weekly payments must be submitted with a designated certificate from a recognised health practitioner or a nurse practitioner, in accordance with ReturnToWorkSA requirements. Certificates may be found at:

- https://www.rtwsa.com/media/documents/Work-Capacity-Certificate.pdf
- https://www.rtwsa.com/media/documents/nurse-practitioner-work-capacity-certificate.pdf

2.2.P In determining a claim for noise-induced hearing loss (NIHL) the following must be undertaken or applied:

- bone-conduction and air-conduction audiometric testing conducted by an appropriate practitioner *(Regulation 67)*
- a physical examination of the worker performed by a suitably qualified otorhinolaryngolist, or other approved medical practitioner *(Regulation 67)*
- where a NIHL claim is made by a worker, agencies need to be aware that the whole of the loss will be taken to have arisen immediately before the notice was given or before the person retired, whichever is most relevant, with the last noisy employer, subject to any proof to the contrary *(s188(2) & 188(3))*
- where the worker has been retired for greater than two years, agencies need to be aware that the worker does not have the benefit of the injury being a presumed injury in the absence of proof to the contrary. *(s9(3))*

Additionally, consideration should be given to obtaining:

- current and any previous audiology reports including audiograms
- the worker's entire employment history including occupations and places of employment
- any alleged exposure to noise in any work with any employer
- details of any previous NIHL claims
- details of any childhood illnesses or adult medical conditions that can impact on hearing such as otitis media or diabetes
- exposure to noise in any other activities outside of employment, for example, shooting, army reserves or car racing etc
- agency employment history including commencement and termination dates
- occupation and work location(s) during agency employment
- any previous hearing tests or audiograms undertaken by the agency
- details of any known noise level testings relevant to the agency employment
- noise level testing from the relevant agency locations(s) regarding noise levels to which the worker would have been exposed during their employment. If no noise level evidence is available, the agency may consider arranging noise level testing to be undertaken at the worker's work location(s), testing to the extent and duration of noise exposure to ascertain whether the worker was exposed to noise capable of causing NIHL. Such noise level testing should be obtained by a person with relevant expertise such as Occupational Therapist, Sound Engineer or the relevant WHS Officer from the agency.

2.2.Q Where a claim involves a motor vehicle accident the worker is requested to report the accident to the police and lodge a claim through CTP insurance regulator at this link. For additional information refer to Standard 5.

2.2.R If a claim relates to the death of a worker or potential serious injury, which may result in common law action, consideration should be given to:

- any HR/WHS investigations through liaison with the relevant team
- commencing or commissioning factual investigations into the circumstances of the matter which may include obtaining witness statements, photographs, documentary and/ or physical evidence, paying particular attention to any possible negligence.

2.2.S It is strongly recommended that prior to conducting investigations agencies refer the matter to the Crown Solicitor for advice. All correspondence, including determination letters, must comply with legislative requirements.

2.2.T In determining additional interim medical expenses, agencies should consider whether the expenses will support return to work recovery.

2.2.U All determination letters should contain the following information:

- reference to the particular claim for compensation (including the date of the Claim Form) and a description of the injury
- the date of occurrence of the injury
- the rate of weekly payments determined (if applicable)
- the worker's right to lodge a notice with the South Australian Employment Tribunal (SAET) should they disagree with a reviewable decision
- the name and telephone number of a contact person should the worker wish to discuss the determination.

2.2.V If any part of the claim is rejected, the determination must also include:

- a statement of the decision that has been made
- the sections of the RTW Act / Regulations relied upon in reaching the decision
- the reasons for the decision (including information about the evidence on which the decision is based)
- a statement of the worker’s rights to have the determination reviewed.

2.2 Hints and Tips

What is Compensable?

An injury is only compensable where it arises from employment. Employment includes:

- attendance at place of work on a working day either before or after the day begins/ends in order to prepare/leave for work.
- attendance at the workplace during an authorized break from work; attendance at the workplace but after work ends for the day or while the worker is preparing to leave, or in the process of leaving, the workplace
- attendance at an educational institution or other legal obligation or at the agencies request or approval.
- attendance at place to receive a medical service or return to work/recovery services or to apply or receive compensation for a work injury

In cases of physical injury the injury must arise out of or in the course of employment and the employment must be a significant contributing cause. In the case of psychiatric injury, the employment must be the significant contributing cause and the injury must not arise wholly or predominantly from an action or decision designated under section 7(4).

For gradually developing injury or disease consideration should be given to:

- Duration of worker's employment
- Nature of the work performed
- Particular tasks of the job
- State of the worker's health before the injury
- The lifestyle of the worker
- Activities of the worker outside the workplace

Examples of cases where an injury may <u>not</u> be compensable include:

- if the injury occurred during a journey which was not undertaken in the course of employment, such as from home to work, or vice vera and there was no real and substantial connection to employment
- the injury arose from a social or sporting activity not related to employment and was not part of the worker's employment or undertaken at the direction or request of the employer
- the injury was wholly or predominantly attributable to serious and wilful misconduct or was wholly or predominantly attributable to a drug or alcohol voluntarily consumed (other than a drug lawfully obtained and consumed in a reasonable quantity).
- a psychiatric injury arose wholly or predominantly from:
  - reasonable action taken in a reasonable manner by the employer to transfer, demote discipline, counsel, retrench or dismiss the worker or to not renew or extend a contract of service
  - as a result of reasonable administrative action taken in reasonable manner by the employer
  - as result of a decision by the employer not to award or provide a promotion transfer or benefit to the worker
  - reasonable administrative action taken in a reasonable manner by the employer in connection with the worker's employment
  - reasonable action taken in a reasonable manner under the Return to Work Act affecting the worker.

If the injury is an aggravation, acceleration, exacerbation, deterioration or recurrence of a prior injury and employment is a significant contributing cause (or in case of psychiatric injury <u>the</u> significant cause) of the aggravation/reoccurrence the injury will be compensable, but only for the extent of and duration of the relevant aggravation/recurrence.

Standard 3 – Payment of entitlements

This standard focuses on requirements relating to financial benefits under Part 4 of the RTW Act, and the processes agencies must have in place to ensure workers receive the correct entitlements.

There is a legal and ethical duty to ensure our people who have a work injury receive a high-quality service, be treated with dignity, and are supported financially.

Supporting workers financially helps keep the focus on recovery and return to work, rather than the stress of meeting day to day needs.

Timely approval and payment of medical, hospital and return to work services are one of the best ways to help workers stay at or provide for an early return to work. Provision of these services often assists in reducing disputation, by helping workers feel valued and cared for.

STANDARD 3 – ELEMENT 1 – MEDICAL EXPENSES

Core requirements

3.1.A Agencies will investigate, assess, and determine a worker's entitlement to be compensated for medical expenses expeditiously. Consideration will be given to the reasonableness of the expense, and that it is a necessary cost of:

- medical services
- hospitalisation (including all associated medical, surgical and nursing services)
- approved recovery/return to work services
- travelling or being transported, to and from any place for purpose of receiving medical services, hospitalisation or approved recovery/return to work services (but not where the worker travels in a private vehicle) (Note: if travel is in a private vehicle the worker is entitled to a travel allowance at rates fixed by a scale published by the Minister)
- accommodation away from home for the purpose of receiving medical services or approved recovery/return to work services
- attendance by a registered or enrolled nurse or by some other person approved by the agency where the worker must have nursing or personal attendance
- the provision, maintenance, replacement, or repair of therapeutic appliances
- medicines and other material purchased on the prescription or recommendation of a health practitioner
- other service or class of service authorised by the agency.
- transportation to a hospital or health practitioner for immediate treatment. *(s33)*

3.1.B If a worker has paid for the costs/charges (and these are necessary and reasonably incurred) agencies will reimburse costs to the worker, otherwise costs will be paid direct to the provider. *(s33(3))*

3.1.C Where the amount of compensation being sought is covered by a scale of charges, agencies will make payment consistent with that scale of charges. *(s33(1))*

3.1.D If a worker is charged above the scale of charges or schedule of fees, agencies can reduce the charge to the scheduled rate, but must provide a notice to the provider setting out the basis for the decision and where the charge has been disallowed.[1] *(s33(4))*

3.1.E If a charge is disallowed or reduced notice to the provider stating, why the charge was disallowed or reduced and the provider's right to have the decision reviewed must be provided. *(s33(7))*

3.1.F Where a charge is disallowed or reduced, the worker is not liable for the disallowed charge, or more than the reduced charge. Where the worker has paid the amount for which they are not liable, the agency will reimburse the worker for the disallowed or reduced charge and may then seek debt recovery from the provider. *(s33(7))*

[1] Note this decision is not reviewable

3.1.G Agencies must inform injured workers (who have not been assessed or determined to be seriously injured workers) of the end of their entitlement period relating to medical expenses, these being:

- 12 months after the last income payment
- or if there is no entitlement to income payments, 12 months from the date of injury. *(s33(20))*

3.1.H Agencies must ensure that entitlement periods for medical expenses do not apply to non-seriously injured workers, in relation to any therapeutic appliances required to maintain a worker’s capacity, or in relation to surgery or prescribed classes of injury where the agency has determined, on application by the worker that it is reasonable and appropriate for the surgery to be undertaken at a later time due to the impact or likely impact of the work injury on the worker’s health and capacity (or future health and capacity).

3.1.I Agencies will ensure that a documented process is in place for workers to apply for pre-approval of costs/future surgery and associated medical expenses and that workers are informed of this process. This process will ensure:

- applications for pre-approval of medical expenses and future surgery and associated medical expenses are made within the relevant entitlement period, save for therapeutic appliances which may be applied for at any time
- applications for pre-approval of medical expenses and future surgery and associated medical expenses are supported by medical evidence from a medical practitioner
- applications for pre-approval of medical expenses must include:
  - the worker’s full name, telephone number and address
  - the worker’s date of birth
  - the claim number
  - the employer’s name
  - the nature of the injury
  - the date the injury was suffered
  - details of the service, appliance, medicine of other materials forming the basis of the application
  - details of the reason for making the application
- workers are informed of the right to apply to abandon the timeframe beyond the entitlement period for future surgery and associated medical expenses where it is reasonable and appropriate for such surgery and associated medical expenses to be provided after the end of the entitlement period *(s33(21)(b)(ii)/(iii)/(iv))*
- agencies determine applications for pre-approval of medical expenses within one month of receipt of the application.

3.1.J Agencies will pay the costs associated with property damage which occurs as consequence of the trauma from which a compensable injury arises in accordance with the Regulations. *(s35 & Regulation 25)*

3.1.K Accounts and reimbursements must be paid within defined timeframes.

SAPS Policy

3.1.L Agencies must have a documented procedure describing how invoices are entered into the SIMS system. *(Treasurer's Instruction 11 – Payment of Creditors accounts)*

3.1.M For all undisputed invoices payment must be made within thirty days from the date received date.

3.1.N Where payment is not made in thirty days the agency will pay an interest penalty where required by Treasurer's Instruction 11.

3.1.O The date received date in SIMS will be[2]:

- for invoices received prior to the offer and acceptance of interim benefits the date received is the date on which the worker accepts an offer of interim benefits
- for invoices received prior to acceptance of liability, the date received is the date liability is accepted (that is, date claim accepted or SAET orders received)
- for invoices received after acceptance of liability the date received is the date the invoice was received by the relevant injury management unit.

3.1 Hints and Tips

What is a reasonable and necessary medical expense?

When considering whether a treatment or cost is reasonable and necessary it is important to consider:

- the appropriateness of the treatment or cost
- the availability of alternatives
- the cost
- the actual potential effectiveness of the treatment; service
- the acceptance by medical experts of the treatment as being appropriate and likely to be effect.

Examples of medical expenses where there may be no entitlement could include:

- Acupuncture not provided by a doctor or physio therapist
- alternative therapies such as those provided by a naturopath, kinesiologist or Bowen therapist
- travel to and from a pharmacy for prescriptions.

Sometimes expenses claimed as a recovery or return to work service may need to be carefully considered. In particular it is necessary that the service has been approved, either by the agency or by ReturnToWorkSA or through regulations.

[2] Treasurer's Instruction 11

STANDARD 3 – ELEMENT 2 – INCOME SUPPORT

Core requirements

3.2.A Average weekly payment calculations should be documented, and a record maintained on file.

3.2.B Weekly payments are to be made in accordance with relevant entitlement periods, with a step down at 52 weeks and, for non-seriously injured workers, cessation 104 weeks from the date of first incapacity. *(s39 & 41)*

3.2.C Where a worker is partially incapacitated for work agencies will pay the difference between the worker's notional weekly earnings and their designated weekly earnings, in accordance with the designated period entitlement.

3.2.D Agencies will have a process to provide for supplementary income support payments where a worker has an incapacity resulting from approved future surgery after the end of the second designated period. The process will ensure that:

- workers are aware of their rights and entitlements (including dates of entitlement commencing and ceasing
- the rate of supplementary payments is adjusted according to changes in the CPI and any other matter prescribed by the regulations
- payments do not continue more than 13 weeks after the surgery concerned. *(s40)*

3.2.E Where, through no fault of the worker, a weekly payment or part thereof, is not paid as required under the RTW Act or the payment is delayed pending resolution of a dispute, agencies will pay any amount in arrears with interest at the prime bank rate for the financial year at which the amount went into arrears, compounded on a weekly basis for each complete week the amount is in arrears. *(s65)*

3.2.F If a worker is undertaking alternative or modified duties which fall outside of their contract of employment (from which the injury arose) the agency must pay the wage or salary commensurate to the alternate/modified duties being undertaken. *(s19)*

3.2.G Agencies must review those calculations of AWE if:

- a component of a worker's remuneration used to calculate the worker's AWE changes
- there is a change in equipment or facilities provided or available to the worker (where relevant to AWE)
- requested by the worker. *(s45)*

3.2.H The agency must inform the worker in writing of a proposed review of weekly payments and invite the worker to provide written representations on the review. *(s46)*

3.2.I Agencies must ensure that workers are advised of their rights to seek a review of the calculation of the AWE and weekly payments; and the manner and form of how such a request should be made. *(s46)*

3.2.J Agencies must undertake a review of weekly payments for seriously injured workers each year of incapacity, and notify the worker of the proposed review, inviting them to provide feedback/written representations about the review prior to commencement. *(s47)*

SAPS Policy

3.2.K Agencies will use a documented process for the calculation of AWE and retain a copy of the calculation for future reference.

3.2.L The time clock for step downs commences from the date of incapacity first occurring, which is the date a worker first has an entitlement to income support.

3.2 Hints and Tips

A time for empathy

Many workers may face significant financial distress if they have reached the end of their 104-week entitlement period and are still unable to work at full or in any capacity. Whilst you cannot necessarily prevent this distress, you can help out by:

- having ongoing regular contact with workers about the upcoming end of an entitlement so they can plan ahead
- making sure that prior to issuing a reduction you have spoken with the worker directly and provided them information on how to access other support and services
- asking them how they are coping and listening to their concerns.
- checking in on the worker post cessation of payments to make sure they are coping and reminding them of other avenues for support.

Another aspect to consider is the end of medical entitlements, and whether this might impact a worker due to inability to access pharmacological support which may have been in place for a long period of time. Not only might this impact from a physical perspective, but psychologically, from loss of access to anti-depressant medications, or even at times dues to a pharmacological reliance on medicines such as opioids used for pain relief. To minimise impact of cessation of medical entitlements make sure workers have access to information on public health services available including mental health support networks.

Never assume that a worker is “doing ok” – always ask, make regular contact and provide information on where they can go for support if they need it.

STANDARD 3 – ELEMENT 3 – SUSPENSION, REDUCTION, DISCONTINUANCE

Core requirements

3.3.A Agencies will provide injured workers written notification of the end of the first designated period (52 weeks) and the reduction of weekly payments to 80% as soon as is reasonably practicable, but not necessarily before it takes effect. *(s48)*

3.3.B Agencies will provide written notification of the end of the second designated period (104 weeks), informing the worker of the date weekly payments will cease before the decision takes effect. *(s48)*

3.3.C Agencies must not reduce or discontinue weekly payments unless one of the following criteria is met:

- the worker consents
- the agency is satisfied based on medical certification that the worker has increased capacity for work (or for discontinuance ceased to be incapacitated for work)
- an arithmetic or clerical error is being corrected
- the weekly payments include a component for overtime and the agency is satisfied that if the worker had continued in the work, they would not have continued to work overtime, or the pattern of overtime would have changed so that the amount of overtime would have diminished
- the worker has returned to work
- the worker has returned or obtained work with another employer or as a self-employed contractor, or the worker has had an increase in remuneration as an employee or a self-employed contractor
- the worker's entitlement to weekly payments reduces because of the passage of time (entitlement periods, retirement age)
- the worker is dismissed from employment for serious and wilful misconduct
- the worker breaches the obligation of mutuality
- the worker's entitlement to weekly payments ceases or reduces because of the occurrence of some other event or the making of some other decision or determination under the RTW Act. *(s48)*

3.3.D If the agency discontinues or reduces entitlement to weekly payments, they must provide written notification to the worker setting out the decision where required by the Act (*s48(6)*):

- 14 days prior to the notice taking effect if the entitlement to weekly payments relates to a period within the first 52 weeks of incapacity
- 28 days prior to notice taking effect in all other cases. *(s48(7))*

3.3.E Where a worker disputes the reduction or cessation and makes application to SAET within one month of the decision and they can elect for recommencement of weekly payments. In this case, the agency must make a payment to the worker for any weekly payments that have not been made between the date of the decision and the date of their reinstatement (excluding any period exceeding 104 weeks). *(s48(9))*

3.3.F If the dispute is resolved in the worker's favour the agency must pay the worker the amount that would have been paid should the payments not have been discontinued or reduced, including interest at the prescribed rate (taking into account any payments made during whilst waiting for the dispute to be settled). *(s48(11))*

3.3.G The agency may recover weekly benefits paid to a worker for which they were not lawfully entitled should a reduction or discontinuance dispute be resolved in the agency's favour where that worker's payments were reinstated only on the basis of such a dispute. *(s48(9) & 48(13))*

3.3.H Agencies must have a process for determining entitlements during periods of leave, including how a worker applies for leave and notifying the worker of the suspension of weekly payments for periods of leave.

3.3.I Where an injured worker gives notice of being absent or planning to be absent from Australia for greater than 28 days, the agency must provide written notice to the worker if any suspension of weekly payments is to occur. Written notice must be made at least 14 days prior to effect and include grounds for the suspension. *(s51)*

3.3.J If an injured worker leaves Australia without giving notice the agency may suspend weekly payments to the worker. *(s51)*

3.3.K If a worker receiving weekly payments is convicted of an offence and imprisoned, weekly payments will be suspended for the period of imprisonment unless the agency decides the weekly payments should be paid to the dependents of a prisoner. *(s193)*

SAPS Policy

Nil

Standard 4 – Early intervention, recovery and return to work

This standard helps agencies realise the primary objects of the RTW Act, that is, to support workers by using an early intervention approach, realising the health benefits of work, recovering from injury, and returning to work, wherever possible.

The requirements relating to Recovery/return to work plans are included within the standard to ensure that injured workers achieve the best practicable levels of physical and mental recovery.

Recovery at work is one of the best ways to help after a work injury. It is a crucial function of agencies in the injury management process.

The South Australian public sector is considered a single employer with regards to provision of suitable employment under the RTW Act. Whilst priority is always placed on returning a worker to their pre-injury employing agency and role, options for providing suitable employment are not exhausted until the ability of all SAPS agencies to provide suitable employment have been considered and excluded.

STANDARD 4 – ELEMENT 1 – WORKPLACE INTERVENTION

Core requirements

4.1.A Agencies must ensure that return to work coordinators are appointed and maintained as required by ReturnToWorkSA in accordance with the return to work coordinator training and operational guidelines.[3] *(s26)*

4.1.B A process must be in place to undertake an initial assessment of recovery and return to work needs as early as practicable following a workplace injury. *(s23, 24 & Schedule 5)*

4.1.C Agencies must document assessment of return to work needs, including:

- consideration of engagement of return to work services
- needs associated with activities of daily living
- identifying and addressing barriers to return to work. *(s15, 23 & 24)*

4.1.D Agencies must ensure assessment and provision of return to work services and activities occurs as early as practicable and where appropriate prior to liability being determined. *(s23, 24 & 25)*

4.1.E Agencies must ensure the development of a Recovery/return to work plan where a worker is likely incapacitated for work for more than 4 weeks. *(s25(1))*

4.1.F Recovery/return to work plans must be prepared in consultation with the worker and where practicable the worker's line manager. *(s25(5))*

4.1.G As far as practicable, Recovery/return to work plans should be developed with consideration of the worker's condition, medical records and in consultation with treating health practitioners. *(s25(5))*

4.1.H If return to work is not reasonably practicable in the short term, a Recovery/return to work plan may be prepared which initially focuses on restoring the worker to the community. *(s25)*

4.1.I Agencies should ensure that the pre-injury operational area maintains contact with injured workers during any absence from the workplace, wherever appropriate. *(Schedule 5, ReturnToWorkSA Audit Tool Focus Area 4)*

4.1.J Recovery/return to work plans for seriously injured workers must not impose return to work obligations but they can, at the request of the worker, include processes to assist a return to work. *(s25(11))*

4.1.K Agencies must undertake periodic reviews of a worker's Recovery/return to work plan, including when:

- the objectives of the plan have been satisfied or completed
- there are any significant changes in the worker's capacity for work
- there are issues that need to be addressed
- there is a change in the return to work objective. *(s13(2), 25 & Reg 17)*

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[3] return to work coordinator training and operational guidelines (DOCX, 240 KB)

4.1.L Recovery/return to work plans must:

- be in writing
- be as simple and flexible as possible
- promote communication and co-operation between the relevant parties
- be appropriate to the circumstances of the worker
- include worker's name, date of birth, claim number, nature of injury, date of injury and employer's name
- include actions and responsibilities of the worker and the agency (employer) that will be undertaken to achieve the earliest possible safe return to work or if relevant return to the community
- include provisions for promoting early intervention, recovery and return to work services and the provision of suitable employment for which the worker is fit
- include specific objectives, including at least 1 of:
    - the worker's return to the pre-injury employment with the pre-injury employer
    - the worker's return to different employment with the pre-injury employer
    - the worker's return to the pre-injury employment but with a different employer
    - the worker's return to different employment with a different employer
    - the worker's return to independence within the community
- the relevant notices as detailed in RTW Regulation 15(h).

4.1.M If, within 6 months of the date of first incapacity, a worker has not returned to employment that is the same as or equivalent to pre-injury employment and they are not working to their full capacity, a review must be undertaken which considers new or other employment options to assist the worker return to suitable employment. *(s25(10))*

4.1.N A review of a Recovery/return to work plan should be undertaken, where practicable, with the worker at their work site and in consultation with line mangers and health providers. *(Reg 17)*

SAPS Policy

4.1.O The duration of a Recovery/return to work plan should be based on a worker’s individual circumstances, return to work status and corresponding medical recommendations. Review intervals should be similarly determined, but must occur as a minimum every three months.

4.1.P The agency must provide a copy of the implemented Recovery/return to work plan to the worker and manager/supervisor.

4.1.Q A SAPS Recovery/return to work plan template is available on SIMS. The template is auto populated with a worker’s claim, injury and return to work details as entered into various SIMS screens but is fully modifiable upon generation. Any modifications can be saved back into SIMS through an upload feature.

4.1.R Agencies are not mandated to use the SIMS Recovery/return to work plan template. Agencies are however, required to record data of all Recovery/return to work plans implemented for an injured worker within a reasonable timeframe.

4.1.S If an agency chooses not to use the SAPS Recovery/return to work plan template, or if they use the template but modify it, they must ensure that the plan complies with all standards and legislative requirements.

STANDARD 4 – ELEMENT 2 – SUITABLE EMPLOYMENT

Core requirements

4.2.A Agencies must offer suitable employment to workers who are able to return to work (whether on a full-time or part-time basis and whether or not to their previous employment), in line with their medical certificate and other relevant information.

4.2.B If an agency receives a worker's written notice seeking employment, that they are capable of performing, the agency must provide suitable employment, or provide a response with reasons why suitable employment cannot be provided, within four weeks from the date of receiving the notice.

4.2.C The offer of employment must, so far as reasonably practicable, be the same as or equivalent to the employment in which the worker was working before the incapacity. *(s18)*

4.2.D The agency is not required to offer suitable employment where:

- if it is not reasonably practicable to provide employment (noting that the onus lies on the agency)
- the worker left the employment with the agency (employer) before the commencement of the incapacity for work
- the worker terminated the employment (I.e., resigned).
- that new or other employment options have been agreed upon between the worker and the agency; or
- the worker has returned to work. *(s18(2))*

4.2.E Agencies inform workers of their rights to seek a review by SAET of any failure of the agency (the employer) to provide suitable employment. *(s15 & 18)*

4.2.F If a worker is not working at his or her full capacity in employment that is the same as, or equivalent to (with regards to remuneration), their pre-injury employment after 6 months from the first date of incapacity for work, the agency will consult with the worker regarding suitable alternate employment options for their return to work. *(s25(10))*

4.2.G If a worker is undertaking alternative or modified duties which fall outside of their contract of employment (from which the injury arose) the agency must pay the wage or salary commensurate to the alternate/modified duties being undertaken. *(s19)*

4.2.H Agencies will maximise recovery and return to work services in an effort to improve positive outcomes before the expiry of 104 weeks of incapacity.

SAPS Policy

4.2.I When written notice is received from a worker seeking employment under s18(3) a copy of the notice should be provided to the injury management unit and HR.

4.2.J To ensure the provision of suitable employment work injured employees are to be provided priority placement for available roles ahead of all other employees.

4.2.K Agencies must have someone responsible for identifying alternate suitable employment if return to the pre-injury work area is not possible or if a placement external to the pre-injury agency is required.

4.2.L Agencies will ensure they maximise recovery and return to work outcomes prior to 104 weeks by:

- modifying work practices where practicable to enable continued employment in the pre-injury role, or suitable alternative employment options in the pre-injury area
- considering alternative employment options where the worker has capacity for work but is unable to work in their pre-injury area or in their pre-injury role
- supporting the worker to transition into new or other employment options if applicable and ensure these are documented in the Recovery/return to work plan. This support may include:
    - information about training / retraining
    - formal training or on the job training
    - seeking feedback on work capabilities; addressing identified areas for improvement
    - vocational counselling
    - counselling and support services (to be extended to immediate family or significant others)
    - access to job interview skills
    - access to job seeking skills and techniques
    - access to career assessment and guidance
    - developmental opportunities such as volunteering or trial job placement.

4.2.M Agencies will ensure a procedure for confirming and monitoring a valid contract of employment is in place, prior to the cessation of return to work support services.

4.2.N Agencies that have not been able to place an injured employee into suitable employment within their agency can seek placement into suitable roles identified in another agency.

4.2.O Agencies with injured workers in rural/remote areas may prioritise employment opportunities available with other agencies in the same region after considering intra-agency relocation issues.

4.2.P When suitable employment in another agency is identified by the pre-injury agency and the other agency rejects the transfer, the other agency must provide documented reasons for rejecting the transfer to the pre-injury agency.

4.2.Q When a pre-injury agency and potential receiving agency are unable to agree on an employee's suitability for a target role, the matter must be escalated for resolution by negotiation between each agency's Chief Executive, or their delegate. If agreement on transfer still remains unresolved after exhausting all avenues for resolution, the matter may be referred to the Commissioner for Public Sector Employment for consideration and advice.

4.2 Hints and Tips

Barriers to a sustainable return to work

At times barriers arise which make returning to suitable employment difficult; these might include:

- a belief of the employer or the worker that a worker can't go back to work until they've completely recovered
- an employer thinking a worker is overstating how much their injury is affecting them
- disagreement or worry about whether a worker can return to work safely without reinjuring themselves
- stress factors in the workplace that might still be present
- a worker feeling, they do not have the skills to perform other work
- a worker feeling like the duties they are given are meaningless or below their capabilities.

Talking with workers about how they are feeling and being open and straightforward with workers about options available is a great place to start dismantling these barriers. Questions which you can ask workers to find out how they are feeling could include asking:

- what effect the injury has had on them, considering the whole person (physical/biological; psychological and social)?
- how much they want to come back to work? Make sure they know its ok to be honest. Better to work through any issues which might arise like "I hate my boss/my job" and try to find solutions then to leave things unsaid
- what they can do outside of work, what is their support network like? Sometimes you can find a path to wellness that is based on helping a worker achieve recovery goals that enable them to do something they love, or that helps them at home. Recovery isn't all about work – it's about the whole person
- are they worried about money as a result of the injury?
- are there stressors in or outside of work that are impacting them?
- how much they understand their injury and treatment options available?

Barriers are often effectively broken down by talking through them and making the recovery process worker centric – not work centric.

STANDARD 4 – ELEMENT 3 – HEALTH PRACTITIONER REPORTS AND EXAMINATION

Core requirements

4.3.A Reports from a health practitioner which are obtained by the agency must be provided to the worker within seven days after receiving the report. *(s182)*

4.3.B Agencies must ensure that workers are not required to submit to medical examinations (at the request of the agency) more frequently than every two months unless the worker has expressly agreed to this. *(s182)*

4.3 Hints and Tips

Managing Work Related Mental Health claims

Claims relating to psychological injury tend to be more complex and often more difficult to manage than physical injury or illness clams. In general, psychological claims are less predictable in terms of recovery and treatment as individuals with the same psychological injury diagnosis may have widely varying treatment strategies and outcomes.

Workers suffering from mental illness may feel a lack of control, helplessness and isolation, feelings which can be detrimental to achieving a sustainable and healthy return to work. It is important to manage psychological claims with sensitivity and assist workers to feel empowered and supported throughout the claims process.

Understandably in many cases of psychological injury it may be difficult to determine the root cause of the injury, to make a decision with regards to liability. This often results in workers being subjected to independent medical assessments with a focus on eligibility decisions rather than prioritisation of treatment and recovery.

Best practice management of mental illness and injury claims requires a focus on the person, and their mental health. When requesting medical reports although they may be used to assist in determination, make sure that questions asked of practitioners include a focus on restoring and supporting to worker to health. Consult with workers about the best approach for them and make certain that decisions with regards to liability are ultimately made as expeditiously as possible. Long delays in determination lead to poorer outcomes, for workers and their employers.

For more detailed information on managing psychological injury claims refer to Safe Work Australia - *Taking Action: A best practice framework for the management of psychological claims in the Australian workers' compensation sector*. https://www.safeworkaustralia.gov.au/system/files/documents/1902/taking-action-framework-2018.pdf

Standard 5 – Lump sum entitlements

The purpose of this standard is to ensure that workers are aware of their rights and receive their entitlements with respect to lump sum payments. There is a focus on legislative requirements within Part 2 Division 5 and Part 4 Division 5 - Division 9 of the RTW Act. Potential lump sum payments include entitlements for economic loss, non-economic loss, redemption of future liabilities and compensation for death.

Lump sum entitlements for economic and non-economic loss can play a very important role in providing economic stability or a chance to make significant changes to improve quality of life and undertake daily living activities. It is critical to actively monitor claims to ascertain when they are stable, and maximum medical improvement is reached so whole person impairment assessment processes can be commenced.

If a worker dies as a result of work injury, a dependent spouse, partner, child or relative may be entitled to compensation in the form of weekly payments, lump sum payments, funeral benefits and counselling services. Death claims require careful, proactive, and empathetic management, to ensure that dependents and families are provided appropriate support. Liability decisions and payment of entitlements should be prioritised and not unnecessarily delayed whilst ensuring that legal aspects are appropriately considered.

The South Australian Public Sector is committed to effective recovery, provision of employment and early and sustained return to work, however redemption of future liabilities may be considered as an option of last resort when all other efforts to return a worker to suitable employment have failed.

STANDARD 5 – ELEMENT 1 – ASSESSMENT OF PERMANENT IMPAIRMENT

Core requirements

5.1.A Agencies will have a defined process for ensuring workers are aware of their potential entitlements and rights to have a whole person impairment assessment. *(s13, 22, Schedule 5 & Impairment Assessment Guidelines (IAGs), IAGs 2nd Edn.)*

5.1.B Agencies must have a process to actively monitor claims for potential permanent impairment and ascertain when an assessment could be undertaken.

5.1.C Whole person impairment (WPI) assessments are undertaken (where the injury is stabilised) by an accredited medical practitioner and in accordance with *IAGs and IAGs 2nd Edn*. *(s22 & IAGs, IAGs 2nd Edn.)*

5.1.D Agencies will provide workers with a list of all accredited assessors and give them the option to elect a permanent impartment assessor. *(IAGs, IAGs 2nd Edn.)*

5.1.E Workers must be given the assessment request letter to review at least ten days before the letter is sent to the permanent impairment assessor. *(IAGs, IAGs 2nd Edn.)*

5.1.F Agencies should ensure that reports regarding permanent impairment are compliant with the *IAGs* or *IAGs 2nd Edn.,* whichever is relevant to the workers date of injury, and that there are appropriate processes in place to confirm compliance. *(IAGs, IAGs 2nd Edn.)*

5.1.G Where compliance of the assessment is not clear, agencies should ensure they write to the worker/representative identifying the issues of concern and what the agency wishes to put to the assessor for further clarification. This should include advising the worker/representative that they are seeking a response or feedback within 7 calendar days. If no response is received to the agency will proceed with seeking clarification as drafted. Where agreement cannot be reached regarding what clarification is to be sought, the agency may wish to seek legal advice.

5.1.H Workers must be made aware of their right of review for decisions regarding permanent impairment. *(s97)*

SAPS Policy

5.1.I The impairment assessment process should not commence until requested by the worker/representative, and before proceeding with an assessment the agency must confirm:

- there is a work injury
- the injury is permanent
- the injury has stabilised and reached maximum medical improvement.

5.1.J A worker should be advised that they are only entitled to one permanent impairment assessment of one or more injuries arising from the same trauma (including consequential injuries).

5.1.K The worker must be provided a complete list of appropriate permanent impairment assessors and consulted on selecting a suitable assessor If the worker does not wish to select the assessor, the agency should obtain a written authority from the worker for the agency to select the assessor, taking account of any requests of the worker.

5.1.L When considering the worker's choice of assessor, agencies should review the files to ensure that the worker's chosen assessor has not previously provided any form of treatment, advice, or assessment. However, if the chosen assessor has been previously involved with the worker, the agency and the worker can agree that that assessor can be used. *(Return to Work Scheme "Impairment Assessor Accreditation Scheme Service Standards")*

5.1.M The agency must provide a detailed request to the assessor and outline what injuries to assess, what not to assess, what pre-existing injuries may need to be assessed and any deductions that may be required in accordance with the *IAGs* or *IAGs* 2nd *Edn*. In a complex matter where, for example, a worker has multiple injuries from different causes or pre-existing impairment which has either resulted from a work injury or other causes and a question of what injuries should be combined arises, early consideration should be given to the need to obtain legal advice concerning the content of the letter to the assessor and the approach to combination more generally.

5.1.N Before sending the request to the assessor, a draft of the report request must be provided to the worker, allowing ten days for them to consider and raise issues, errors, or omissions with the request, prior to forwarding to the assessor.

5.1.O A copy of the assessment report must be provided to the worker within seven days of the relevant injury management unit receiving it. Due to the evolving case law in the area of assessments under section 22, and in particular the combination of injuries, agencies should give early consideration to whether legal advice should be sought concerning the determination to be made.

5.1 Hints and Tips

When should the impairment assessment process commence?

An injury should be medically stable for at least three months and be unlikely to change in the foreseeable future with or without further medical treatment before an assessment of permanent impairment should commence.

What should be considered when selecting an assessor in consultation with the worker?

Depending upon the nature of the compensable injury more than one assessor may be required to assess whole person impairment. The selection process should consider:

- the body system to which the injury related (the assessor must be accredited for that body system)
- the nature and complexity of the injury
- possible conflicts of interest
- availability of assessors
- whether multiple assessors are required.

It is important to provide the worker a full list of all the assessors that may be able to undertake the assessment relevant to their injury and impairment.

What needs to be included in the letter of request for assessment?

The letter of request needs to provide information to the assessor on what injuries to assess, what not to assess and what pre-existing injuries may need to be assessed and deducted. Additionally, if known, provide instruction on:

- which injuries should be combined in the whole person impairment
- which injuries should be assessed separately
- any information from previous assessments relevant to calculating the % of WPI
- any information on previous WPI assessments that should be deducted
- any relevant clinical studies, radiological investigations, tests and results
- information on whether the injury is part of an accepted claim or whether it is in dispute.

STANDARD 5 – ELEMENT 2 – REDEMPTIONS

Core requirements

5.2.A An injured worker, or their representative or the employing SAPS agency may initiate the redemption process.

5.2.B Agencies must ensure that seriously injured workers are aware that they must make an election on whether they intend pursuing common law damages or redemption of weekly payments, but cannot pursue both and that liabilities associated with medical services for seriously injured worker may not be redeemed. *(s53(5))*

5.2.C Where an agency notifies a worker in writing that the agency is prepared to enter negotiations for redemption, the agency must indemnify the worker for reasonable costs of obtaining professional, financial, and medical advice up to the limit prescribed by regulation. *(s53(4))*

5.2.D Agreement to redeem liabilities associated with weekly payments or medical services cannot be made unless the worker has received:

- competent professional advice about the consequences of redemption
- competent financial advice about the investment or use of money to be received on redemption
- advice form a recognised health practitioner about any future medical services, therapeutic appliances or other forms of assistance they may be likely to require on account of their work-related injury or related treatments. *(s53(2))*

5.2.E Where required, the redemption agreement should state the AWE rate and the rate of weekly payments.

5.2.F The agency must keep all documentation relating to redemption of future liabilities within the relevant claim file including:

- evidence the worker has obtained professional and medical advice
- the redemption agreement.

SAPS Policy

5.2.G A redemption should only be considered where:

- the worker's injury is stable
- potential return to work options have been considered and failed
- when necessary to resolve a claim in order to pursue a Targeted Voluntary Separation Package (TVSP), rejuvenation or early retirement scheme.

5.2.H Prior to a redemption being negotiated, the Agency should aim, where practical, to finalise the worker's entitlement to compensation for economic and non-economic loss. There is an exception to this position in circumstances where a redemption is being negotiated in connection with the offer of a TVSP, rejuvenation or early retirement scheme. In the latter case, the respective guidelines impose a condition that, prior to a payment for a TVSP, rejuvenation or early retirement scheme any outstanding workers compensation claims for the State of South Australia be finalised (which includes claims for economic and non-economic loss).

5.2.I When obtaining approval and sign-off from the Crown Solicitors Office on the redemption, current information must be provided and must consider the worker's current medical status and work capacity. Any supporting medical evidence must be current.

5.2.J Redemption agreements should be executed by the CSO, for and on behalf of the Crown in right of the State of South Australia, or in circumstances where the redemption has been the subject of advice by an external legal provider pursuant to approval under Treasurer's Instruction 10, signed by the Chief Executive, for and on behalf of the Crown in right of the State of South Australia (or their delegate, authorised to bind the State of South Australia).

5.2.K The written approval of the agency's Executive Officer, or authorised delegate, is required to negotiate a redemption.

5.2.L A redemption of weekly payments should not usually be contemplated without the worker resigning their employment from the public sector. If there is any departure from this practice, consultation is recommended with the Crown Solicitor's Office and approval is required from the agency's Chief Executive or authorised delegate. A departure from this practice does not apply to a TVSP or a rejuvenation payment.

5.2.M All redemptions are to be approved in writing by the agency's Executive Officer responsible for injury management, or authorised delegate.

5.2.N Funding approvals will remain valid for a maximum period of three months or until a date specified on the approval document.

5.2.O There is a standard redemption agreement and suite of associated documents set out in Appendix 2. For consistency, the approved suite of redemption documents must not be departed from. In rare cases, if a redemption agreement requires to depart significantly from the standard documentation, the Agency should seek advice from the Crown Solicitor's Office.

5.2.P A redemption of medical expenses only can be agreed to where it is cost effective taking into consideration the risk to government of doing so and the likelihood and type of future medical treatment, surgery and need for therapeutic appliances, and the fact that ordinarily in that case, the worker will remain employed by the agency. However, if a TVSP is involved, all claims must be finalised as required by the TVSP Guidelines including claims for medical expenses unless the agency has been granted an exemption.

5.2.Q Where a seriously injured worker agrees to a redemption representing the finalisation of their weekly payments until retirement age:

- If there is no TVSP/VSP, they will have an employment preclusion period of 156 weeks. However, if the period remaining until retirement at the time of the redemption is less than 3 years, the applicable preclusion period is derived by dividing the total weekly income payment (gross) by the gross notional weekly earnings, up to a maximum of 156 weeks.
- If there is also a TVSP/VSP, the applicable employment preclusion period in the redemption agreement will reflect the preclusion period in the TVSP (up to a maximum of 156 weeks).

5.2.R Where a non-seriously injured worker agrees to a redemption:

- If there is no TVSP/VSP, the applicable employment preclusion period is derived by dividing the total weekly income payment component of the redemption (gross) by the gross notional weekly earnings. The applicable employment preclusion period is not to exceed 104 weeks.
- If there is also a TVSP/VSP, the applicable employment preclusion period in the redemption agreement will reflect the preclusion period in the TVSP, up to a maximum of 104 weeks.

STANDARD 5 – ELEMENT 3 – ECONOMIC AND NON-ECONOMIC LOSS PAYMENTS

Core requirements

5.3.A Economic loss payments are made to workers with an assessed whole person impairment of 5%-29% providing that:

- the impairment does not arise from a psychiatric injury, consequential mental harm injury or noise induced hearing loss
- the claim is not transitional/existing claim pre-July 1, 2015
- the worker has not since died. *(s56)*

5.3.B Non-economic loss payments are made to workers with an assessed whole person impairment of 5% or more providing that:

- the impairment does not arise from a psychiatric injury, consequential mental harm injury
- the worker has not since died. *(s58)*

5.3.C Agencies must ensure that only one payment of economic and/or non-economic loss is made for any injury arising from the same trauma and must undertake a lump sum check prior to calculating lump sum payments to be made. *(s56 & 58)*

5.3.D Where two or more injuries have arisen from the same trauma the injuries can be treated and assessed as one, to the extent set out in the *IAGs and IAGs 2nd Edn. (s56(5), s57(6), IAGs & IAGs 2nd Edn.)*

5.3.E In the case of a subsequent work injury that consists of an aggravation, acceleration, exacerbation, deterioration or recurrence of a prior work injury or a new work injury for which an economic loss lump sum has been previously paid the amount previously paid must be deducted from the lump sum payable. *(s56(6))*

5.3.F In the case of a subsequent work injury that consists of an aggravation, acceleration, exacerbation, deterioration, or recurrence of a prior work injury for which a non-economic loss lump sum has been previously paid the amount previously paid must be deducted from the lump sum payable. *(s58(7))*

5.3.G The prescribed sum for non-economic loss must be calculated in accordance with the table set out in Schedule 1 of the regulations, based on the degree of WPI.

5.3.H To calculate the economic loss payment, use the equation:

LS (Lump sum) = PS (prescribed sum) X AF (age factor) X HWF (hours worked factor)

where hours worked factor is based upon the number of hours being worked by the worker at the date of injury, expressed as full-time work. *(s56(4))*

5.3.I Agencies must issue any lump sum determination in writing and include the calculation applied, any exclusions for further assessments under the same claim and the worker's review rights. *(s56, 58 & 97)*

5.3.J Agencies must ensure that all relevant documents are maintained on file.

SAPS Policy

5.3.K The final sum of amount paid must be rounded to the nearest whole dollar.

5.3 Hints and Tips

Calculating lump sum entitlements in case of aggravation of noise induced hearing loss

In *Onody v Return to Work Corporation of South Australia* [2019] SASCFC 56 (24 May 2019) a decision in the Full Court of the Supreme Court of SA provides direction with regards to the WPI threshold and calculation of non-economic payments for noise induced hearing loss (NIHL) in instances where a prior lump sum payment had been made. In particular the court found that:

- for s58 (non-economic loss) the threshold for impairment (of 5%) is considered met if the total gross hearing loss combined is equal or greater than 5%.
- For s58 calculations of payment, the amount of non-economic loss paid in previous payments is to be deducted from the total payable for the gross WPI

This decision arose from the facts of Onody. Onody made a claim for NIHL compensation in 1996 which was accepted, such that Onody received compensation for a 6% WPI.

Onody continued work in a noisy environment and made a subsequent claim for NIHL in 2016. His hearing loss was then assessed as 9% WPI. s58 of the RTW provides for a non-economic loss payment for WPI of 5% or greater. Onody claimed compensation for 9% WPI, being the gross total WPI at the time.

It was determined by ReturnToWorkSA that Onody’s impairment for deterioration of NIHL was only 3% (9% WPI less 6%WPI) and that therefore Onody did not meet the 5% threshold of s58.

Following dispute proceedings, and subsequent appeals by Onody, the matter came before the Full Supreme Court of SA.

The full court held that for the s58 entitlement threshold the gross hearing loss of 9% WPI was to be used, and the amount of compensation to be paid would be reduced by the amount of non-economic loss previously paid for the original 6% WPI.

STANDARD 5 – ELEMENT 4 – PAYMENTS ON DEATH

Core requirements

5.4.A Agencies must ensure that weekly payments, set in accordance with rates detailed in s59 of the RTW Act, are paid to entitled dependents, including supplementary allowances for care of dependent children who are in the care of a person (other than a dependant spouse or partner). *(s59)*

5.4.B Agencies must ensure that weekly payments to dependents are reviewed at least once every year. *(s60)*

5.4.C Agencies will notify entitled dependents of the right to have weekly payments commuted to a capital payment.

5.4.D Agencies must make dependents aware of their rights and entitlements, including the right to request a review of weekly payments (at an interval of not less than six months). *(s59 & 60)*

5.4.E If a review proposes a reduction in weekly payments the agency must give at least 21 days' notice to the person affected and include information on the grounds for reduction as well as the person's rights of review. *(s60(7))*

5.4.F Agencies will pay funeral benefits up to the prescribed amount (indexed according to CPI) for workers who have died as a result of work injury. Benefits may be paid to the person conducting the funeral or the person who paid or is liable for the costs of the funeral. *(s62)*

5.4.G Agencies will pay and make family members of deceased workers aware of entitlements for the cost of counselling services, payable in accordance with gazetted scales. *(s63)*

5.4.H Agencies will use the calculation methodology set out in s61 of the Act for lump sum payments to a worker's partner, spouse, and children.

SAPS Policy

5.4.I Early consideration is given to referral to the Crown Solicitors Office for advice and representation for death claims.

5.4.J Agencies will obtain a claim form, and the following information to assist in determination:

- death certificate
- proof of relationship with deceased worker
- factual investigation into the worker's death
- medical reports/opinion

  If agency liability is determined then to understand the dependency, the agency should seek

- proof of financial dependency
- forensic accountant examination and certificate of financial dependency.

5.4.K A commutation of weekly payments may not be negotiated or agreed without prior written approval of the Executive Officer responsible for Injury Management or their authorised delegate.

5.4.L Where an offer of commutation has been made, the agency cannot withdraw the offer without the agreement of the worker. *(s59(14))*

5.4.M Funding approvals for commutation will remain valid for a maximum period of three months.

STANDARD 5 – ELEMENT 5 – RECOVERIES

Core requirements

5.5.A Agencies must ensure that a procedure is in place which ensures that appropriate recoveries are made describing recoveries from third parties where a worker suffers injury as a result of third-party actions. *(s66)*

5.5.B If coercive powers to obtain evidence from a workplace are to be used, pursuant to s183 of the RTW Act, agencies must take guidance and direction from Crown Solicitor's Office.

5.5.C If a worker is injured as a result of negligence of another driver in a vehicle related incident the agency ensures that recovery action is in compliance with the applicable agreement between the State and the third party insurer (either the MAC agreement for motor vehicle accidents prior to 1 July 2016 or the Commercial Rules for motor vehicle accidents on and from 1 July 2016).

5.5.D In the case of a worker who is injured as a result of negligence of a wrongdoer which has not arisen from a motor vehicle accident, agencies must be aware of the three year time limit within which any legal proceedings are required to be issued and to ensure that timely advice is sought from the Crown Solicitors Office should it become apparent that the matter may not be resolved prior to the expiration of the time limit.

SAPS Policy

5.5.E Where a worker suffers injury as a result of the actions of a third party that gives rise to an entitlement to compensation pursuant to the RTW Act and if the worker is entitled to claim damages from that third party (the wrongdoer), the Agency will seek recovery of the compensation paid and payable by it from the wrongdoer.

5.5.F Categories of compensation that are recoverable by the Agency are:

- Medical and related expenses
- Weekly payments
- Lump sum payments.

5.5.G Expenses that are not recoverable by the Agency are:

- Return to work costs (rehabilitation)
- Legal costs
- Claims investigation costs, including the cost of medical reports.

5.5.H To exercise the statutory right of recovery for an injury to a worker, notice of intention to seek recovery must be provided to the wrongdoer as soon as practicable and, in the case of a claim against a CTP insurer, within two (2) months of the injury. This notice has the effect of a charge (see section 66(7)(e) of the RTW Act), i.e., it binds the wrongdoer to pay the amount of the notice to the Agency before it pays any common law damages to the worker.

5.5.I The notice must include details of the payments paid in respect of which recovery is sought.

5.5.J The notice must also include an estimate of future possible payments of income maintenance, medical costs, and lump sum to be made.

5.5.K Regular updates of compensation paid must also be provided to the parties involved.

5.5.L The Agency is entitled to seek recovery even if the worker decides not to pursue a claim for damages against the wrongdoer.

5.5.M However, if a worker pursues damages against the wrongdoer, the Agency will exercise its right to seek recovery of any compensation paid from any award of damages made to the worker. The worker should be advised of the Agency's intention to seek the recovery and be provided with copies of the recovery notices issued by the Agency to the wrongdoer.

5.5.N It is important to remember that the Agency's right of recovery is dependent upon the worker having an independent right to bring an action for damages against the wrongdoer arising out of the same trauma which gave rise to the entitlement to workers compensation.

5.5.O The amount of the Agency's recovery is the lesser of the amount of compensation paid or payable by the Agency on the one hand and the amount of common law damages which the wrongdoer would be liable to pay to the worker on the other hand. Therefore, if the worker is entitled to $200,000 by way of common law damages from the wrongdoer, but the Agency has paid out $300,000 in workers compensation benefits, the Agency can only recover $200,000 from the wrongdoer under section 66. The amount which the Agency may recover may be reduced because the worker's own negligence has contributed to the injuries. This is because the amount of common law damages recoverable by the worker may be reduced by the extent of the worker's contributory negligence.

5.5.P The identification of potential recovery actions, initial notification, and finalising actions to recover amounts from the wrongdoer or their insurer are the responsibility of the Agency. A potential right of recovery may not be immediately obvious. Typically, it will arise from the negligent driving of a motor vehicle by a person other than the worker, but it may also arise from:

- other forms of negligence, such as unsafe premises, failure to supervise contract staff
- vicarious liability for the negligence of contract staff on the premises
- intentional torts such as assault or battery
- breaches of contract such as the provision of faulty equipment or inadequate services.

5.5.Q If in any doubt about whether a worker's injury is the result of the tort or breach of contract of another person or organisation, legal advice should be sought. To exercise the statutory right of recovery against other insurers or persons ("wrongdoers"), proceedings must be issued in the District Court by the Agency within three (3) years of the injury. Those proceedings will be issued on behalf of the Agency by the Crown Solicitor's Office, or a solicitor appointed to act on behalf of the agency.

5.5.R In such cases, legal advice must be sought no later than two years from the date of injury, to enable adequate time for advice to be provided and the necessary pre-action Court procedures to be undertaken.

5.5.S In some cases, it may be critical that it is identified as early as possible that there may be a potential right of recovery against a wrongdoer under section 66. If the Agency's claim ultimately needs to be proven in court or under an arbitration, it may be important that evidence is preserved (such as faulty equipment) and that witnesses' memories are preserved in a statement form as soon as possible. For example, the employer's powers for determination of claim under section 31 of the RTW Act may be used to obtain a full statement from the worker about the circumstances of the injury or accident. Statements might be obtained from witnesses to the accident and police records may be sought.

5.5.T Exceptionally, the coercive powers in section 183 of the RTW Act may be used to obtain evidence from a workplace, to seize documents or to require any person to answer questions relevant to the recovery matter. Advice should be sought from the Crown Solicitor before using these powers.

Recovery in the case of motor vehicle accidents

5.5.U Often, a worker will be injured as a result of negligence of another driver in a work- related motor vehicle accident.

5.5.V In such a case, the recovery action is taken against the Compulsory Third Party (CTP) insurer. This can occur even if the negligent driver is another employee of the Agency driving the Agency's vehicle.

Motor vehicle accidents before 1 July 2016

5.5.W The insurer for accidents pre-dating 1 July 2016 is Berkshire Hathaway Insurance Group, 1300 618 389.

5.5.X Berkshire Hathaway has formally agreed to adopt the previous agreement between the State and the Motor Accident Commission (the MAC Agreement).

5.5.Y In accordance with the MAC Agreement, it is not necessary for proceedings to be issued in the District Court. It is however necessary for the Agency to provide to the Insurer amounts paid or payable by the Agency under the RTW Act. If no agreement can be reached on recovery, the matter will proceed to arbitration.

5.5.Z Despite Berkshire Hathaway binding itself to the MAC Agreement, it is strongly recommended that written confirmation be obtained from Berkshire Hathaway before the expiration of the three year limitation period for the bringing of court proceedings for recovery under section 66, that Berkshire Hathaway agrees that the provisions of the MAC Agreement apply, that the State need not issue court proceedings to enforce its recovery rights under section 66 and that, in the event that court proceedings need to be issued, Berkshire Hathaway will not take any time point.

5.5.AA The provisions of the MAC Agreement should be referred to for questions about the exchange of information between Berkshire Hathaway and the Agency and about the procedure for resolution of disputes.

Motor vehicle accidents from 1 July 2016

5.5.BB From 1 July 2016 notice of recovery is to be made to the CTP Insurance Regulator GPO Box 1095 ADELAIDE SA 5001 or via website www.ctp.sa.gov.au or 1300 303 558.

5.5.CC The CTP Insurers are bound by Commercial Rules entered into by them with the Treasurer as to the conduct of section 66 recovery claims against them by self-insured employers such as Government agencies. Clause 25 particularly deals with interaction of the CTP Insurers with self-insured employers.

5.5.DD The key features of clause 25 are as follows:

- The employer should use its best endeavours to notify the CTP insurer as soon as possible, but in any event within two months of a worker's compensation claim being made.
- The CTP insurer must not take any issue with an extension of time point, provided the employer has given notice of its section 66 claim within three years of the accident.
- Medical reports obtained by a CTP insurer with respect to a worker must be provided to the employer without charge. If the CTP insurer seeks copies of the employer's case management file under a subpoena or non-party discovery order, the documents sought must be restricted to claims forms, medical reports, medical certificates, and any determinations made from time to time and any court proceedings or correspondence arising out of those determinations.
- The CTP insurer is obliged to negotiate a fair and reasonable settlement with a worker of any common law claim brought against it by the worker. Similarly, even if the worker does not make his or her own common law claim against a CTP insurer, the CTP insurer must endeavour to negotiate a fair and reasonable settlement with the employer. There is provision for arbitration in the event of the dispute between the employer and CTP insurer not being resolved.

5.5.EE Despite the above, it is strongly recommended that, even if a section 66 notice has been provided by the employer to the CTP insurer within three years of the accident, written confirmation should be obtained from the CTP insurer that the procedure in clause 25 of the Commercial Rules will apply, that there is no need for the employer to issue court proceedings against the CTP insurer to enforce its section 66 rights of recovery and that the CTP insurer, in the event that court proceedings are necessary, will not take any issue on the extension of time point. This written confirmation should be received before the expiration of the three- year statutory limit, failing which court proceedings may need to be issued.

When recovery should not be pursued

5.5.FF Recovery cannot be pursued if the worker has no entitlement to damages from the alleged wrongdoer (that is, there is no wrongdoing on the part of the alleged wrongdoer, or the worker cannot pursue the claim against the wrongdoer).

5.5.GG However, the agency may choose to not seek recovery of compensation paid under the RTW Act from the wrongdoer if:

- the value of the recovery is negligible and outweighs the costs to the Agency in pursuing the recovery action;
- liability is denied by the wrongdoer or insurer and the chances of succeeding in recovery are poor or the costs prohibitive;
- the agency has a commercial relationship with that third party that may be negatively impacted upon by any action to seek recovery of compensation paid; or
- there is a contractual indemnity granted for the benefit of the third party that would preclude recovery of compensation paid.

5.5.HH In any of the above cases, the agency should seek legal advice before deciding not to pursue recovery.

When a recovery amount is agreed in cases not involving District Court proceedings

5.5.II In cases where an agreement has been reached with the Motor Accident Commission, the form of agreement to accept recovery is attached as Appendix 2.

5.5.JJ In cases where the agreed amount includes an amount for future payments, the agency may receive a request from the worker or their representative for payment of any unused amount.

5.5.KK It is considered that the worker has no entitlement to be paid the unused portion of the recovery amount because the money has been recovered by the Agency and it is the Agency's money and not the worker's money.

5.5.LL However, the Agency can agree to pay the unused portion to the worker either by:

- A redemption agreement under sections 53 and 54 of the RTW Act whereby the worker is paid the unused portion of weekly payments and medical costs; or
- A deed of release under section 66(h) of the RTW Act whereby the worker retains the monies. A deed of release is conditional upon the worker agreeing that any liability under the Act for the injury, including a liability to provide recovery/return to work services or to provide compensation as a seriously injured worker, is discharged.''

5.5.MM A form of a deed of release is available in Appendix 2.

Standard 6 – Reviewable decisions

The RTW Act has reducing disputation and adversarial contests to the greatest possible extent as an objective. Clear and open communication and dealing with disputes in a timely manner, with a conciliatory approach can help to achieve effective resolution of issues.

This standard promotes evidence-based decisions in compliance with the RTW Act and relevant orders of the South Australian Employment Tribunal (SAET).

STANDARD 6 – ELEMENT 1 – DISPUTE RESOLUTION

Core requirements

6.1.A Agencies must ensure that workers are advised of the process for review of reviewable decisions. *(s97)*

6.1.B Agencies must have a reconsideration officer and have notified, in writing, the Registrar of SAET tribunal of:

- the person's name
- the name of the employing agency
- the person's position in the organisation they work, or their occupation
- details of relevant qualifications or experience
- an address for correspondence
- the person's telephone number, email address and a fax number. *(s102 & Reg 43)*

6.1.C On receipt of an application for a review of a decision, the agency must assign a reconsideration officer and have the decision reconsidered in light of the matters set out in the application. *(s102)*

6.1.D The reconsideration officer must provide the SAET Registrar with written notice of the result of the reconsideration within 10 business days. This notice must include detail of whether the decision has been varied, and if so in what manner it has been changed. *(s102)*

6.1.E SAET Orders or directions issued must be complied with.

6.1.F Agencies must respond to an Application for Expedited Decision in a timely manner, including responding to correspondence from the Tribunal as to when decisions are expected to be made, within the timeframes set out by the Tribunal in its correspondence.

SAPS Policy

6.1.G Reconsideration officers must examine the history and relevant circumstances of the decision and if necessary, contact the worker or their legal representative to clarify issues and explore possible avenues for resolution of the matter.

6.1.H If on reconsideration it becomes evident that the matter should be resolved by varying the decision, the reconsideration officer should issue a Variation of Disputed Decision to the SAET and relevant parties within 10 business days.

6.1.I If the reconsideration outcome is to confirm the decision, a Confirmation of Decision Under Review must be provided to the SAET and relevant parties within 10 business days and an indexed, paginated book of relevant documents must be provided to the SAET within 21 days from receipt of the Application for Review. and a copy of the book served on the worker.

6.1.J SAPS agency staff or the Crown Solicitor's Officer or a panel lawyer approved under TI10 (if referred by the SAPS agency) must attend to the listed Initial Directions Hearings, Conciliation Conferences, Pre-Trial Hearings and Trials until the dispute has been resolved and finalised.

STANDARD 6 – ELEMENT 2 – PROVISION OF INFORMATION

Core requirements

6.2.A Agencies must ensure that workers are made aware of their right to seek access to their claim information. *(s180)*

6.2.B If an agency receives a request from a worker to provide them access to their claim file, the agency must:

- provide copies of all documents relevant to the workers claim file (which are in possession of the agency of their delegate) within 45 days of the date of request.
- where there is non-documentary material relevant to the claim this must be made available for inspection by the worker at a reasonable time and place as agreed by the agency and the worker; or if no agreement can be reached at a public office of the agency or their delegate nominated by the worker at least 45 days but not more than 60 days after the request is made (at a time during business hours nominated by the worker). *(s180)*

6.2.C Agencies must not provide to a worker material which is, either:

- relevant to an investigation of dishonesty in respect of the claim
- material protected by legal professional privilege, or
- material which by disclosure to the worker could be reasonably expected to endanger the life or safety of any person. *(s180(3))*

6.2.D Agencies must ensure workers are aware of their rights of review in relation a decision to exclude material from information provided to them under a s180 request, and that the application for review:

- must be in writing, addressed to the employing agency and provide an address in Australia to which notice of a decision should be sent
- must be made within 30 days after the day which the worker received notice of the decision (unless the agency allows longer). *(s180(5))*

6.2.E Agencies must respond to applications for review within 14 days, noting that a failure to make a decision within that timeframe will be taken to be a confirmation of that decision. The response should include the workers' rights to have the agencies response reviewed by the Ombudsman, including that any request to the Ombudsman must be made within 30 days and in the manner and form required by the Ombudsman. *(s180(7) & (8))*

6.2.F Agencies must comply with the decision of the Ombudsman.

SAPS Policy

6.2.G Where required, advice on what constitutes legal privilege must be obtained from the Crown Solicitors Office or external legal provider with approval pursuant to Treasurer's Instruction 10. The Crown Solicitors Legal Bulletin No 36C sets out information about legal professional privilege. This Bulletin can be found on the CSO website.

6.2 Hints and Tips

What is Legal Professional Privilege?

Legal professional privilege (also known as Legal Privilege) is right which protects, in certain circumstances, disclosure of:

- confidential communications (oral or written) between a lawyer and client if the communications were for the dominant purpose of obtaining or giving legal advice, or for the provision of legal services; and
- confidential communications (oral or written) between a lawyer and client if the communications were for the dominant purpose of existing or anticipated litigation (in both judicial and quasi-judicial proceedings).

When legal professional privilege applies, it enables a client to avoid disclosing the privileged communication. However, for legal professional privilege to apply the 'dominant purpose' test must be satisfied and the communication must be confidential. To be privileged, communications must be for the dominant purpose of existing or anticipated litigation, or for the dominant purpose of obtaining or giving legal advice, or for the provision of legal services.

A dominant purpose is more than a significant or substantial purpose but does not have to be the sole purpose. The Crown Solicitor's Office, Legal Bulletin No. 36C provides an example of how this test can be applied:

One practical test is to ask whether the communication would have been made (whether the document would have been brought into existence) irrespective of the obtaining of legal advice. If so, the communication (document) may not satisfy the dominant purpose test.

Documents which may be legally privileged include for example:

- emails, letters, file notes relating to discussions between the agency and the Crown Solicitor's Office, legal officers or other legal representatives
- advice from the Crown Solicitor's Office, legal officers or other legal representatives
- surveillance reports (if obtained in anticipation of litigation)
- factual Investigations (if obtained in anticipation of litigation and not merely to establish circumstances of an injury)
- lump sum funding requests/approvals
- strategic claim file reviews undertaken in assumption of pending litigation.

Can Legal Privilege be lost?

Legal professional privilege can be waived intentionally or unintentionally, and once waived may need to be disclosed in litigation or under the Freedom of Information Act 1991 (SA). Legal privilege will be lost if the agency does something inconsistent with keeping the communication confidential, for example telling a third party about the advice received. Even where the information provided is generalised, privilege on the communications regarding that legal advice would be lost. Importantly this may also mean that legal privilege of any other documents relating to the advice disclosed might also be lost.

For more information on Legal Professional Privilege please see Crown Solicitor's Office, Legal Bulletin No. 36C.

Standard 7 – Seriously injured workers

The RTW Act makes special provisions for workers who are seriously injured. These include income support until retirement age, lifetime treatment, care and support services, payments for non-economic loss and the option to pursue damages at common law.

This Standard focuses upon processes to support seriously injured workers and ensure they receive their entitlements under the RTW Act.

STANDARD 7 – ELEMENT 1 – SERIOUSLY INJURED WORKERS

Core requirements

7.1.A Agencies will ensure that workers are made aware of their right and the associated process to apply to be taken as a seriously injured worker on an interim basis in accordance with the Regulations. *(s21(3) & Reg 13)*

7.1.B Agencies will ensure there is a process used to consider whether or not to make an interim decision to the effect that a worker will be taken to be a seriously injured worker in the absence of an application by the worker.

7.1.C Interim decisions that a worker a worker will be taken to be a seriously injured worker must be based on evidence from a medical practitioner and must be made in consultation with the worker. *(Reg 13)*

7.1.D Communication processes must be in place to inform an injured worker who has been assessed to have a WPI of greater than 30% or who has been taken to be seriously injured by virtue of an interim decision of their status and resulting entitlements.

7.1.E Agencies must have a process which triggers consideration of serious injury status throughout the life of a claim for the purpose of early identification of seriously injured workers.

7.1.F Agencies must ensure that interest on back-pay entitlements resulting from an interim decision is provided where applicable. *(s21(6), 21(7) & S65))*

7.1.G Agencies must ensure that Recovery/return to work plans or care plans for seriously injured workers do not impose any obligations to return to work, but may provide support for a return to work if requested by the worker. *(s25(11))*

7.1.H A plan describing the services, care, and support to be provided to the seriously injured worker to assist restoration to the community should be developed in consultation with the worker, where appropriate. *(s25(2))*

7.1.I Agencies must ensure that a person whose permanent impairment has been assessed under the repealed Act at 30% or more is taken as seriously injured. *(Schedule 9 clause 34(1))*

SAPS Policy

7.1.J Agencies will follow processes for permanent impairment assessments as described in SAPS Injury Management Standard 5.

7.1.K When considering any interim decision on serious injury, advice may be sought from the Crown Solicitor's Office where appropriate.

7.1 Hints and Tips

Should a Recovery/return to work plan be in place for a seriously injured worker?

In most circumstances a Recovery/return to work plan should be in place for a seriously injured worker, providing of course that the plan does not impose any obligation on a seriously injured worker to return to work.

It is permissible under s25(2)(d) of the RTW Act, to not prepare a plan, if the agency decides that due to severity of injury a focus should be on other forms of support, however this exception includes the provision that this should only be an exception "*unless or until the worker becomes capable of participating in a plan*".

A Recovery/return to work plan which focuses on services and support to be provided to a seriously injured worker and places no obligation to return to work is a great way of ensuring the requirements and spirit of the legislation are met and supporting seriously injured workers to remain connected and involved in their recovery and restoration to the community.

STANDARD 7 – ELEMENT 2 – COMMON LAW DAMAGES

Core requirements

7.2.A Seriously injured workers whose assessments result from new injuries under the RTW Act must be made aware of their right to elect to pursue common law damages. Any such election must be made within three years of the date of injury. *(s73, Reg 39 & Civil Liability Act 1936 SA)*

7.2.B Agencies must ensure that workers are aware they cannot commence action for damages or pursue a redemption until an election is made. *(s73)*

7.2.C Agencies will ensure that workers have obtained legal advice prior to electing to pursue common law damages, and that they are provided their entitlements to legal costs for this advice. *(s73(6))*

SAPS Policy

7.2.D An agency must, if there is possible negligence, breach of statutory duty or other tort, and particularly in the case of a death or serious injury:

- refer the matter at an early stage to the Crown Solicitor's Office for advice regarding any investigation. In doing so, the agency will be more likely to be able to protect against the disclosure of confidential material captured by legal professional privilege, including documents or materials arising from those investigations
- subject to the legal advice provided, commence or commission factual investigations into the circumstances of the matter, which may include obtaining witness statements, photographs, documentary and/or physical evidence, paying particular attention to any possible negligence. Consideration must be given to any HR/ WHS investigations through liaison with the relevant team in the agency, prior to commencing the investigation. Agencies should aware that the product of agency-driven investigations conducted prior to seeking legal advice will probably not attract the protection of legal professional privilege and will need to be disclosed and produced in proceedings.

7.2.E If a worker elects to pursue common law damages, agencies must refer conduct of the matter to the Crown Solicitor's Office.

7.2 Hints and Tips

What are common law damages under the RTW Act?

Common law damages are a monetary remedy for injury or loss sustained by a worker due to negligence or other tort of their employer (or other party through vicarious liability). Damages are assessed and awarded by the court. A worker is only able to access common law damages if their degree of whole person impairment is assessed at 30% or more and:

- in the case of a compensable physical injury, the assessment has no regard to impairment that results from psychiatric injury or consequential mental harm
- in the case of a compensable psychiatric injury, results primarily from the negligence or other tort of the worker's employer and not from any consequential mental harm.

Common law damages are restricted to damages for economic loss not non-economic loss and do not include damages with respect of treatment, care support services.

Standard 8 – Performance monitoring

SAPS agencies are obligated as the Crown self-insured employer, to ensure that they effectively administer their delegations pursuant to s134 of the RTW Act. These delegations include the fundamental principles and obligations described in s13 and the Service Standards set out in Schedule 5 of the RTW Act.

It is imperative that agencies proactively measure, monitor and report to ensure that legal and other obligations are met, and the highest possible standards of service are provided to injured worker.

STANDARD 8 – ELEMENT 1 – SERVICE STANDARDS

Core requirements

8.1.A Agencies will undertake periodic assessment or audits to verify that processes and procedures are in place to ensure the agency meets the Service Standards of the Act implemented. *(ReturnToWorkSA Audit tool Focus Area 8)*

8.1.B Agencies will have processes to enable a worker who has a concern about whether the agency has complied with the Service Standards to raise the issue with the agency and understand their right to escalate to the Ombudsman. *(Schedule 5, Part 3 and 4)*

8.1.C Agencies must consider and address issues associated with operation of the Service Standards and:

- monitor and analyse any issues arising from complaints processes
- identify and address concerns with operational policies and processes
- inform workers of steps undertaken to address their concerns and prevent reoccurrence of breaches or failures.

SAPS Policy

8.1.D Agencies will work with a person lodging a complaint to address and resolve problems and concerns in an effective way, advising the complainant of what steps have been taken.

8.1.E Agencies will advise of the procedure that can be followed to lodge a complaint with the State Ombudsman if the complainant is not satisfied with the resolution of the matter by the agency.

8.1.F Agencies must provide a response to a complaint within 10 business days after the complaint is lodged or, if the matter requires extended investigation, an interim response will be provided within 10 business days with an indication of when a final response will be provided.

8.1.G If it is found that the agency has breached any of the Service Standards, the agency must do one or more of the following remedies:

- provide a written or oral apology
- furnish a written explanation
- meet with the worker to consider their views and to achieve a resolution of the matter
- provide information to the worker, outlining, where relevant—
  - the status of any claim and extent of entitlements
  - the review rights that exist under the RTW Act
  - the services that are available and the timeframes that should apply in relation to a dispute.
- provide the worker with a copy of their file in accordance with section 180 of the RTW Act or under the *Freedom of Information Act 1991*
- invite feedback about any response and ensure that any questions are answered, or requests are responded to in an appropriate manner
- take any other reasonable steps to remedy the matter.

8.1 Hints and Tips

Implementing the Service Standards

All agencies are required to meet the Service Standards, as part of their obligations as a self-insured Crown employer under the RTW Act.

SAPS Service Standards have been developed to help detail more specifically how agencies will meet each of the Standards, and these have been included, along with a template complaints process for breaches of the Standards, as an appendix to these SAPS Injury Management Standards.

Each SAPS injury Management Standard also includes a selection of the most applicable SAPS Service Standards along with self-assessment criteria which could be tested through audit and/or survey.

SAPS agencies are encouraged to provide the SAPS Service Standards and complaint policy to workers as part of the initial information pack provided at time of injury. Agencies should also use the self-assessment criteria to measure and understand the agencies level of achievement of Service Standards and where necessary implement corrective actions to address any improvement opportunities identified.

STANDARD 8 – ELEMENT 2 – PRINCIPLES, OBLIGATIONS & LEGISLATVE COMPLIANCE

Core requirements

8.2.A Agencies have identified and implemented strategies to monitor, measure and review claims administration and recovery and return to work services and verify the requirements of the RTW Act and associated regulations have been met. *(ReturnToWorkSA Audit Tool Focus Area 8)*

8.2.B Agencies identify and implement strategies to improve injury management outcomes and practice where relevant. *(ReturnToWorkSA Audit Tool Focus Area 8)*

SAPS Policy

8.2.C Agencies will undertake a periodic audit to verify the effective implementation of injury management processes and administration of delegations.

8.2.D Where deficiencies in performance or processes are identified agencies will undertake corrective actions to address these.

8.2 Hints and Tips

Fundamental principles, rights and obligations and SAPS agencies

The RTW Act delegates s13 Fundamental principles, rights and obligations to self-insured employers (including Crown), which means that agencies, for the purposes of the RTW Act, must:

- adopt a service-orientated approach that is focused on early intervention and the interests of workers and the agency (as an employer)
- seek to act professionally and promptly in everything the agency does
- be responsible and accountable in its relationships with others
- take reasonable steps to comply with any request made by a worker to review the provision of any service to the worker under the RTW Act or to investigate any circumstance where it appears that the agency is not complying with any requirement of the RTW Act as to the retention, employment or re-employment of the worker
- develop and maintain plans or strategies that are designed to establish practices and procedures under which the specific circumstances of an injured worker the agency will be addressed and with the objective of:
    - ensuring early and timely intervention occurs to improve recovery and return to work outcomes including after retraining (if required)
    - achieving timely, evidence-based decision-making that is consistent with the requirements of the RTW Act
    - wherever possible, providing a face-to-face service where there is a need for significant assistance, support or services
    - ensuring the active management of all aspects of a worker's injury and any claim
    - encouraging an injured worker and the employing agency to participate actively in any recovery and return to work processes
    - minimising the risk of litigation.

Agencies need to consider how they will meet these obligations. For example, what strategies and could be put in place to reduce the risk of litigation? What plans might be implemented to provide face to face assistance and when would this occur? Agencies should detail activities or strategies against each obligation, and then use audit, survey, or other mechanisms to measure and monitor whether or not the strategies are achieving the desired outcomes.

STANDARD 8 – ELEMENT 3 – CONFIDENTIALITY

Core requirements

8.3.A Agencies must have suitable facilities to ensure confidentiality can be maintained whilst interacting with workers and service providers. *(s185)*

8.3.B Agencies will ensure information is stored securely and access is only available to persons with relevant access authority. *(s185)*

8.3.C Information such as meeting minutes which are disseminated widely should be checked to see if there is claimant information or confidential details and if there is, the information should be redacted. *(s185)*

SAPS Policy

8.3.D If a worker has income protection insurance attached to their superannuation, they may make a claim for income protection payments, and Super SA may request any information required to access and process the claim for Income Protection Payments or Death or Total and Permanent benefits from the employing agency. *(Southern State Superannuation Act 2009 s26)*

8.3.E When making a claim for income protection payments, the worker should provide the name of their claims consultant to Super SA as the contact. Super SA has developed a Notice of Release of Information Form (refer to Appendix 3) which can be distributed to claimants as required.

8.3 Hints and Tips

When can information about a worker's claim, physical or mental condition be disclosed?

There are some circumstances in which an agency, as an employer and self-insurer under the RTW Act may disclose information about a worker, or their claim. These circumstances include:

- if it is reasonably required for, or connected with the carrying out of the proper conduct of the business
- in connection with the operation of the RTW Act
- made with consent from the person to whom the information relates
- required by a court or tribunal
- authorised or required under any other Act or law
- made to ReturnToWorkSA or the Lifetime Support Authority of SA
- for purpose of entering agreement with the Lifetime Support Scheme in accordance with the *Motor Vehicle Accidents (Lifetime Support Scheme) Act 2013* (SA)
- authorisation by the Minister
- where authorised by regulation.

Appendix 1: South Australian Public Sector Service Standards

These standards are designed to encourage positive relationships between SAPS agencies, workers and providers and acknowledge the need to work together to achieve the best outcomes for all, especially by adopting early intervention and return to work processes when a worker is injured at work.

The SAPS Service Standards describe what workers and service providers can expect from SAPS agencies and will be implemented to ensure that agencies provide service of the highest standards and fairness.

Each SAPS agency will undertake periodic audits and survey to understand their level of achievement of these service standards, and where applicable implement actions to improve the standards of service provided.

Service Standard 1 – Agencies will view a worker's recovery and return to work as the primary goal if a worker is injured at work

Agencies will:

- provide resources to support Claims Managers and Return to Work Coordinators to identify support and services for workers
- identify meaningful suitable duties for injured workers
- actively encourage injured workers to participate in Recover/return to work plans and services
- keep workers and their health providers informed of available services and support
- always promote the health benefits of work.

Service Standard 2 – Agencies will ensure that early and timely intervention occurs to improve recovery and return to work outcomes including retraining (if required).

Agencies will:

- intervene as soon as possible when a worker is injured, and where needed consider retraining workers to help them return to work if required
- contact workers within 3 days of being notified of their injury or claim
- assess a worker's need for recovery and return to work services through an initial needs' assessment within 10 business days from date of first incapacity
- identify pathways to return to work and consult with workers about all possible opportunities.

Service Standard 3 – With the active assistance and participation of workers and their line managers, agencies will ensure that recovery and return to work processes focus on maintaining the relationship between workers and their work managers and colleagues.

Agencies will:

- ensure that they actively consult and collaborate with workers and their line managers about return to work decisions and strategies
- arrange face to face visits to meet with workers, to discuss any issues, barriers, or opportunities to ensure the best outcomes possible.

Service Standard 4 – Agencies will ensure that line managers and relevant stakeholders are aware of and fulfil their recovery and return to work obligations because early and effective workplace-based coordination of a timely and safe return to work benefits an injured worker's recovery.

Agencies will ensure understanding and fulfil RTW obligations by:

- providing information, advice and support to workers, managers and RTW coordinators
- helping managers identify suitable duties for injured workers
- training managers and RTW coordinators in their roles and responsibilities where required.

Service Standard 5 – Agencies will treat workers and providers fairly and with integrity, respect and courtesy and comply with stated timeframes.

Agencies are committed to providing the highest level of service and will:

- be respectful, courteous, and clear in communications
- complete actions and follow up on requests within agreed timeframes
- if a time frame cannot be met, contact the relevant stakeholder, and let them know
- respond to emails and phone calls within three business days, and written letters within 10 business days
- ensure accounts are paid and workers are reimbursed within 30 days of receipt.

Service Standard 6 – Agencies will be clear about how they can assist workers to resolve any issues by providing accurate and complete information that is consistent and easy to understand (including options about any claim, entitlements, obligations, and responsibilities).

Agencies will:

- provide clear accurate information in an easy-to-understand format suitable for the end user
- seek to understand any issues or concerns and help to resolve them
- provide unbiased, objective information to workers about claim entitlements, obligations, and responsibilities
- make sure that avenues for feedback and issue resolution are clear and always available.

Service Standard 7– Agencies will assist a worker in making a claim and if necessary, provide a worker with information about where the worker can access advice, advocacy services and support.

Agencies will

- be flexible in the way they receive and provide information
- assist RTW coordinators, workers, and their managers in completing claim documentation where needed
- provide information on how to reach or access other services if needed.

Service Standard 8– Agencies will take all reasonable steps to provide services and information in a worker's preferred language and format, including through the use of interpreters if required, and to demonstrate respect and sensitivity to a person's cultural beliefs and values.

Agencies will

- always check to make sure they are providing information and services in the right language and format for workers at the start of any claim process and use interpreters where required
- be sensitive to the needs, values, and beliefs of workers.

Service Standard 9– Agencies will respect and maintain confidentiality and privacy in accordance with any legislative requirements.

Agencies will:

- only provide information when permission has been granted to disclose it, or where legislation requires them to
- put in place security protocols to ensure a worker's information is always confidential and cannot be accessed by anyone who does not have access authority.

Service Standard 10– Agencies will provide avenues for feedback or for making complaints and be clear about what can be expected as a response.

Agencies will:

- provide information to workers on how they can provide feedback or make a complaint, and how the agency will manage these
- ensure rights of review and appeal are clearly detailed where relevant in correspondence with workers
- always respond to complaints within 10 business days.

Service Standard 11– Agencies recognise the right of a worker to be supported by another person and to be represented by a union, advocate, or lawyer.

Agencies will:

- provide information to workers about rights to support and advocacy, and where applicable where to find these
- invite workers to have a representative with them when meeting face to face
- respect representatives and advocates and their role in supporting workers.

FEEDBACK AND COMPLAINTS ABOUT THESE SERVICE STANDARDS

The priority of (**Agency Name**) is to provide workers and providers with the highest standards of service and help to achieve the best possible outcomes. If you have any concerns about the services, we are providing please let (**Agency Name**) know directly by talking with or contacting the individual who had been providing you the service.

If for some reason you are not comfortable discussing your feedback with the individual concerned, you can contact the (**nominated agency representative**) at the details below:

(Name)

(Position- Agency)

(Address)

(mobile) (email)

If you raise a complaint, we will make sure we respond to you within ten business days, and work with you to resolve any concerns.

If you remain unsatisfied after working with us or we have not suitably addressed your concerns and they relate to services provided under the *Return to Work Act 2014* (SA) you can lodge a complaint with the Return to Work Complaints Team who can be contacted on: 13 18 55 or complaints@rtwsa.com

If you are not satisfied with how ReturnToWorkSA's Complaints Team has handled your complaint, you have the right to refer the matter to the State Ombudsman for investigation.

Appendix 2: South Australian Public Sector Forms

The following SAPS forms and templates are provided for agency use:

- Discharge – Compulsory Third Party Insurer
- Deed of Release pursuant to section 66(7)(h)
- Annexure A to Deed of Release
- Annexure B to Deed of Release
- Super SA Notification of Release of Information
- Redemption agreement
- Annexure A to redemption agreement
- Annexure B to redemption agreement
- Annexure C to redemption agreement
- Annexure D to redemption agreement
- Resignation letter for redemption agreement
- Payment authority for redemption agreement.

Your Reference:
Our Reference:

DISCHARGE

1. Subject to clause 2 hereof, the NAME OF INSURER will pay and the State of South Australia in right of the NAME OF AGENCY (the State) will accept the sum of $ ***** .** in full and final satisfaction of the entitlement of the State of South Australia in right of the NAME OF AGENCY pursuant to section 54 of the pursuant to section 66 of the Return to Work Act 2014 ("RTWA") to recover from the NAME OF INSURER the amounts of compensation paid or payable by it to ***name***** (the worker) as a result of injuries sustained by the worker in the motor vehicle accident details of which are set out in the Schedule below.

2. In the event that the worker shall subsequently make a claim against NAME OF INSURER and recover, whether by judgment, settlement of otherwise, damages in a sum in addition to the amount referred to in clause 1 hereof ("the excess damages") the release given by the State in clause 1 does not extend to prevent or in any way bar the State from giving notice of, and enforcing, a first charge pursuant to section 66(7) of the RTWA on the excess damages.

SCHEDULE

DATE OF ACCIDENT: *
PLACE OF ACCIDENT: *
INSURED: *
WORKER: *

DATED the ** of ** 2021

………………………………………………….. ………………………………………………….

Duly authorised officer of the STATE OF SOUTH AUSTRALIA	Duly authorised officer of
(in right of THE (NAME OF AGENCY)	(NAME OF INSURER)

RETURN TO WORK ACT 2014 - SECTION 66 (7)(h) DEED OF RELEASE

IN THE MATTER OF SECTION 66(7) OF THE RETURN TO WORK ACT 2014

- and -

IN THE MATTER OF AN AGREEMENT BETWEEN:(insert name of worker)

"Worker"

- and -

THE STATE OF SOUTH AUSTRALIA IN RIGHT OF (NAME OF AGENCY)

"Self Insured Employer"

(the parties)

WHEREAS:

A. The worker was at all material times employed by the Self Insured Employer (NAME OF AGENCY) as a (occupation) for and on behalf of the Crown in right of the State of South Australia.

B. On or about [insert date of injury] the worker suffered a work injury (the injury) out of her/his employment with the Self Insured Employer (NAME OF AGENCY) particulars of which are as follows –

-

C. The Worker has received or has an entitlement to damages from another person (**the wrongdoer**) pursuant to rights arising from the same trauma as gave rise to the rights to compensation under the Return to Work Act 2014 (**the RTWA**).

D. The Self Insured Employer has paid compensation to the Worker and but for this Deed of Release continues to be liable to pay compensation to the Worker in respect of the injury and pursuant to the RTWA.

E. Pursuant to section 66(7) of the RTWA, the Self Insured Employer is entitled to recover from the Wrongdoer the amount of compensation paid or payable to the Worker under the RTWA.

F. Pursuant to section 66(7)(h) of the RTWA, the parties wish to enter into this Deed of Release (**Deed**).

AND IT IS HEREBY COVENANTED AGREED AND ACKNOWLEDGED by the parties that -

1. The amount of compensation paid and payable by the Self Insured Employer to the Worker and which is to be recovered from the wrongdoer has been agreed in the sum of $ xx (the compensation).
2. The Self Insured Employer and the Worker agree that after the Self Insured Employer has recovered the full amount of compensation the Worker is entitled to retain the balance of damages paid or payable to the Worker by the Wrongdoer in the sum of $xx and that the Self Insured Employer has no title or interest in such balance of damages.
3. The Worker agrees that any liability by the Self Insured Employer to the Worker under the RTWA in respect of the injury is discharged and the Worker hereby releases the Self Insured Employer, its agents and assigns and agrees to hold them harmless against any past, present, or future action, suit, claim, or demand made by the Worker or on behalf of the Worker in respect of any liability whatsoever by the Self Insured Employer to the Worker under the RTWA arising out of the injury, and without limiting the general nature of the release including all income maintenance, lump sum compensation, expenses for medical treatment and the like, recovery and return to work services and all other obligations under the RTWA consistent with section 66(7)(h)(ii) of the RTWA.
4. The Self Insured Employer in its capacity as the employer of the worker has no further obligation to provide suitable employment to the worker consistent with section 66(7)(h)(iii) of the RTWA from and after the execution of this Deed and the receipt by the Self Insured Employer of the full amount of the compensation.
5. The worker HEREBY INDEMINIFIES the Self Insured Employer and its agents, servants, officers, successors, insurers and assigns and agrees to hold them harmless against any past, present, or future actions, suits, causes of actions, proceedings, claims or demands made by any person or entity for payment, repayment or reimbursement of all or any damages, costs, expenses or benefits of any type arising out of or in any way connected with the injury.
6. The Worker warrants that they have received competent professional advice about the consequences of entering into this Deed, as evidenced by Annexure “A”.
7. The worker warrants that they have received competent financial advice about the consequences of entering into this Deed, as evidenced by Annexure “B”.

Entire Agreement

8. The parties agree that this Deed constitutes the entire agreement of the parties in respect of the matters dealt with in this Deed.

Severance

9. If any part of this Deed is or becomes void or unenforceable that part is, or will be, severed from this Deed so that all parts that are not or do not become void or unenforceable remain in full force and effect and are unaffected by that severance.

Counterparts

10. This Deed does not become binding on the parties until it has been signed by all parties.
11. This Deed may be executed in any number of counterparts, which together will be taken to constitute one deed. Where counterparts are used the date of the deed will be the date

that the last counterpart is delivered to all parties

12. An executed copy of this Deed may be exchanged by email. An email transmission copy of this Deed signed and witnessed in counterpart will be deemed an original of this Deed.

Governing Law and Jurisdiction

13. This Deed is governed by the laws of South Australia. The Courts of the State of South Australia have exclusive jurisdiction in relation to this Deed.

Authority to Execute

14. Each party to this Deed warrants that any person executing the Deed on the party's behalf has the authority to do so.

DATED the day of 2021

EXECUTED as a Deed

SIGNED by the worker

…………………………………………………

Signature of (insert name of Worker)

In the presence of:

…………………………………………………

Signature of (insert name of Witness)

…………………………………………………

Witness Name

SIGNED for and on behalf of THE STATE OF SOUTH AUSTRALIA in the right of (insert name of agency)(the Self Insured Employer)

…………………………………………………… in the presence of:

ANNEXURE “A” PROFESSIONAL ADVICE

SUBJECT: Release of liability under section 66(7)(h) of the *Return to Work Act 2014*

I, ... (the worker), have received competent professional advice about the consequences of entering into a deed of release (this Deed) under section 66(7)(h) of the Act from …………………………….. as required by section 66(7)(i)(i)

of the Act.

Although not limited to, I have received advice on the following:

- That on signing this Deed and receipt of the balance of damages I have no further entitlement to payment of any income maintenance, lump sum compensation, expenses for medical treatment and the like, recovery or return to work services and all other obligations under the RTWA consistent with section 66(7)(h)(ii) of the RTWA in relation to the injury described in recital A.
- That on signing this Deed and receipt of the balance of damages I may not be able to claim medical benefits from Medicare nor my health fund for treatment regarding my injury described in recital A.
- The application of section 49(3) of the Act and that on signing this Deed and receipt of the balance of damages, I acknowledge that in the event of another claim I may be taken to be receiving weekly payments of $0.00 for the purpose of section 49(1) of the Act.
- Taxation implications of signing this Deed and receipt of the balance of damages, if any. In particular, I have been advised that I may seek a private ruling in accordance with the Income Tax Assessment Act 1997.
- Centrelink implications in relation to receipt of the balance of damages. (Information available from the South Australian Centrelink Compensation Recovery Team on 8402 8088).
- Housing SA implications in relation to receipt of the balance of damages, if any. (Information available from Housing SA’s Benefit Review Branch on 1300 728 600).
- That after receipt of the balance of damages in the sum of $xx the Self Insured Employer has no further obligation to provide suitable employment to me.

…………………………………….. *Worker’s Name*	………………………………….. *Adviser’s Name*
…………………………………….. *Worker’s Address*	……………………………………… *Adviser’s Company name and address*
…………………………………… Worker’s Signature	……………………………………… Adviser’s Signature
……………………………………… *Date and time signed by worker*	……………………………………… *Date and time signed by adviser*

ANNEXURE “B” FINANCIAL ADVICE

SUBJECT: Release of liability under section 66(7)(h) of the *Return to Work Act 2014*

I, …………………………………… (the worker), have received competent financial advice about the consequences of entering into a deed of release under section 66(7)(h) of the Act from ………………………………………………………….as required by section 66(7)(i)(ii) of the Act.

……………………………………….. *Worker's Name*	………………………………….. *Adviser's Name*
………………………………………..	………………………………………
………………………………………..	………………………………………
Worker's Address	……………………………………… *Adviser's Company name and address*
…………………………………… *Worker's Signature*	……………………………………… *Adviser's Signature*
……………………………………… *Date and time signed by worker*	……………………………………… *Date and time signed by adviser*

Super SA Notification of release of information

In the event that a worker makes a claim for Income Protection and / or Death and Total and Permanent benefits, Super SA will require certain information to determine and assess the claim. For this purpose, Super SA has authority and power under section 26 of the Southern State Superannuation Act 2009 (The Triple S Act) and section 54 of the Superannuation Act 1988 (Superannuation Act) to request information, which it reasonably requires for the purposes of administering those two Acts.

On this basis, Super SA may from time to time request an employer / Injury Management Units and any external return to work service provider where involved, to release and provide any medical reports, workers compensation claim information, Recovery / Return to Work plans, Redemption documents, assessment reports and any other documents, reports and information relating to injury(s) suffered whilst employed in the South Australian Public Sector.

In response to this request, the employer / Injury Management Units and any external return to work service provider where involved, will release any such information in relation to injury(s) as authorised under sections 185 and 186 of the *Return to Work Act 2014* (RTW Act).

Please note that member consent is not required.

Any information provided to Super SA will be treated confidentially.

***RETURN TO WORK ACT 2014* (SA)**

REDEMPTION AGREEMENT

THIS AGREEMENT is made the day of 2022

BY:

of , in the State of South Australia (hereinafter referred to as "the worker"), of the one part

and

THE STATE OF SOUTH AUSTRALIA in right of Department of ... (hereinafter referred to as "The State of South Australia"), a self-insured employer of the other part.

WHEREAS:

A. The worker is an employee of the State of South Australia, who has sustained the following work injuries: -

- Date: Injury:
- Date: Injury:
- Date: Injury:

and any aggravation, exacerbation, acceleration, deterioration, and recurrence thereof, including any physical, psychological and/or psychiatric sequelae, and any other injury or disability whatsoever arising from employment with the State of South Australia.

B. The State of South Australia has undischarged liabilities to the worker, in relation to the work injuries referred to in paragraph A above, to make weekly payments of income maintenance pursuant to Part 4 Division 4 of the Return to Work Act 2014 (SA) (“the Act”) and to make payments of the kind referred to in section 33 of the Act.

C. The worker undertakes to resign from employment on and from (hereinafter referred to as “the date of resignation”), both parties waiving any rights as to notice.

D. The worker and the State of South Australia have reached agreement for the redemption of the State’s liabilities referred to in paragraph B, whereby the liability to make weekly

payments and to make payments under section 33 of the Act is to be redeemed on and from the date of resignation for a capital payment in the sum of DOLLARS AND CENTS ($) in respect of weekly payments pursuant to section 53 of the Act and DOLLARS AND CENTS ($) in respect of payments under section 33 of the Act pursuant to section 54 of the Act.

E. The worker's current notional weekly earnings are set at a rate of $ and the worker is currently in receipt of weekly payments of $0.00/the worker is not currently in receipt of weekly payments .

F. In compliance with section 53(2)(a) and section 54(4)(a) of the Act, the worker has received competent professional advice from solicitor or representative about the consequences of redemption (the cost of which, up to the limit of prescribed regulations, is to be met by the State of South Australia), and such is evidenced by “Annexure A” attached.

G. In compliance with section 53(2)(b) of the Act, the worker has received competent financial advice from accountant/financial adviser about the investment or use of money to be received on redemption (the cost of which, up to the limit of prescribed regulations, is to be met by the State of South Australia), such being evidenced by “Annexure B” attached.

H. In compliance with section 53(2)(d) of the Act, a recognised health practitioner has certified that the extent of the worker's incapacity, resulting from the work injuries, can be determined with a reasonable degree of confidence, as evidenced by “Annexure C” attached.

I. In compliance with section 54(4)(b) of the Act, the worker has received advice from a recognised health practitioner about future medical services (and if relevant, therapeutic appliances and other forms of assistance related to future health) that the worker will or is likely to require on account of the work injury and any related surgery, treatment or condition (the cost of which, up to the limit of prescribed regulations, is to be met by the State of South Australia), as evidenced by “Annexure C” attached.

IT IS AGREED THAT:

1. The State of South Australia will pay to the worker the sum of ZERO DOLLARS AND ZERO CENTS ($0.00) in full satisfaction of all of the worker's entitlements to weekly payments and the sum ZERO DOLLARS AND ZERO CENTS ($0.00) in full satisfaction of all the worker’s entitlements to services under section 33 of the Act and the worker will hereafter forever discharge the State of South Australia from its liabilities and obligations (whether past, present or future) in relation to making weekly payments and payments of services under section 33 of the Act arising out of or in any way connected with the injuries set out in paragraph A of this agreement.

2. For a period of from the date of resignation/date of redemption agreement, the worker agrees:

   (i) not to apply for, accept, engage, or remain in any employment or work whatsoever (whether as an employee, trainee or apprentice) in the South Australian public sector or any office in or for the State of South Australia (whether or not remunerated and whether temporary, contract, ongoing or by appointment);

   (ii) not to enter into any contract to provide services to a South Australian public sector agency or the South Australian Government whereby is to personally perform all or a substantial part of the work to be performed under that contract;

   (iii) not to provide services to the State of South Australia as an employee or contractor of a labour hire agency or other body contracted to provide personnel or to carry out work or to provide services to or for the State of South Australia (being work or services which would normally be expected to be carried out by an employee of the State of South Australia); and,

   (iv) not to perform the same or similar work functions for a third party in respect of work required under a contract or purchasing arrangement to be provided by that third party to a South Australian public sector agency or the South Australian Government.

3. The worker acknowledges and agrees that has suffered no other injuries or loss of physical, psychological, psychiatric, or sensory capacity arising from employment with the State of South Australia and that has no other claim, right or entitlement under the Act arising from employment with the State of South Australia.

4. The State of South Australia shall make an advance payment to the Commonwealth of 10% of the total redemption recorded herein in accordance with section 33B of the *Health and Other Services (Compensation) Act 1995* (Cth) as appears from “Annexure D” attached.

IN WITNESS whereof these presents specified in this and the preceding three (3) pages have been duly executed by the parties the day and year first hereinbefore written.

SIGNED by the said

…………………….........

In the presence of

Witness
Witness Name:
Witness Address:

SIGNED for and on behalf of

THE STATE OF SOUTH AUSTRALIA CROWN SOLICITOR

Per:…………………………………..

“ANNEXURE A”

PROFESSIONAL ADVICE

Redemption under section 53 and section 54 of the *Return to Work Act 2014* (SA).

I, , have received competent professional advice about the consequences of a redemption payment of ZERO DOLLARS AND ZERO CENTS ($0.00), $0.00 in full satisfaction of my entitlement to weekly payments and $0.00 in full satisfaction of my entitlement to payments under section 33 of the Act from:

……………………………………………………………………………………………………

……………………………………………………………………………………………………

Although not limited to, I have received advice on the following:

1. That on the receipt of this redemption payment, I have no further entitlement to weekly payments and to payments under section 33 of the Act in relation to any work injuries suffered by me arising from my employment.
2. The application of sections 49(1) and 49(2) of the *Return to Work Act 2014* (SA), as applicable (and the fact that I will be taken to be receiving continuing weekly payments of $0.00 had it not been for this redemption).
3. Taxation implications of the redemption payment, if any.
4. Centrelink implications in relation to the redemption payment, if any.
5. That the receipt of a redemption payment for medical services may restrict my entitlement to claim future medical expenses, incurred as a result of any work injury, from Medicare or my private Health Fund.

…………………………………………… Dated…………………………………

…………………………………………… Dated…………………………………
Adviser

Adviser’s name and address: ………………………………………….
………………………………………….
………………………………………….

"**ANNEXURE B**"

FINANCIAL ADVICE

Redemption under section 53 of the *Return to Work Act 2014* (SA).

I, , have received competent financial advice about the investment or use of the redemption payment of ZERO DOLLARS AND ZERO CENTS ($0.00), $0.00 in full satisfaction of my entitlement to income maintenance and $0.00 in full satisfaction of my entitlement to payments under section 33 of the Act from:

…………………………………………………………………………………………………

…………………………………………………………………………………………………

which I am satisfied is appropriate to my circumstances.

……………………………………. Dated:…………………………………………

…………………………………….. Dated:…………………………………………..
Adviser

Adviser's name, company, and address: …………………………………………
…………………………………………
…………………………………………

"ANNEXURE C"

MEDICAL CERTIFICATE

Redemption under section 53 and section 54 of the *Return to Work Act 2014* (SA).

I, ………………………………..…………., hereby certify that for the purpose of Section 53(2)(d) of the Act, the extent of 's incapacity resulting from work injuries can be determined with a reasonable degree of confidence.

I, …………………………………………..., hereby certify that for the purpose of Section 54(4)(b) of the Act, has received advice from me about future medical services (and if relevant, therapeutic appliances and other forms of assistance related to future health) that will or is likely to require on account of the work injury and any related surgery, treatment, or condition.

Signature: ………………………………………   Date……../………./……….

Qualifications: ………………………………………

Name: ………………………………………

Address: ………………………………………

………………………………………

………………………………………

"ANNEXURE D"

NOTICE OF ADVANCE PAYMENT

In accordance with section 33A of the *Health and Other Services (Compensation) Act 1995* (Cth) ("the Act"):

1. The State of South Australia ("the compensation payer") intends to make an advance payment under section 33B of the Act in respect of compensation payable under a judgment or settlement to the worker ("the compensable person").
2. The amount of the payment will be 10% of the total redemption, namely $0.00.

3. The Commonwealth can retain some or all of the advance payment for eligible benefits paid by the Commonwealth in respect of services and care rendered or provided in the course of treatment for, or as a result of, the compensable person's injury. If the amount specified in the notice under section 33C of the Act is less than the amount of the advance payment, the difference is payable by the Commonwealth to the compensable person.
4. The compensable person will be required to make an additional payment to the Commonwealth in respect of the eligible benefits if the amount specified by written Notice given to the compensable person under Section 33C of the Act is greater than the amount of the advance payment.

I have read and acknowledge this notice.

Signed ………………………………………

Dated …./…../…..

Signed ……………………………………….
Name of Witness ……………………………
Dated …./…../…..

Appendix 3: Agency Self Assessments

The following self assessment templates are provided for agency use.

Agency Self-Assessment - Standard 1

☐ Procedures or Manuals are in place describing injury management processes and activities, responsibilities, and resources.

☐ Current position descriptions are in place for Injury Management Personnel (Claims Manager, Return to Work Coordinator, Reconsideration Officers)

☐ Return to Work Coordinators are appointed and have certificate of training

☐ Reconsideration officer(s) are appointed and registered with SAET

☐ Procedures include competency and training requirements of injury management personnel

☐ A documented review of injury management resources (human, physical and electronic) has been undertaken (in accordance with procedural requirements) within the last three years

☐ Injury Management Goals and strategies to achieve these have been identified

☐ Level of achievement of goals and targets is measured, monitored, and reported on

☐ Where goals or targets are not met, actions are identified to address this, or goals and targets are reviewed

Comments:

Completed By:

Name: ______________________ Position: ________________________

Signed: ______________________ Date: ___________________________

Agency Self-Assessment - Standard 2

☐ Procedures or Manuals describe the injury/incident/illness notification and reporting processes and responsibilities

☐ There is a documented process for ensuring workers are provided information about their rights and the claim process

☐ Information provided to workers includes all core requirements

☐ A record of information provided to workers is maintained

☐ Workers are advised of their rights to advocacy and support.

☐ Claim files are maintained with supporting notes and documents

☐ Determinations are provided in writing with relevant information and notices using approved standard letter

☐ Where claims are not determined in 10 business days workers are notified of the pending claim and investigations and offered interim benefits

☐ Pending claims are regularly reviewed to ensure determination of the claim is expedited on receipt of additional information

Comments:

Completed By:

Name: ______________________ Position: ________________________

Signed: ______________________ Date: ___________________________

Agency Self-Assessment - Standard 3

☐ Procedures or manuals describe processes and responsibilities for investigation, assessment, determination and payment of medical expenses, property damage and weekly payments. Procedures include processes for reduction, suspension, and discontinuance of weekly payments.

☐ There is a documented process for payment of accounts including entering information into the SIMS system

☐ Timeframes for payments of accounts are monitored to ensure they are paid within timeframes (30 days)

☐ Notices are provided to providers where applicable if charges are disallowed or reduced

☐ Injured workers are informed of entitlement periods, including prior to cessation of entitlement periods

☐ There is a defined process for applications for future surgery, and workers are informed of this process.

☐ AWE calculations are documented, and records maintained

☐ Notices are provided to workers where weekly payments are discontinued, reviewed or adjusted.

☐ Workers are advised of their rights to seek review of weekly payments and AWE calculations including the manner the application must be made

☐ Interest is paid on weekly payments made in arears due to dispute, error or order of the tribunal

Comments:

Completed By:

Name: ______________________ Position: ________________________

Signed: _____________________ Date: __________________________

Agency Self-Assessment - Standard 4

☐ A RTW Coordinator has been appointed, is trained and registered with ReturnToWorkSA

☐ A suitable RRTW process and early intervention strategies are implemented including:

- initial needs assessments (including daily living needs, barriers to RTW and services required)
- RRTW plan development processes, including consultation requirements
- RRTW review processes, including 6- month vocational reviews

☐ RRTW plans meet core requirements and contain all information as required by the RTW Regulations

☐ RRTW plans are signed by worker, manager and health practitioner where practicable

☐ RRTW plans are developed where it is likely that a worker may be incapacitated for four weeks or more (note may be developed prior to 4 weeks)

☐ Defined processes are in place for managing applications for suitable employment and for ensuring workers are aware of these processes

☐ A process is in place to ensure strategies are implemented to maximise RRTW outcomes prior to 104 weeks

☐ Procedures or processes are in place to ensure medical reports are provided to the worker within seven calendar days

☐ Procedures are in place to ensure that workers are not required to submit to medical examinations (at the request of the agency) more frequently than every two months

Comments:

Completed By:

Name: ______________________ Position: ________________________

Signed: ______________________ Date: ___________________________

Agency Self-Assessment - Standard 5

- ☐ Procedures or Manuals describe the processes for assessment of WPI
- ☐ Claims are monitored and WPI assessment processes are implemented when injuries are stabilised.
- ☐ Workers are consulted and given their choice of WPI Assessor
- ☐ Records of authority forms support workers are provided the WPI Assessment request letter prior to sending it to the assessing doctor
- ☐ Assessment reports are provided to workers within seven days of receipt from the assessing doctor
- ☐ Workers are notified of their rights to review decisions regarding permanent impairment
- ☐ Written notifications to workers regarding an agency willing to enter negotiations for redemption include indemnifying worker of reasonable costs of obtaining professional and medical advice
- ☐ Redemptions include authority the worker has received professional, financial and medical advice
- ☐ Redemption agreements fix the amount of payment and discharged weekly payment amounts
- ☐ Redemption agreements are approved in writing by the Agency Executive officer
- ☐ Lump Sum calculations are on file and consider minimum thresholds, injury type, number of injuries from the same trauma; any prior lump sums, and correct calculation methodology
- ☐ Determinations are in writing, include calculations; exclusion to further assessments and worker’s review rights
- ☐ In cases of a death claim consideration of a referral is made to the Crown Solicitor’s Office
- ☐ Benefits are provided to entitled dependents as prescribed by the RTW Act
- ☐ Weekly payments to dependents are reviewed at least once each calendar year
- ☐ Where weekly payments are reduced, affected persons are notified 21 days prior to the reduction
- ☐ Procedures are in place describing actions in case of third party recoveries
- ☐ Where weekly payments are reduced, affected persons are notified 21 days prior to the reduction

Comments:

Completed By:

Name: ______________________ Position: ________________________

Signed: ______________________ Date: ___________________________

Agency Self-Assessment - Standard 6

☐ Procedures or Manuals describe processes for review of decisions, including appointment and nomination of reconsideration officers

☐ Reconsideration notices are provided to the SAET within 10 business days of the agency receiving the application for review

☐ SAET Orders are responded to and actioned within stipulated timeframes

☐ Applications for an expedited decision are responded to in a timely manner

☐ Agencies have a procedure in place for responding to s180 requests, including information on what material is to be provided and review processes

☐ Applications for s180 access to claim files are responded to within 45 days

☐ Applications for review of decisions relating to provision of material under s180 applications are responded to within 14 days

Comments:

Completed By:

Name: ______________________ Position: ________________________

Signed: ______________________ Date: ___________________________

Agency Self-Assessment - Standard 7

- ☐ Procedures or Manuals describe the determination and management of serious injury claims, including processes for interim assessment
- ☐ RRTW plans do not place obligations of return to work on seriously injured workers
- ☐ Agencies have a plan in place to detail the care and support needs of seriously injured workers to enable restoration to the community
- ☐ Seriously injured workers are made aware of their rights to pursue common law damages
- ☐ Where common law damages are sought agencies refer the case to Crown Solicitor's Office
- ☐ Worker obtains legal advice prior to electing to pursue common law damages, and are provided their entitlements to legal costs for this advice

Comments:

Completed By:

Name: ______________________ Position: ________________________

Signed: ______________________ Date: ___________________________

Agency Self-Assessment - Standard 8

- ☐ The agency has described the processes and mechanisms it will put in place to meet the Service Standards
- ☐ An audit or review has been undertaken to verify if the agency is meeting the Service Standards
- ☐ The agency has documented a complaint process for workers to report or complain about a failure to meet the service standards and communicated this to workers
- ☐ Complaints about the agency and its achievement of the Service Standards are monitored and actions to address deficiencies are implemented and communicated to workers.
- ☐ Complaints are responded to within 10 business days
- ☐ Appropriate remedies to complaints are provided
- ☐ Agencies have undertaken audit or review to verify effective implementation of injury management processes and administration of s134 delegations
- ☐ Where deficiencies in performance or processes are identified agencies will undertake corrective actions to address these
- ☐ Suitable facilities and information storage systems are in place to maintain confidentiality

Comments:

Completed By:

Name: ______________________ Position: ________________________

Signed: ______________________ Date: ___________________________

Agency Self-Assessment – SAPS Service Standards

☐ Claims Managers and RRTWC's have been provided access to resources to identify support and services for workers

☐ Meaningful suitable duties are identified for workers

☐ Injured workers participate in return to work plans and services

☐ Workers and their health providers are informed of available services and support

☐ Health benefits of work are actively promoted

☐ Appropriate remedies to complaints are provided

☐ Workers are contacted by claims manager and/or RTWC within 3 business days of injury notification

☐ Initial needs assessments for recovery and return to work services are completed within 10 business days of first incapacity

☐ Pathways to return to work are identified, including retraining where relevant and workers are consulted about all possible opportunities

☐ Injured workers and their line managers are actively consulted and collaborated with about return to work decisions and strategies

☐ Face to Face meetings with workers are arranged and used to discuss any issues, barriers or opportunities

☐ Information, advice and support is provided to workers, managers and RTW coordinators

☐ Assistance is provided to managers to identify suitable duties for injured workers

☐ Injury Management Roles and responsibilities training is provided to managers and RTW coordinators

☐ Emails and phone calls are responded to within 3 business days and written letters responded to within 10 business days

☐ Accounts and reimbursements are paid within 30 days of receipt

☐ Initial needs assessments for recovery and return to work services are completed within 10 business days of first incapacity

☐ Clear accurate, easy to understand information is provided to workers including information if claim entitlements, worker and employer responsibilities and obligations

☐ Workers are assisted to complete claim documentation where required

☐ Workers are informed of how to reach or access other services where relevant

☐ Information and services are provided to workers in their preferred language and format in a manner which is sensitive to worker cultural values and beliefs.

☐ Protocols are in place to ensure worker information is confidential

☐ Information is provided to workers on how they can provide feedback or make a complaint and how the agency will respond to these

☐ Rights of review and appeal are clearly detailed where relevant in correspondence to workers

☐ Complaints are responded to within 10 business days

☐ Workers are informed of their rights to support, advocacy and where applicable where to find these

Comments:

Completed By:

Name: ______________________ Position: ________________________

Signed: ______________________ Date: ___________________________

Appendix 4: Worker Survey Example Questions

		Strongly disagree	Disagree	Undecided	Agree	Strongly agree
1	I believe that my manager, claims and return to work coordinators have viewed my recovery and return to work their primary goal					
2	I have been provided meaningful suitable duties where relevant					
3	I have been informed of available services and support					
4	My employer and claims manager/RTWC have promoted the health benefits of work					
5	I was contacted by claims and/or RTW coordinators within a few days of my injury or claim being reported					
6	My initial needs for rehabilitation and services and my RTW options and pathways were assessed in consultation with me					
7	My queries, and concerns have been addressed promptly, and I have been informed of how to make a complaint					
8	Reimbursements and expenses have been paid promptly					
9	I have been treated with respect and courtesy throughout the claims and return to work process					

10	My manager has been involved and supported me in my return to work					
11	Information provided to me was easy to understand and in my preferred language					
12	My privacy and confidentiality have been respected					
13	I am aware of my rights to representation and advocacy and where to access these					

Considering your claims and return to work experiences:

What did we do well?

What could we have done better?

Do you have any other comments or feedback?

OFFICIAL

The Office of the Commissioner for Public Sector Employment

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Version 1.0 / February 2022

Government of South Australia

Office of the Commissioner for Public Sector Employment