Lawyers for the People

AUSTRALIAN LAWYERS ALLIANCE

NSW Workers Compensation Reform Regulations and Guidelines Feedback

Submission to the State Insurance Regulatory Authority (SIRA) and the Department of Customer Service (DCS)

15 May 2026

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Protecting and promoting justice, freedom and the rights of the individual.

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Who we are

The **Australian Lawyers Alliance (ALA)** is a national association of lawyers, academics and other professionals dedicated to protecting and promoting access to justice and equality before the law for all individuals.

Our members and staff advocate for reforms to legislation, regulations and statutory schemes to achieve fair outcomes for those who have been injured, abused or discriminated against, as well as for those seeking to appeal administrative decisions.

The ALA is represented in every state and territory in Australia. We estimate that our 1,600 members represent up to 200,000 people each year across Australia.

Our head office is located on the land of the Gadigal people of the Eora Nation. As a national organisation, the ALA acknowledges the Traditional Owners and Custodians of the lands on which our members and staff work as the First Peoples of this country.

More information about the ALA is available on our website.[1]

[1] www.lawyersalliance.com.au.

Introduction

1. The ALA is grateful for the opportunity to provide feedback on the draft *Workers Compensation Legislation Amendment Regulation 2026* ("Regulation"), together with the associated forms and guidelines. We also wish to thank you and your staff for the time you made available for our in-person consultation.

2. As you are aware, the ALA has played a significant role in the public hearings before both the Standing Committee on Law and Justice and the Public Accountability and Works Committee. We are of the view that the reforms did not adequately advance the scheme's objectives of ensuring that injured workers have access to treatment, rehabilitation, and appropriate compensation. We remain concerned that certain aspects of the Regulation are similarly inconsistent with those objectives. Of particular concern is the retrospective operation of some provisions, which, in our view, unacceptably restricts the existing rights of injured workers.

3. Just as with the two Amending Acts, the significance of these Regulations cannot be understated. Given the role they play in the reform package, we are concerned that the consultation process has been short and rushed. Our submissions below set out some of our concerns with the Regulation, but it is fair to say that the more closely we have considered the provisions, the more concerned we have become. More time is needed to fully examine all provisions and reduce the risk of unintended consequences.

4. The rushed drafting of these Regulations is evident from the incomplete sections and typographical errors they contain. A further example of the compressed consultation process is an email received as late as 14 May 2026, in which the ALA was provided with a PDF entitled *Consultation Session- WC Reform Regulations and Guidelines*. This was the first time, on the day before submissions were due, that we had seen this document. We have not had sufficient time to give it detailed consideration, but on first review there appear to be a number of differences between what is asserted to be in the Regulations and what the Regulations in fact say. This document, together with the rushed consultation process, causes us to be concerned that the Regulation contains provisions that are not intended to have the effect they presently have. For that reason, we urge caution before promulgating the Regulations in their current form, pending significant review and revision.

5. In preparing this feedback document and submission the ALA has taken to account and reflected upon the following:

The workers compensation system objectives contained in section 3 1998 Act.

The purpose of this Act is to establish a workplace injury management and workers compensation system with the following objectives—

(a) to assist in securing the health, safety and welfare of workers and in particular preventing work-related injury,

(b) to provide—

- *prompt treatment of injuries, and*
- *effective and proactive management of injuries, and*
- *necessary medical and vocational rehabilitation following injuries,*

in order to assist injured workers and to promote their return to work as soon as possible,

(c) to provide injured workers and their dependants with income support during incapacity, payment for permanent impairment or death, and payment for reasonable treatment and other related expenses,

(d) to be fair, affordable, and financially viable,

(e) to ensure contributions by employers are commensurate with the risks faced, taking into account strategies and performance in injury prevention, injury management, and return to work,

(f) to deliver the above objectives efficiently and effectively.

Accrued Rights | the doctrine of Ultra Vires

By section 30 of the *Interpretation Act 1987* read in conjunction with Section 5 accrued rights are protected from the amendment or repeal of an Act or statutory rule except where a contrary intention is expressed in the Act or Rule. These sections have been said to mirror the common law rule:

> *The general rule of the common law is that a statute changing the law ought not, unless the intention appears with reasonable certainty, to be understood as applying to facts or events that have already occurred in such a way as to confer or impose or otherwise affect rights or liabilities which the law had defined by reference to the past events*.[2]

[2] Dixon CJ in *Chang Jeeng v Nuffield (Australia) Pty Ltd* (1959) 101 CLR 629 at 637–638

Where that contrary intention does not appear in the Act or Rule, and accrued rights are affected, the offending provision may be said to be "beyond power" or ultra vires, rendering it invalid or void.

Government policy and regulatory approach

The *New South Wales Government Guide to Better Regulation* TC 19-01 sets out the seven Better Regulation Principles to be applied when designing and developing regulatory proposals. Those principles include that Government action should occur only where it is in the public interest, that is, where the benefits outweigh the costs; that the objectives of government action should be clear, concise, specific, and directed to the root cause of the problem; that the impact of the action should be properly understood by considering the costs and benefits of a range of options, including non-regulatory options, using all available data; and that the action should be effective and proportionate.

These principles must be considered and reflected in a document evidencing analysis under the *Subordinate Legislation Act 1989* or a Regulation Impact Statement prepared in accordance with that Act.

The Regulations

Schedule 1 [1] – [9]

Clause 3 definitions

6. In the ALA view, many of the definitions are not necessary because they are either contained in the Acts or because they do not add anything (see below). Some are an attempt to 'amend the legislation' when there is no power to do so.

7. As a general principle, and consistently with the *Interpretation Act 1987*, to maintain continuity of service and administration under the legislation, and to avoid confusion in an already complex legislative environment, where no change has been made in the amending Acts to a definition, the Regulation should not provide a new definition or rewrite an existing one.

8. As a further principle, the regulation should not attempt to circumvent the ordinary application of the amending Act by the creation of new definitions which are beyond the scope and authority of the amending Act.

9. Relevant examples:

Ambulance service (merely refers to a clause which refers to the 1987 Act definition)

Hospital treatment (merely refers to a clause which refers to the 1987 Act definition)

Medical or related treatment: already defined in section 59 1987 Act (which is relevant for the purposes of exempt workers and coalminers)

Treatment or service – unnecessary and serves no purpose other than to purport to apply 'rules' authorised under section 60(2C) 1987 Act to workers not currently bound by that provision

Workplace rehabilitation service (merely refers to a clause which refers to the 1987 Act definition)

Injured worker – this definition is required to apply section 60(2C) to categories of workers not bound by that sub-section. This is beyond power and misunderstands the workers compensation legislation. *Injured worker* is a misconceived definition and cannot and should not be implemented.

Clause 3A Prescribed death

10. Draft clause 3A reflects an amendment to new section 8G of the 1987 Act approved by the Legislative Assembly. It should be allowed.

11. The Regulation should be expanded to include another relevant event raised in submissions to the various committee inquiries into the amendment Bills, framed around workers who are exposed to, or experience the aftermath of, a fatality or serious incident in the workplace.

12. In the Second Reading Speech of the 2025 Amendment Bill Minister Cotsis stated:

"The intent is to target workers compensation towards events and behaviours that an *ordinary person would reasonably expect to cause a compensable injury. In no uncertain terms, this bill preserves compensation for PTSD caused by trauma or exposure to traumatic events. This includes a worker arriving on the scene of horrific accidents, and exposure to other traumatic events. The bill expressly covers injuries caused by the psychological impact of repeated exposure in the course of a worker's duties to the traumatic experiences of others that result from traumatic incidents. This can include a supervisor who is repeatedly exposed to the traumatic experience of others." (*Emphasis added)

13. Section 8G (amendment Act 2025) includes:

(c) witnessing—

(i) a traumatic incident happen, or

(ii) a dead or seriously injured person at the scene of a traumatic incident, …

14. Section 8G is limited to specific workplace happenings. It is not in the broad terms stated by the Minister.

15. The verb 'witness' ordinarily means "to see". The ALA is aware there is case law expanding that meaning to 'seeing, hearing or experiencing' however the regulation has to be read on its face. The ordinary worker is not going to be aware of the common law or expansion of definitions by courts.

16. "*Traumatic incident*" is defined in this section 8J. The definition does not capture what the Minister states as "*a worker arriving on the scene of horrific accidents and exposure to other traumatic events*".

17. The traumatic incident must be 'witnessed' (seen), or the worker must 'see' a dead or seriously injured person. The Minister, however, described circumstances in which a worker arrives after the event and is traumatised by what they experience. Further, it is unclear what "other accident" in subsection (a)(iv) is intended to capture.

18. Section 8G does not refer to 'exposure on a worksite to the aftermath of a traumatic incident'. If it is intended that such exposure be captured, the Regulation should clarify that ambiguity rather than leave the issue to be ventilated through litigation arising from significantly traumatic events.

19. If our recommendation is accepted, a present-day example of workers who would be covered by this expanded definition of "relevant event" would be those involved in the incident that occurred on Monday, 1 April 2019, involving the death of Christopher Cassiniti.[3]

20. In the Cassiniti scenario, many workers did not 'witness' the traumatic incident (7 tonnes of bricks falling from a height onto workers, together with collapsed scaffolding), nor did they see the deceased or seriously injured workers. They were, however, exposed to the event by being on site, rushing to see what had happened, and learning of the fate of their co-workers. Real-time video of the aftermath of the incident captures the severe distress of many workers.

21. Traumatic incidents (as defined) inevitably lead to SafeWork NSW and police investigations, and a worker may be required to recount, repeatedly, their experiences or aspects of their work or workplace that may have contributed to the incident, or to provide statements. They may then be called as witnesses in coronial investigations and subsequent criminal or civil proceedings. This, in and of itself, can lead to trauma.

[3] https://www.nsw.gov.au/media-releases/construction-company-director-lose-licence-following-death-of-worker

22. Workers who experience an injury in such a 'Relevant event' should be permitted to claim for psychological injury if it is so caused.

Recommendation 1

To include as a 'relevant event' circumstances where a traumatic incident is not witnessed but the worker is exposed to the incident.

Clause 5C Covid-19 – matters relating to incapacity

23. This regulation misconstrues the nature of the virus and incapacity and the existing clauses. This is already provided for in the Regulation and does not require change.

24. There are workplaces (including NSW Government workplaces) that still operate as if the Health Orders are in place and prevent workers from attending if they have COVID 19 even though the worker is *physically capable of working* and fulfilling their duties.

Recommendation 2

Clause 5C is unnecessary and should be removed.

Part 4A Treatment and services for injuries

Dealing with Part 3 Division 3 1987 Act | Consequences of the change from "reasonably necessary" to "reasonable and necessary" (section 60 and section 60AA WCA 1987 as amended by Workers Compensation Legislation Amendment Act 2025 Schedule 1.9[6])

25. The provisions amended to accommodate the change from "reasonably necessary" to "reasonable and necessary" are sections 60 and 60AA of the 1987 Act (as applicable depending on the worker classification).

26. The changes are contained in Schedule 1.9[6] to the 2025 Amendment Act and commence from the date of proclamation of that Act.

Which workers are affected?

27. The substitution of "reasonable and necessary" for "reasonably necessary" in section 60 applies to:

- **exempt workers** where 'exempt worker' means a police officer, a paramedic, a firefighter including firefighters employed by Forestry Corporation of New South Wales, National Parks and Wildlife Service and Transport for NSW (Reform Act 2026 Savings and transitional provisions *Application of amendments to exempt workers*).[section 60 and 60AA]

  *Note: **'exempt workers'** have not before explicitly included firefighters employed by Forestry Corporation of New South Wales, National Parks and Wildlife Service and Transport for NSW.*

- **Coalminers** (Savings and transitional provisions in the Reform Act 2026 *Application of amendments to coal miners*) [section 60 only]

- **All other workers** except those with a dust disease.

What is 'special' about section 60?

28. Section 60 sub sections (1) and (2) have not undergone change or amendment for many years. However, sub sections (2A), (2B) and (2C) were introduced in 2012 and do not apply to exempt workers[4] or coalminers. Likewise, section 59A, which limits the duration of provision of medical treatment, does not apply to those classifications of workers and section 60AA does not apply to coalminers but does apply to exempt workers.

29. The amendments in 2012 changed the character of section 60 from an "indemnity" provision[5] to a provision whereby *pre-approval* from an insurer is required *before* the treatment or service can be given or provided (other than for excepted treatments or services).

What is the framework which the Draft Regulation impacts?

30. Sections 60 and 60AA fall within a broader framework set out in Part 3, Division 3 of the 1987 Act titled "Compensation for medical, hospital and rehabilitation expenses"[6].

31. This framework provides:

    > Definitions as to what constitutes a service or treatment[7];

[4] As defined in 2012 - police officers, firefighters and paramedics.
[5] Where payment is to be made after the costs have been incurred and properly verified: *NSW Sugar Milling Co-op Ltd v Manning* (1998) 44 NSWLR 442.
[6] The current title of Part 3 Division 3.
[7] Section 59 1987 Act

> The conditions applicable for provision of treatment and services;

> The proviso that a worker is *not liable* for service charges above the applicable rates[8]; and

> The *maximum rates* applicable for services and treatment for which an employer can be liable[9] [10].

32. Additionally, sub sections 60(2A), (2B) and (2C) add, with respect to workers not coalminers or exempt workers:

- That the Guidelines can impose *conditions* on the giving or provision of services;
- The requirement for treatment and service *providers* to be *appropriately qualified* to provide the treatment or service[11]; and
- The *restrictions and limitations* on how long medical and treatment services will be paid including the threshold requirements, including that the service must be "*given or provided" within* the relevant time period[12].

Part 4A Discussion

33. Against the framework in Part 3 Division 3, the draft regulations (clauses 8O, 8P, 8Q) propose:

> New and potentially contradictory *definitions* (see section 59 1987 Act);

> The *rules* to determine whether it is reasonable and necessary for a treatment or service to be given or provided (only applicable to those covered by section 60(2C));

> mandatory obligations for workers, medical providers and insurers to comply with BEFORE the giving or provision of the treatment or service [the service provider and worker must establish, and the insurer must determine];

> those *treatments or services which employers 'are not liable for'* with great specificity by way of 'example'; and

[8] Section 60A 1987 Act
[9] Sections 61-64A 1987 Act
[10] Rates as set out in Fees Orders issued by SIRA from time to time
[11] Section 60(2A)(c) 1987 Act
[12] Section 59A 1987 Act

> provides definitions of "*injured worker*" and "*medical or related treatment"* purporting to bring coalminers and exempt categories of workers under sub sections 60(2A), (2B) and (2C) which is not authorised and potentially ultra vires.

Why is Part 4A in the Regulation?

34. This Part in the draft Regulation is purportedly authorised by section 60(2C) 1987 Act. Section 60(2C) provides:

(2C) The Workers Compensation Guidelines may make provision for or with respect to the following—

(a) *establishing rules to be applied in determining whether it is ~~reasonably necessary~~ reasonable and necessary for a treatment or service to be given or provided,*

(b) *limiting the kinds of treatment and service (and related travel expenses) that an employer is liable to pay the cost of under this section,*

(c) *limiting the amount for which an employer is liable to pay under this section for any particular treatment or service,*

(d) *establishing standard treatment plans for the treatment of particular injuries or classes of injury,*

(e) *specifying the qualifications or experience that a person requires to be **appropriately qualified** for the purposes of this section to give or provide a treatment or service to an injured worker (including by providing that a person is not appropriately qualified unless approved or accredited by the Authority).*

35. The Workers Compensation Guidelines contain the description of treatments and services which are the exceptions to insurer pre-approval (section 60(2A) 1987 Act). Section 60(2A) does not apply to coalminers or exempt workers. The exceptions to insurer pre-approval are essential to workers (other than coalminers and exempt workers) accessing treatment promptly after injury.

36. Any rules imposed or exceptions to rules, or restrictions on the provision of reasonable and necessary medical treatment should be found in the one place to ensure clear and concise information and reduce confusion.

Recommendation 3

Given that the Act provides for the Workers Compensation Guidelines to provide the rules, limitations and excepted treatments, that Part 4A of the Regulation (subject to other observations and recommendations made) be moved to the Guidelines (with an express statement as appears elsewhere in the Guidelines that the rules made under section 60(2C) and other Guidelines made under that section do not apply to coalminers and exempt workers [see below]).

Regulation 8O

37. Insofar as regulation 8O attempts to define what has already been defined and remains as defined in the 1987 Act, the regulation should be rejected.

38. The definition of "injured worker" is ultra vires. The regulation cannot draw in coalminers and exempt workers under section 60(2A) - (2C) without an express intention to amend section 60 for those workers.

39. The balance of the definitions is unnecessary or unduly complicating (see response above re Definitions).

Recommendation 4

That regulation 8O is removed entirely.

Regulation 8P

Coalminers and exempt workers

40. Section 60(2C)(a) 1987 Act **does not apply to exempt workers and coalminers.**

41. Section 60 applying to coalminers and exempt workers is an "indemnity provision". The worker is entitled to be reimbursed for the cost of treatment. There is no requirement or obligation to seek pre-approval for treatment. There is an obligation for those workers to establish in the Commission that the treatment or service was reasonable and necessary if reimbursement or indemnity is not provided by the insurer.

42. Whilst a rationale has not been provided by DCS or SIRA in the 'Feedback sessions' the ALA submits that Regulation 8P is intended to affect the entitlement of coalminers and exempt workers. Insofar as this regulation attempts to apply to coalminers and exempt workers, it can not.

43. If our position is correct, then there is no utility in Part 4A of the draft Regulations.

Rules for determining whether treatments and services reasonable and necessary [sic]

44. For the reasons stated above the ALA calls for the rules as authorised by section 60(2C)(a) be removed from the regulation and placed in the Guidelines and expressly declared not to apply to coalminers and exempt workers.

45. As a matter of clear and unambiguous drafting, the heading of this regulation requires attention.

46. It is well understood that the requirement of "reasonable and necessary" is more onerous than the replaced requirement of "reasonably necessary".

47. That being so and section 60 and 60AA as amended having not come into commencement, the rules as set out are premature. These provisions sit within a framework which sets controls for the containment of medical and treatment expenses. That framework should be allowed to 'settle' after the new 'test' is applied before rules of the nature provided in 8P are brought into effect.

48. The rules which are mandatory, require that the treatment or service

    (1) be clinically justified for the injury the subject of the claim;

    (2) be cost effective and represent value for money where 'value for money' is defined by comparing the benefits of the proposed treatment with the cost of alternative treatments; and

    (3) be the lowest cost option.

49. The rules mitigate against treatment when they should reflect the objectives of the system. They appear contrary to the objects of the system and the concept of workers compensation. They appear to seek lowest cost services as opposed to value based services.

50. Some of the questions which come to mind are:

    > What is meant by 'clinically justified'? How is this to be 'determined'?

    > How is it to be determined and by who that a treatment or service is 'cost effective' and represents 'value for money' before the treatment or service is provided?

    > How is it to be determined and by who what the costs of 'alternative treatments or services are' and that for any particular worker, those alternatives will achieve a relatively similar outcome?

> How is it to be determined that there is 'no other accessible treatment or service options that can provide similar benefits to the worker at lower cost?

> Is this a 'race to the bottom' or mere opportunistic deprivation of treatment options?

> How does a worker know about the rules and what is required to access recommended treatment or services?

51. **Likely consequences** if these rules are implemented are:

- increase in delay in decision making and many more decisions against treatment by insurers;
- increased disputation about treatment;
- greater demand on treatment and service providers to justify their services which will lead to perverse treatment options and poorer outcomes for workers;
- greater demand for weekly benefits (as workers wait for disputes to be determined);
- delayed return to work (as workers wait for a Commission determination and then provision of the treatment or service); and
- increased cost to employers by having to replace workers who are involved in disputation about benefits.

52. **Unintended consequences** include

- *Op*erational difficulty/impossibility: The rules are difficult for insurers to comply with in the time frames imposed for consideration of claims (21 days) and will likely prove impossible to satisfy leading to denial of claims. The cost of compliance with the rules and disputation arising from denials will exceed (in many cases) the cost of the treatment. Insurers are required to consider cost efficacy before denying a claim.
- *Increased disputation:* The obligations imposed by the 'rules' is that treatment cannot be approved if the rules cannot be met. There is no safety valve. The inability to comply with the rules will increase disputation and proceedings in the Commission.
- *Deterioration in return to work outcomes*: Delaying return to work is contrary to the objectives of the system. Delay in return to work drives increased expenditure by way of weekly compensation and ultimately the cost of treatment. The cost of compliance with the rules will outweigh the cost of the service.

- *Cost shifting*: This could be viewed as a cost shifting exercise to the NSW Public Health System and Medicare. The NSW Public hospital system is already under pressure. Pushing workers to public surgery lists will not only shift expense away from the WC system but exacerbate delays in health outcomes for workers.
- Bearing in mind the narrative around the reforms to improve return to work outcomes and the Workers Compensation System objectives (section 3 1998 Act) the rules do not lend to "prompt treatment of injuries, and effective and proactive management of injuries, and necessary medical and vocational rehabilitation following injuries". Instead, the rules invoke and inspire a 'race to the bottom'.

Recommendation 5

The ALA recommends that the Rules be promulgated in the Guidelines at such time after the commencement of the amendment Acts to allow for less administrative burden on insurers by virtue of the new 'test' and for emerging issues or concerns or perverse outcomes to be contained. Promulgating the rules as currently framed before the test has settled in use and practice may lead to perverse outcomes, such as health practitioners providing poor service, poorer health outcomes and so on.

Regulation 8Q Treatment and services costs for which employers not liable

53. Section 60(2C)(b) allows for Guidelines limiting the kinds of treatment and service (and related travel expenses) that an employer is liable to pay. Clause 8Q is very prescriptive and made more so by the provision of specific examples, some of which have beneficial treatment outcomes (shock wave therapy, cannabinoid medication and GLP1 medication).

54. Overtly prescriptive and specific regulation leads to denial of cost-effective treatment or services, greater disputation, delay of provision of service, and consequential (given the requirement for some workers that treatment be given or provided within a limited time), failure to treat.

55. Whilst some of the services listed may well be justified in being listed surely there must be an opportunity for evidence-based treatments recommended by health practitioners to be provided. If these treatments are provided on the PBS, will they remain on the list? The Regulation is revisited every 5 years. That is too long to allow a newly recognised treatment of service to remain on the list without review.

Recommendation 6

The ALA recommends that the 'examples' in 8Q be removed so as not to limit the expansion or reduction of the specific category of treatment or service, and that each sub paragraph have added, where missing, "other than as prescribed by a health practitioner or available or soon to be available under the National Medicines Policy and on the Pharmaceutical Benefits Scheme (PBS)."

Part 8A Primary Psychological injuries

Purpose of the regulation?

56. The 2025 amendment Act introduces a new 'structure' into the 1987 Act for the making of a claim for psychological injury.

57. The new provisions (Part 1, Division 2, "Interpretation and related provisions – psychological injuries" comprising sections 8 to 8Q) introduce definitions for what is, and what constitutes, psychological injury and the 'relevant events' that might give rise to such an injury.

58. There must be a connection between a relevant event, 'employment' and the psychological injury. A worker must establish:

- a 'relevant event' caused a primary psychological injury
- There is a real and direct connection between employment and the relevant event, and
- employment is the main contributing factor to the psychological injury.

59. For claims where a worker alleges they have been subjected to sexual harassment, racial harassment, bullying, or excessive work demands additional tests apply to determine whether an act or omission 'amounts to' being subjected to bullying, sexual harassment, racial harassment or excessive work demands: An objective test must be used and the worker's perception is relevant but only to the extent the worker's perception of the event is reasonable. In addition, consideration must be given to matters prescribed by the **regulations.**

60. Section 8Q 1987 Act also authorises regulations to be made prescribing what must be considered when determining whether an injury is a "primary psychological injury" and the **"evidence"** a worker must provide for a claim in relation to a primary psychological injury.

61. For claims alleging **relevant conduct**[13], a new claims process and dispute resolution process is set out in the 1998 Act, Part 3, Division 3A "Special provisions for primary psychological injuries caused by bullying, excessive work demands and harassment".

62. It is important to examine the requirements under the 1998 Act new Part 3, Division 3A to determine whether the regulation as set out in Part 8A is required and to what extent.

New claims process and dispute resolution for relevant conduct claims

63. Claims for psychological injury involving relevant conduct are to be managed as a discrete claims type under new sections 280AB to 280AJ 1998 Act. These provisions suggest relevant conduct claims are to be managed differently to other psychological injury claims via a new process involving strict timelines, interim entitlements, and new dispute resolution mechanisms. For all other psychological injury claims the existing claims and dispute resolution processes will apply.

64. What the amendment Acts for relevant conduct claims require:

1. Claim to be made by worker

The special provisions relating to psychological injuries caused by bullying, excessive work demands and harassment require that "a claim for a relevant injury" be made.

It is unclear in the *legislation* as to what constitutes a claim being made. That is because section 264B of new Division 1A 1998 Act provides that the existing Divisions 1 and 2 which deal with the giving of notice of injury and making a claim for compensation do not apply in relation to relevant conduct claims. Those Divisions include notification of injury and provisional liability and its conditions. 'Provisional liability' (up to 12 weeks of weekly payments and medical expenses up to a cap) and 'reasonable excuse' are not relevant and do not apply to relevant conduct claims.

There being no explanation within the legislation as to what is required, the Regulation is required to clarify what is meant by "a claim in relation to a relevant injury caused by relevant conduct"[14].

[13] Relevant Conduct" claims are those claims for compensation made where a psychological injury is allegedly caused by bullying, sexual harassment, racial harassment or excessive work demands: New Section 280AB 1998 Act as amended by the *Workers Compensation Legislation Amendment Act 2025.*

[14] Section 280AA 1998 Act 'Application of division

2. Insurer Decision

Within 42 days (6 weeks) of a claim being made, the insurer must either accept the claim and commence weekly payments or dispute liability.

If the insurer does not decide within 42 days, it is *deemed to have accepted the claim*.

Evidence: A finding by a commission, court, or tribunal that relevant conduct occurred is taken as evidence the relevant conduct occurred.

3. Interim entitlements during determination of liability

- While the claim is being determined, the worker is entitled to:
    - **Weekly Payments** at 75% of their pre-injury average weekly earnings (PIAWE),
    - **Medical Expenses:** Up to $7,500 or the amount specified in Workers Compensation Guidelines.
- These interim entitlements cease:
    - 14 days (2 weeks) after insurer disputes liability, or
    - 56 days (8 weeks) after the claim is made.
- If the claim is accepted, the worker receives back payment for the difference between interim payments and full entitlement, plus reimbursement for reasonable medical expenses paid before acceptance.

4. Disputing Liability and Review Process

- If the insurer disputes liability, it must notify the worker within 42 days (6 weeks) of the claim being made.
- The worker can request a review of the disputed claim; the insurer must conduct the review and notify the worker within 14 days (2 weeks).
- The review decision replaces the previous insurer decision.
- The worker **must** seek a review of the dispute before it can be referred for determination by the PIC or the IRC.

5. Dispute Resolution: Industrial Relations Commission

- If the insurer disputes the claim on the basis that the conduct was not relevant conduct, the worker may apply to the Industrial Relations Commission (IRC) for a

determination. Note that a (prior or new) finding by a commission, court or tribunal that relevant conduct has occurred is taken to be evidence the relevant conduct occurred (section 280AC 1998 Act).

- The IRC may resolve the dispute by conciliation or, if not resolved, determine whether the conduct was relevant conduct and issue a certificate**.**
- The IRC's determination is binding and cannot be referred to the Personal Injury Commission.
- If the IRC determines the conduct was not relevant conduct, no further compensation is payable.
- If the IRC determines the conduct was relevant conduct, the insurer must issue a decision notice within 7 days. Note there is no timeframe for the delivery of a determination by the IRC.
- The IRC's usual process is that after an application is lodged, compulsory conference takes place within approximately seven days thereafter if the matter does not resolve there is a timeframe, usually 3 weeks for the applicant to lodge material on which they intend to rely, then a further 3 weeks for the respondent to lodge material on which they intend to rely, then a period for the Commission to determine how the proceedings will further commence and then a hearing date(s) are set. In general, 3 to 4 days are required for a determination to be made. There is no timeframe for the delivery of a decision by the Commission. The IRC cannot make an order for costs.
- If the insurer continues to dispute liability, the dispute is referred to the **Personal Injury Commission**.

6. Commencement of Payments and Offences

- Weekly payments must commence within 7 days after a claim is accepted or deemed accepted.
- Back payments must be made within 21 days after acceptance.
- Offences and penalties apply for failure to commence payments or for referring non-genuine disputes to delay payments (maximum penalty: 50 units).

7. Costs and Funding

- Costs of the IRC exercising jurisdiction under this division are paid from the Workers Compensation Operational Fund.

Comparison of existing and new claims processes:

EXISTING CLAIMS PROCESS **CHAPTER 7 PART 2 DIVISIONS 1, 2 AND 3 1998 ACT**	**NEW CLAIMS PROCESS FOR RELEVANT CONDUCT PSYCHOLOGICAL INJURY CLAIMS** **CHAPTER 7 PART 2 DIVISION 3A 1998 ACT**
Notification of injury to be provided to employer/insurer. Claim form not immediately required. Certificate of capacity sufficient to commence liability decision	Claim form must be provided (or as provided by Regulations. [1]
Provisional liability payments (of up to 12 weeks duration plus medical expenses) must be commenced within 7 days (1 week) of notice unless reasonable excuse or claim declined outright (decision notice issued). Weekly payments at 90% PIAWE	No provisional liability. No reasonable excuse. Interim payments of weekly compensation at 75% PIAWE plus medicals up to total of $7,500
If a reasonable excuse given by insurer worker must make a claim (by provision of a completed claim form)	
Insurer must determine liability within 21 days (3 weeks) of notification or 21 days (3 weeks) within the provision of a claim form after a reasonable excuse. No deemed acceptance.	Insurer must make a decision on liability within 42 days (6 weeks) of claim. Deemed acceptance of liability if no decision on liability made within 42 days of claim.
If liability accepted, benefits commence in accordance with the provisions of the 1987 Act	If liability accepted, backpay of weekly compensation to meet legislative entitlements and medical expenses to be paid.
If liability disputed, worker can seek optional internal review. Insurer review decision must be issued within 14 days (2 weeks) of request.	If liability disputed on the basis of relevant conduct (even if other bases included) worker must seek review by insurer of decision (s280AE(4)). Insurer must issue review decision within 14 days.

If decision on liability maintained after review or worker does not seek optional review, worker must apply to the Personal Injury Commission for dispute resolution.	If insurer maintains dispute concerning relevant conduct worker must apply to the Industrial Relations Commission for determination of the dispute under Chapter 7, Part 3, new Division 3 1998 Act.
	If Industrial Relations Commission determines no relevant conduct, determination is binding and claim cannot be determined by the Personal Injury Commission. If Industrial Relations Commission determines relevant conduct has occurred, the insurer must issue a decision notice about the claim within 7 days of receiving the certificate of determination. If the insurer accepts liability, the worker is entitled to compensation from the **date the claim was made**.
	If the insurer continues to dispute liability, the dispute must be referred for determination by the **Personal Injury Commission**.

The proposed regulations in Part 8A

65. Part 8A of the Regulation only deals with psychological injury claims.

66. Psychological injury claims will, by virtue of the amendments to the 1998 Act, be divided into two categories:

    Category 1 - psychological injury claims based on relevant conduct, and

    Category 2 - primary psychological injury claims not based on relevant conduct.

67. Under the 1998 Act as amended Category 1 psychological injuries are subject to a different claims process (Chapter 7, Part 2, Division 3A 1998 Act) subject to the new *regulations*.

68. All other injuries, both Category 2 psychological injuries and all physical injuries remain subject to the existing claims process under Chapter 7, Parts 1 to 3, 1998 Act and are to be made in accordance with the Workers Compensation *Guidelines*[15]. (The Workers Compensation

[15] See section 260 1998 Act: Subsection (1) A claim must be made in accordance with the applicable requirements of the Workers Compensation Guidelines. See Worker

Regulation 2016 does not currently prescribe how a claim is to be made by a worker.)[16]

69. This is where it becomes confusing. Both the Guidelines and the Regulations will contain information relevant to the making of a claim. For category 2 psychological injuries both the Guidelines and regulations will set out requirements for the making of a claim.

70. Regulation 42D recognises this confusion and attempts to resolve it by providing that effectively where the Guidelines and the Regulation can both make provision for the making of a claim for psychological injury, the new regulations prevail.

71. Apart from Regulation 42E and 42I the balance of the regulations in Divisions 2 & 3 of the Regulation apply only to Category 1 claims, i.e. relevant conduct claims.

72. With respect, the confusion created is not resolved. Category 2 psychological injuries are entitled to provisional liability payments and are not required to make a formal claim or submit a claim form until either a reasonable excuse notice has been issued, or compensation is likely to be claimed beyond the provisional liability limits and the insurer determines that there is insufficient information to determine ongoing liability.

73. The Guidelines require certain information in order for there to be an initial notification of injury. That information currently mirrors exactly what is contained in Regulation 42E, with the exception that Reg 42E requires, in addition a medical certificate specifying one or more mental or psychiatric disorders and the worker's consent to use and disclose the information for purposes reasonably connected with responding to and managing the claim. The additional requirements of regulation 42E presuppose that a claim form is required whereas one is not required initially where the injury is a category 2 psychological injury.

74. Were regulation 42E confined in its application to relevant conduct psychological injuries (Category 1 in this submission) it would not be confusing save for the fact that all other claims requirements are dealt with by the Guidelines and relevant conduct claims requirements are dealt with by the regulation.

Regulation 42I

75. Similarly, Regulation 42I which sets out matters and circumstances that an insurer must take into account in determining whether an injury is a *primary* psychological injury would be better dealt with in the Guidelines. A primary psychological injury is one which is not a secondary

[16] See: https://www.sira.nsw.gov.au/__data/assets/pdf_file/0011/438338/Workers-Compensation-Guidelines-March-2021.pdf

psychological injury[17]. The distinction between a *primary* and *secondary* psychological injury is well understood.

76. Given that there are tight timeframes for determining liability for a category 2 psychological injury (made by notification), and the requirement that a claim form be submitted for Category 1 psychological injuries (meeting the onerous requirements of Regulation 42G), we submit that Regulation 42I is either unnecessary or duplicates requirements already set out in the Guidelines/Regulations.

77. The regulation will hamper the administration of claims made for all psychological injuries, not just relevant conduct claims. If the matters and circumstances insurers are mandated to take into account are not available, the regulation requires them to seek it out. This will lead to delay in determination of claims and increased disputation including challenges on the basis of privacy or privilege.

78. The ALA takes objection to the mandatory nature of regulation 42I, and the extent of the matters and circumstances listed. This is to determine *primary injury* only, not determine liability. A worker's privacy may be breached, sensitive material may be exposed, proceedings or investigations initiated and not resolved (as would be expected at the point at which the material is required – prior to liability for a claim being determined) may be compromised or jeopardised by the examination of the material, particularly that listed in sub clause (g).

Recommendation 7

The ALA considers that Regulation 42I is unnecessary and as it only applies to insurers is not appropriate for the regulations. It should be removed in its entirety or alternatively be modified (made optional not mandatory) and placed in the Standards of Practice or the Guidelines.

Regulation 42F – Additional "evidence" for relevant conduct claims

79. Regulation 42F only applies to Category 1 injuries.

80. The reference to "evidence" and not 'information' reflects the wording in new section 8Q 1987 Act. We assume that this is deliberate and not a mistake. Sub clause (a) is mistakenly confined to proceedings in the Industrial Relations Commission (which can at present and until the 'new' jurisdiction under the 1998 Act is established, only apply to public servants and local

[17] Section 8C 1987 Act as inserted by the *Workers Compensation Legislation Amendment Act 2025*.

government employees). Both public sector and private sector employees may have pursued proceedings or have been involved in proceedings in the Fair Work Commission, other commission, a court or other tribunal

81. It is patently clear that the Government intends that workers with relevant conduct claims are to jump through many more hoops than any other injured person seeking compensation and that they will be punished if they do not provide absolutely every detail forming the basis of their claim. The regulations unfairly single out workers with relevant conduct claims in circumstances where those workers are already treated within the amendments

82. The punitive elements of this regulation are demonstrated by the consequences of a worker not providing the details required in Subclauses b and c. A sexually harassed worker may be so traumatised particularly at this point in the claims process, but they would be unable to provide details of the specific nature of each instance of the conduct complained of all the date time and location of each instance of the conduct. They may not want to name the persons involved in the conduct or the witnesses, if any, to the conduct as they may have taken a complaint to the New South Wales police and that complaint may be the subject of an investigation or should be kept private and confidential until such time as other processes in other places have completed.

83. We do not understand what "reasonably practicable" means or implies given the specificity of the "evidence" is listed.

Recommendation 8

We recommend that Regulation 42F(a) be amended to include proceedings in a commission, court or tribunal (as provided in new section 280AC 1998 Act[18])

We further recommend:

(1) that subclause 42F(b) be amended to provide that non-provision of the 'evidence' is not a barrier to making a claim and can not form the basis of an issue estoppel in proceedings before the IRC or PIC.

(2) that sub clause 42F(c) be removed as unnecessary and unduly onerous.

[18] Section 280AC(2) A finding by a commission, court or tribunal that relevant conduct has occurred is taken to be evidence the relevant conduct occurred.

Regulation 42G

84. Regulation 42F read in conjunction with regulation 42G appears to be designed to defeat a worker with a relevant conduct claim and dissuade such a worker from making a claim.

85. Regulation 42G only applies to relevant conduct claims. It is far more onerous than provisions applying to other psychologically injured workers.

86. This regulation permits an insurer to determine they have received an incomplete claim form and therefore not commence interim payments.

87. It renders mandatory the provision of 'evidence' required to be provided "as far as reasonably practicable" in the preceding regulations 42F and 42E. It renders non-provision of "evidence" to the satisfaction of the insurer a complete bar to making a claim. There is no relief provided if the insurer is not satisfied with 'evidence' specified in clauses 42E and 42F. While the insurer is required to specify what action a worker must take to "complete the claim", if the worker cannot take that action (which may be to provide evidence of a kind), the worker is left in limbo.

88. A worker with a relevant conduct claim who provides an "incomplete claim" is punished unlike any other worker in that interim entitlement payments are only commenced on the submission of a "complete claim".

89. There is no maximum period for a worker to complete a claim form. Entitlements will only run from the completion date this creates an incentive for insurers to find deficiencies in the claim. There is no process provided for a worker to dispute an insurer's incompleteness finding in this loop could repeat indefinitely. This is wholly unsatisfactory.

90. The consequences for workers not providing evidence to the satisfaction of the insurer may be profound. They will not be assisted by the legal advice at this stage of a claim and are unlikely to understand the consequences of failing to provide specifics as required by regulation 42F(b) (for example, "the specific nature of each instance of the conduct"; "the date, time and location of each instance of the conduct"). They may be prevented from raising an instance of conduct in future proceedings and may be deprived of compensation in legitimate circumstances.

91. The unintended consequences of a regulation such as 42G are delay in claims determination, prolonged absence from work, delay in returning to work and additional costs to an employer in replacing even on a temporary basis a worker who has no capacity for work but whose claim is incomplete.

Recommendation 9

We recommend by reason of the potential for insurers to find deficiencies in legitimate relevant conduct claims and to not 'acknowledge' that a claim has been made without specific timeframes for them to determine liability, coupled with the potential serious consequences for workers if they do not comply completely with the requirements of regulation 42G, that Regulation 42G be removed.

Alternatively, the making of a 'complete claim' could be reworked so that the receipt of a claim form as is required to make a relevant conduct claim sets in place a timeline so as not to render section 280 AC meaningless in the circumstance of an incomplete claim form. No worker should be singled out for punishment in circumstances where their rights and entitlements have been constrained by the legislation. If claims are permitted to be made where relevant conduct is the cause then those claims should be permitted to proceed within a fixed timeframe for determination of liability by the insurer. A worker can then pursue their claim as is required.

Regulation 42J

92. Regulation 42J requires an insurer to give notice of various matters "as soon as practicable". 'As soon as practicable' is not an enforceable deadline. If insurer cannot calculate back payment, it must only 'inform' worker of steps taken and expected.

93. Subclause 42J(1)(c) refers to the Workers Compensation Guidelines (an inadvertent error?) when it is these regulations that specify the entitlement to reimbursement of reasonable and necessary medical and related treatment in relevant conduct claims. The ALA supports that the suggestion that the Guidelines set out the entitlement to medical and created treatment.

94. Subclause 42(2)(j) does not provide a timeframe within which the insurer must make the payment. To not provide one and provide no basis to compel an insurer to make back payment is wholly unsatisfactory. This invites delay with no penalty are specified.

Recommendation 10

The ALA recommends that regulation 42J be amended to include a timeframe for back payment and at the expiry of which the worker can seek orders from the PIC and that a penalty be imposed against the insurer and employer.

Regulation 42K

95. This regulation only applies to relevant conduct claims and references clause 38 of the regulation which sets out the information that is to be contained in a section 78 notice of an

insurer's decision to dispute liability. The additional information specified in regulation 42K(1)(a), (b) and (c) is essential to an effective section 78 notice in relation to relevant conduct claims.

96. However, providing information about an optional and a mandatory review is confusing and gives rise to the potential for a worker to pursue proceedings in the IRC before seeking the mandatory review.

97. Given that clause 38 already deals with notice of insurer decisions it would be preferable that clause 38 be amended to include as a further sub-clause the information required for relevant conduct claims in regulation 42K(1)(b) and (c). Regulation 38(d) already provides that the insurer must provide details of the procedure for requesting a review of the decision and thus already covers regulation 42K(1)(a).

Recommendation 11

The ALA recommends that for clarity, simplicity and to facilitate streamlined operationalization of the regulations that clause 38 be amended to include the information in regulation 42K of regulation 38.

Consequential recommendation 11A

The ALA further recommends that **clause 41** (existing) of the regulation be amended for the purposes of all claims to include as a type of report that an insurer has to provide with a section 78 notice, all accounts of witnesses to a relevant event specified in a psychological injury claim, all audio and video recordings held by the worker's employer relevant to the claim, all reports relating to a relevant event obtained by the insurer from the employer, or a union, or the New South Wales police Force, or SafeWork NSW, or the fair Work Commission, or another investigative body (as referred to in regulation 42I).

Regulation 42L

98. This regulation only applies to relevant conduct claims and sets out the purposes of section 280AE 1998 Act the procedure for the mandatory review of a relevant conduct claim before a dispute may be referred to either the PIC or the IRC.

99. Section 280AE(7) allows for the Guidelines to specify the notification of decisions and the procedure for conducting a review of a decision about a relevant conduct claim.

Recommendation 12

That the contents of regulation 42L be removed to the Guidelines as is authorised by the 1998 Act.

The ALA repeats its recommendation regarding amendment of existing clause 41 to include the material and information referred to as "matters and circumstances insurer must take into account" in regulation 42I.

Comment on Part 8A

100. No worker should be singled out for punishment in circumstances where their rights and entitlements have been constrained by the legislation. If claims are permitted to be made where relevant conduct is the cause then those claims should be permitted to proceed within a fixed timeframe for determination of liability by the insurer. A worker can then pursue their claim as is required.

101. We reiterate that Part 8A in its entirety is confusing if only because all but regulations 42E and 42I relate only to relevant conduct claims (or as we named them Category 1 psychological injuries). For Category 2 psychological injuries and physical injury claims the Workers Compensation Guidelines provide the equivalent material.

102. The regulations should clarify, streamline and simplify processes rather than complicate them. This part of the regulations is complicated and unfairly targets workers with psychological injuries arising from relevant conduct. Preventing the making of a claim is neither intended by the legislation nor would it be sound government policy.

103. Our primary position is that all workers should be guided by the same processes for notification of an injury and the making of a claim.

104. It would be simpler and sounder if consideration was given to modifying some of the regulations and removing them to the Guidelines. A similar comment/recommendation has been made in relation to the regulations regarding medical and related treatment.

105. The ALA has given consideration to the ease with which the regulations can be operationalised and administered. Our position is that the regulations may prove to be impossible to operationalise efficiently.

Part 9A Principal Assessments

106. The regulations in Part 9A address the requirements of new sections 153K, 153Q which are contained within the 1987 Act Part 6, Division 2 and relate to the proposed SIRA conducted 'principal assessment' process.

107. ***Principal assessment*** is defined in the 1987 Act (new section 152) as "*an assessment of the degree of permanent impairment of an injured worker under Part 6, Division 2 1987 Act by an assessor included on the SIRA register of permanent impairment assessors*."

108. The new permanent impairment process is found in Part 6 1987 Act. The new process does not apply to permanent impairment 'assessment' of exempt workers or coalminers.

109. In the DCS and SIRA document "Workers Compensation Reform: Regulations and Guidelines Information sessions", the Government informed that the reforms in relation to the new process "*will be implemented in two phases (from July 2026, then July 2027)*."

110. Regulations 49A and 49B apply to SIRA Principal Assessments.

Regulation 49A

111. This regulation is not objected to. The content of regulation 49A however could be easily placed in the Guidelines rather than the Regulations.

112. Regulation 49A however presumes that no evaluation of impairment has been undertaken prior to the principal assessment. Generally speaking, a worker seeks permanent impairment evaluation when they want to assert a claim for permanent impairment compensation. There are existing impairment thresholds for all benefits or entitlements a worker might seek for which they require an impairment evaluation to "make a claim".

113. The principal assessment process and the requirement for an application form presupposes that a worker will self-determine when the optimal time is to seek that "assessment". That is impossible. There is absolutely no way a worker can make that self-determination or, in fact, an insurer or a legal representative. Impairment evaluations in accordance with the New South Wales Guidelines have to be conducted by trained medical specialists (trained assessors).

114. At present, a worker will obtain an evaluation of their impairment from a trained assessor expressed in a medical report which they will "serve" on the insurer when they make a claim for lump sum compensation or seek extension of an entitlement. The making of the claim then commences a claims determination process which will result in an acceptance or denial of the claim. If the claim is accepted an agreement is entered into under section 66A 1987 Act. If the

claim is denied, the worker can make an application to the PIC for resolution of a dispute. If the only issue in dispute is the degree of permanent impairment, the matter will be referred to a Medical Assessor for assessment of the degree of permanent impairment.

115. The Principal Assessment Process is not triggered by a claim or by an evaluation. The ALA cannot conceive of a single worker who could apply for Principal Assessment without an evaluation by a trained assessor. Concepts such as 'stabilisation of injury', 'maximum medical improvement' and thresholds are beyond the understanding of most people.

Regulation 49B

116. Regulation 49B is made under section 153Q 1987 Act. That section refers to "Further principal assessments".

117. It is clear that the consequences of a worker being found with high needs (>20%WPI) or highest needs (>30%WPI) has not been taken into consideration in the drafting of this regulation.

118. Section 153Q provides that a further principal assessment may be undertaken but only if strict conditions are met, namely if the worker and insurer agree that there has been an unexpected and material deterioration in the worker's condition since the last principal assessment was conducted.

119. *"Unexpected and material deterioration"* is defined by a two-limb test, with both lens having to be satisfied: "*there being no reasonable cause to believe the worker's condition would deteriorate*" and "*the deterioration results in an increase in the worker's degree of permanent impairment of at least a further 10%".*

120. Section 153Q does not state that there will be only one further principal assessment. This restriction is contained in regulation 49B. Furthermore, on a strict reading of 49B a worker may lose their right to receive further lump sum compensation if their first attempt at obtaining a further principal assessment is unsuccessful by virtue of the fact that the assessments results in an increase of whole person impairment less than 10%. This is because the restriction in 49B is by reference to the assessment itself rather than the qualification of further lump sum compensation on receiving an assessment that is equal to or greater than a further 10 percentage points above the principal assessment.

121. Furthermore, the 153Q does not provide that there can only be a further principal assessment in circumstances where an insurer agrees or fails to respond. The Regulation makes no provision for what is to occur if the insurer wishes to dispute the entitlement to undertake a further principal assessment and how that dispute is to be resolved.

122. Given the highly onerous requirements of "*unexpected and material deterioration*" it is inconceivable that a worker would overcome this test more than once unless they had an extremely serious injury with unforeseeable catastrophic consequences. In other words, section 153Q sets an extremely high bar.

123. Regulation 49B provides where agreement by an insurer has not been received within 21 days after a request is made, the regulation further deems the insurer to have agreed to a request for a further principal assessment. Regardless of how many days an insurer is given to respond to a request for further principal assessment, the insurer themselves is in no position, just as the worker is in no position, to determine if they will meet the second limb of the test. The second limb requires an assessment in accordance with the *NSW workers compensation guidelines for the evaluation of permanent impairment Fourth edition*. That evaluation can only be provided by a trained assessor, not a claims officer, claims manager or lawyer.

124. **Comment:** The ALA considers regulation 49B to be irrelevant and unnecessary. There are so few workers that would meet the first limb of the test let alone the second limb, that to limit workers to only one further principal assessment is unnecessary. The ALA submits that a worker who was able to meet the unexpected and material deterioration test more than once is a worker who ought to be permitted to undergo more than one further principal assessment.

Recommendation 13

That regulation 49B be removed as it is unnecessary and is protecting insurers from an impossible circumstance.

Regulation 49C

125. The requirement for the certificate to include "a description of the deterioration in the workers condition since the workers last principal assessment" is not needed and should be removed.

126. Section 153Q(2) already requires that the worker and insurer agree that "it appears there has been an unexpected and material deterioration in the workers condition". By virtue of that agreement (or any other mechanism that the regulations may provide from time to time) the assessment is already taking place, and the worker will either be entitled to further compensation, or they will not. If there has been no deterioration, then the impairment will not have increased and nothing will turn on what is written by way of a description to comply with the proposed 49C regulation.

Recommendation 14

Regulation 49C in unnecessary and should be removed.

Part 9B Commutation of Compensation

127. In answer to a question by the Public Accountability and Works Committee about the proposed threshold increase for lump sum compensation and work injury damages, in their hearing on 17 June 2025, the Treasurer stated:

> *"… we absolutely accept that there is a need for there to be commutations put into the system. What that's likely to do is encourage a person to get a WPI earlier. That actually means that they're more likely to access treatment earlier. They're also more likely to be on a path to return to work earlier. Ultimately, should they then find themselves in a position in which they choose to want to leave the scheme, they have that right."*

128. The Treasurer's evidence suggested that that access to commutations would be expanded, allowing injured workers to exit the scheme earlier, and utilise commutations more freely as a settlement option in dispute and that that there would be a relaxation of the whole person impairment threshold of 15% to allow access to commutations in a broader range of circumstances.

129. The ALA has been calling for open exit and settlement options by way of commutation or compromise settlement for many years. That being so the ALA welcomes this 'opening' of commutations but expresses concern at the limited classes of case permitted to utilise the mechanism and the timeframes imposed on its exercise.

130. The regulations allow for relaxation of the impairment threshold (15%) for defined classes of workers injured **prior to 1 January 2023** and only for a limited time. The rationale for the limitation by date of injury is not provided nor has it been explained. Why is a worker injured in 2023 to 2026 not able to access a commutation?

131. The impending framework concerning commutations is contained within new sections 87E to 87H 1987 Act. At section 87EA, the amendments will permit the regulations to define classes of cases to which a commutation may be available.

132. Regulations 49F and 49G prescribe two classes of cases for which commutation will be opened:

Class 1 cases being workers who sustained injury between 4:01 pm 30 June 1987 and 1 January 2023 where that worker has an existing and continuing entitlement to weekly payments and medical expenses (not including claims for hearing loss), and

Class 2 cases being workers who sustained injury between 4:01 pm 30 June 1987 and 1 January 2023 where that worker has an existing and continuing entitlement medical expenses (not including claims for hearing loss)

133. For both class 1 and class 2 cases the worker has to have received the requisite benefit for the past 52 weeks and have agreed their degree of permanent impairment with the insurer but does not have to achieve the threshold of 15% WPI in order to commute.

134. A commutation arrangement is typically achieved by negotiation and agreement between worker and employer/insurer. Neither worker nor employer/insurer can be 'forced' into a commutation agreement.

135. Regulation 49I prescribes that independent financial advice must be obtained either if required by the approving member in the Commission or if the commutation sum is $100,000 or greater.

136. The ALA considers that the provision of financial advice to a worker is an unnecessary impost on the scheme. Workers who meet the classification of worker under the Regulations have a driving incentive to exit claims management by the insurer and to assert financial autonomy. Financial advice at a cost of $2,000 (as is proposed by the Regulations to be paid by the insurer)is unlikely to assist a worker to seek or accept a commutation of their existing and future entitlements.

137. The ALA is deeply concerned by the arbitrary time limit imposed by Regulation 49K that demands that workers apply for (by "expression of interest") and have their commutation approved by the Commission by 1 July 2028. This is an arbitrary time frame within which workers may not even be informed of the opportunity to commute.

138. If such an arbitrary and restricted timeframe is to be imposed then insurers must be obliged to notify each and every eligible worker by multiple means that they can submit an expression of interest to commute their rights. The obligation to notify workers must be placed on insurers so that all workers who are eligible can avail themselves of the opportunity.

139. The time limitation in regulation 49H that an 'expression of interest' must be submitted to the insurer within 12 months of the commencement of the legislation is onerous. This must be expanded. Workers need to be notified first before such time limitations can be imposed.

- Under the proposed regulation 49K, an injured worker must apply for the approval of a commutation within 24 months of the commencement of the legislation.

140. The timeframe of 24 months following commencement of the amendments to the 1987 Act to have any commutation arrangement approved also warrants expansion.

141. As stated above, class 1 and 2 workers are unlikely to be aware of the availability of commutation unless informed by the insurer. The insurer must be obligated to inform the worker of the availability of a commutation arrangement and the process for achieving one, including the necessity of receiving independent legal advice, and not just once but at least every 6 months.

142. Despite the ALA being disappointed with the regulations and limitations on both classes of cases and workers who can express interest in commuting their rights, the ALA supports the regulation subject to the recommendation below.

Recommendation 15

(a) That the words "*within 12 months after the commencement day"* in Regulation 49H(1) be removed or alternatively be amended to be within 12 months of receiving written notification from the insurer of the right to lodge an expression of interest.

(b) That a commutation arrangement for class 1 and 2 workers be open to approval at any time after agreement and not limited to 24 months after the commencement of the legislation.

Recommendation 16

The commutation provisions in Regulation be reviewed in their entirety with a view to expanding commutations to all workers so that they provide genuine exit and settlement options regardless of date on injury by removing the threshold in section 87EA so that worker who "*find themselves in a position in which they choose to want to leave the scheme, they have that right."*

Legal costs - ILARS funding

Clause 133A

143. By amendment to the *Personal Injury Commission Act 2020* by the amendment Acts, The government has now gained the function of not only regulating legal costs for all workers and insurers including those paid out by ILARS, but can also fix the "funding envelope" for

expenditure on ILARS by the IRO. This is a significant limitation on the ability for workers to obtain legal advice and assistance with their claims and disputes.

144. Clause 133A provides that the maximum costs provided for by the Independent Review Office will be the scale of costs set out in the *Independent Legal Assistance and Review Service Funding Guidelines*. On face value it seeks to maintain the current position however Regulation 133A goes further to say that that it is the Guidelines "in force immediately before the commencement of the *Workers Compensation Legislation Amendment Act 2025*" that will set the maximum costs.

145. The effect of this is that unless and until the Regulation changes, legal and associated costs will be frozen in time at a level that may or may not be commensurate with the current level of funding or different.

146. The failure of the ILARS Guidelines or Schedule 6 1987 Act to be indexed over time has long been a source of concern for the ALA and other peak legal bodies. It serves to save money at the expense of workers and risk a decline in quality of work and service to workers which impacts directly on access to justice.

147. These concerns are not new and have been explored in detail. We refer you to the IRO's 2024 Indexation Review by Dr Matthew Butlin[19] for further discussion on the issue of legal costs and indexation. Recommendations made by Dr Butlin have not been implemented with the current Officer indicating they will not be.

148. It is worthy to note that the fees in the ILARS Funding Guidelines were set in 2021 and have not been indexed or reviewed since that date. With the declaration that there will be no indexation mechanism for ILARS rates and the amendment Act introducing more complex dispute resolution processes to be funded out of a shrinking 'envelope' (provided for not by the Government but by the Workers Compensation Operation Fund), the ALA is concerned that workers will be denied access to justice simply because there is not enough to 'go around'. In the alternative, lawyers will be expected to subsidise their client's claims by accepting professional fees well below what is fair and reasonable.

149. Not only are there no provisions for indexation but the effect of regulation 133A is that there will further increases or changes to the Guideline will be within the control of the Government and not the Independent Review Officer. This removes any vestige of independence of the IRO.

[19] https://www.iro.nsw.gov.au/sites/default/files/2024-06/Indexation%20Review%20Report%20-%20Final.pdf

If the Regulations are never revisited, then lawyers representing injured workers can expect to be paid the same rates that they are currently paid into perpetuity.

Recommendation 17

We recommend adding words to 133A so that the maximum costs provided by IRO are those set out in ILARS Funding Guidelines as made from time to time.

Alternatively, to provide that the rate is the current rates provided for in the guidelines indexed annually by reference to the Producer Price Index Australia Legal Services.

Schedule 6 Maximum costs – compensation matters

150. The Regulation provides for amendments to the professional fees allowed to for workers and insurers in relation to commutations, and to financial advisors for the cost of financial advice.

151. The amendment in Schedule 1[21] of the Draft Regulation brings the fees for commutation in Schedule 6 in line with the rates set out in the ILARS Funding Guidelines (in place for 5 years now without change). Whilst it represents an increase in the fees from the current rate set out in Schedule 6 it remains inadequate for the work required to assist an injured worker or insurer with a commutation.

152. The ALA has for many years called for a wholesale review of the legal costs in Schedule 6. The structure of Schedule 6 has not changed or been reviewed for many years despite the significant changes to the legislative framework, the dispute resolution processes and pathways and the work required to be completed by legal representatives for their clients. The legislation is more complex and "labyrinthine" and increasingly difficult to navigate than it has ever been. This has resulted in Schedule 6 being considered by the legal profession as "***not fit for purpose***".

153. The ALA remains concerned that the rates that are paid are wholly inadequate and that they do not respond to the Commission's procedural pathways nor outcomes and resolution stages. This has been the position since 2010. Despite indications of the failings of Schedule 6, nothing has been done to remedy it.

154. In recent days there has been significant reporting of Legal Aid NSW's decision to tighten eligibility for access to family law representation to those who are victims of domestic violence and aboriginal people. Members of the ALA are already seeing signs within the profession that lawyers working in the workers compensation space are at breaking point. As more lawyers

choose to either exit the market or young lawyers choose not to enter the market, the access to quality representation will diminish. Without wholesale reform the NSW government can expect that the system will eventually create headlines similar to that in the Legal Aid space and injured workers find it increasingly difficult to find lawyers.

Recommendation 18

That Schedule 6 be subjected to a wholesale review by a Ministerial Committee with at least 4 representatives of the NSW legal profession to determine whether Schedule 6 is fit for purpose and to make recommendations for a new Schedule.

That in the interim period, Schedule 6 be amended to reflect the ILARS Funding Guidelines fees (as at 15 May 2026) and the ILARS disbursement fees.

That professional fees for services provided by legal representatives for workers and insurers be indexed annually in accordance with the Producer Price Index Australia Legal Services.

Schedule 8 savings and transitional provisions

155. The ALA is concerned by the savings and transitional regulations and their impact on all workers currently in the system. To understand our concern, we have set out below what we understand each impactful clause does.

Division 1 Clauses

Clause 1

156. Sets out new definitions relevant to a new process to apply before Principal Assessments called "Interim assessments". The word assessment is used at least 60 times throughout the Draft Regulation. No definition of "assessment" is provided.

Clause 2

157. Establishes that the Savings and Transitional Provisions are intended to take effect despite any inconsistency with the 2025 amendment Act. This clause calls for consideration of sections 5 and 30 of the *Interpretation Act* 1987 when considering the impact and effect of the Part.

Clause 3

158. Redefines “unexpected and material deterioration” (previously defined in Part 6 1987 Act as amended) for application to new processes defined within the Part not contained within the 2025 amendment Act.

Clause 4

159. Provides that proceedings commenced and/or not finally determined before the commencement of the saving and transitional regulations are to apply Part 6 1987 Act prior to its commencement.

Clause 5

160. Provides that for workers who have their permanent impairment “assessed” before commencement of the principal assessment process (conducted by SIRA) must make a section 66 claim (for lump sum compensation) before 1 July 2028.

161. **Workers who do not make a claim within that timeframe are prohibited from making a section 66 claim and are therefore deprived of a right and entitlement**.

162. The ALA submits that the right to claim lump sum compensation can not be removed by regulation and any attempt to do so is, as best both capricious and beyond power.

Clause 6

163. Provides that after the commencement of the Principal Assessment process it will apply to all injuries whether incurred before or after the commencement new Part 6 1987 Act. It is expected that commencement of the Part will happen around 1 July 2027.

164. At that time if the worker with a claim has undergone one or more “assessments” of the degree of their impairment, that worker will be prevented from a Principal Assessment by SIRA of their existing claim and will not be entitled to a Further Principal Assessment unless they meet the requirements of section 153Q(2) 1987 Act.

165. Section 153Q(2) provides that the worker and insurer must agree “that it appears there has been an “unexpected and material deterioration in the worker’s condition since the last assessment”. “Unexpected and material deterioration” is defined in section 153Q (3) and is far more onerous test than the present test (section 327(3) 1998 Act) “deterioration of the worker’s condition that results in an increase in the degree of impairment”.

Clause 7

166. Defines a new process called “pre-reform impairment assessment”.

167. This process encompasses “an assessment undertaken and relied upon by a worker to establish an entitlement to weekly payments, section 66 lump sum compensation or to meet the threshold for work injury damages or a medical assessment conducted by the Commission under the current Chapter 7, Part 7 1998 Act.

168. This clause applies to all workers injured from 1 January 1987 and operates until the date that interim assessments commence (Division 2 of the new Savings and Transitional regulations).

Clause 8

169. Renders a section 66A agreement (“complying agreement” about a worker’s degree of impairment) made at any time before Principal Assessments commence binding on the worker, insurer or employer with whom the agreement is made for all purposes.

170. Section 66A 1987 Act is replaced by section 153S 1987 Act which will provide for “permanent impairment agreements”. Permanent Impairment Agreements form part of the Principal Assessment process in the new Part 6 1987 Act predicted to commence around 1 July 2027.

171. Clause 9, in conjunction with the definition of ‘interim period assessment’ will lead to perverse outcomes. What will occur in practice is that there will be a race between the applicant and the respondent to get the first assessment. That assessment will become the interim assessment and the other party will not be entitled to have a further assessment. Despite what Clause 11 says this will mean that one party or the other could find themselves in a dispute at the Personal Injury Commission with the adequate evidence. See our submission on clause 11 below for further detail on why this is the case.

172. From the Applicants point of view this could mean that they are unable to advance a claim for whole person impairment for a particular body system if the insurer did not include that body system in the interim period assessment.

173. From the Respondents point of view they could find themselves having to defend a claim for whole person impairment for body systems that they have no ability to get evidence to support their defence.

Division 2 Interim Period Assessments

174. Creates a new assessment process ("Interim Period Assessment") to operate in the "interim period" (defined in clause 1 as between the commencement of Division 1 of Part 6 1987 Act and the commencement of the Principal Assessment Process by SIRA on or about 1 July 1987).

175. The Interim period is expected to be between 1 July 2026 (when the amendment Acts and the regulation substantially commence and 1 July 2027 or whenever SIRA commences conducting Principal Assessments.

176. "Interim period assessment" is defined in clause 1 and means an "assessment" (undefined) conducted in the interim period in accordance with the New South Wales workers compensation guidelines for the evaluation of Permanent Impairment by an assessor included on the register of assessors maintained by SIRA.

Clause 9

177. Prohibits a worker and insurer from undertaking an interim period assessment if liability for the injury is in issue and a determination about that liability has not been made by the Commission.

178. Declares that an interim period assessment is taken to be a worker's principal assessment for entering into an "impairment agreement".

179. "Impairment agreement" is not the same as a section 153S Permanent Impairment Agreement. It is defined in clause 1 as an agreement that states the degree of permanent impairment the worker or insurer agree has resulted from the injury and other matters related to permanent impairment and which includes a certification by the insurer that they are satisfied the worker obtained independent legal advice before entering into the assessment.

180. An injured worker must receive independent legal advice before entering into an impairment agreement (in the interim period).

Clause 10

181. Prevents an injured worker who has entered into an impairment agreement from having a further assessment unless the worker and insurer "agree it appears there has been an unexpected and material deterioration in the worker's condition since the last assessment".

Clause 11

182. Deals with when there is a dispute about an interim period assessment. If after an interim period assessment a worker and insurer cannot agree as to the worker's degree of permanent

impairment, the insurer must provide a section 78 1998 Act notice and either party can "elect to have the disagreement determined by the Commission as a medical dispute".

183. This clause contradicts Part 4, Division 3 1998 Act specifically section 288 which limits the jurisdiction of the Commission, where the dispute is about lump sum compensation, to applications made by the worker only.

184. The Commission has power to deal with disputes. "Disagreement" is not defined.

185. The party who elects to have the disagreement dealt with by the Commission must present medical evidence supporting their position. Given that there are restrictions on medical reports the commission can consider and that a worker may be unable to obtain medical evidence supporting their position (see clause 13), this clause may force parties into an untenable position. The Commission is unlikely to refer a disagreement to medical assessment if there is no countervailing medical position.

Clause 12

186. The Commission's determination is of the degree of permanent impairment and entitlements of a worker take precedence over the savings and transitional regulations in Division 2.

Clause 13

187. This clause limits the costs of an interim period assessment to those costs provided by section 153I 1987 Act.

188. Section 153I restricts costs to being paid only where there is an assessment permitted by Act or the regulations.

189. Costs are not payable for more than one permanent impairment assessment of the worker unless the assessment is for the purposes of disputing a permanent impairment assessment or where the parties agree there appears to be an unexpected and material deterioration, or the assessment is for any other purpose prescribed by the regulations.

Comment on Division 2

190. The clauses referred to in Division 2 create a complicated assessment process which is completely unnecessary in light of the existing and established procedure.

191. The interim assessment process is futile. Insurers are highly unlikely to agree to an assessment, just as they are highly unlikely to agree that it appears that a worker has an unexpected and material deterioration. Workers are trapped. The process is futile; it will lead to perverse outcomes.

192. No complaint has been made about permanent impairment assessments and in particular section 66 claims over the course of the reforms.

193. The amendment Acts provide for a new Principal Assessment procedure conducted by SIRA. Until that procedure is established and commences to function the status quo should be maintained. The interim assessment process does nothing to reduce disputation, reduce costs, improve return to work outcomes. But it is unduly unfair to workers injured before the commencement of the amendment Acts, particularly Part 6 of the 1987 Acts.

194. Workers injured before the commencement of the amendment Acts will have received advice or will be proceeding with their claims based on information provided by insurers. The savings and transitional regulations change the nature of their rights and significantly reduce their entitlements. Whereas they have an expectation as to entitlements, that expectation can no longer be relied upon.

195. Who is to inform workers that their rights and entitlements have changed? The difficulties associated with educating and informing workers are insurmountable. The consequences for workers of this Division are immense.

196. The difficulties in workers and insurers implementing a new and untested process are many. The ALA expects that there will be challenges to this interim assessment process on the basis that it is beyond power and that it tramples on the accrued rights of workers injured before the commencement of the amendment Acts.

Recommendation 19

That Division 1 so far as it impacts on Division 2, and Division 2 of the savings and transitional regulations be removed or disallowed.

Division 3 Cessation of weekly payments (and recommencement)

197. Division 3 deals with cessation of weekly payments. It is concerned with the circumstances in which a worker may be entitled to recommencement of weekly payments after their payments have ceased by virtue of them meeting the requisite impairment threshold and the date from which those payments are to recommence.

198. The 2025 amendment Act will provide in sections 39 and 39A that recommencement of weekly payments will only occur after the worker satisfies the requisite impairment from the date of

that assessment and not from the date of cessation of payments (as is currently: *Hochbaum*, *Whitton*).

Clause 14

199. Provides that the new provisions in the Act will apply to claims made both before and after the commencement of the amendment Act. Ensuring that no worker whose weekly payments have ceased and are recommenced will receive "back payment" to the date of cessation but rather to the date of "assessment".

Clause 15

200. This clause is to prevent an unintended consequence the delayed commencement of Principal Assessments by essentially providing that interim period assessments have the same status as a principal assessment when considering the date from which to recommence weekly payments.

Clause 16

201. This clause specifically provides for the cessation of weekly payments for psychological injuries at 130 weeks for injuries notified after 30 June 2026 and before the new provisions in sections 8 to 8Q 1987 Act commence.

Division 4 Clause 17 Determination of the degree of permanent impairment

202. This clause is self-limiting in that it ceases to apply from the commencement of SIRA's Principal Assessment process.

203. This clause purports to cover all injured workers injured at any time before there is principal assessment process is functioning. It appears, although complicated, to provide that any assessment of impairment undertaken at any time by a worker is taken to be a principal assessment whether or not the worker received independent legal advice before the assessment.

204. The relevance of this is that any worker is not entitled to a second or subsequent assessment unless it appears there has been an unexpected and material deterioration in the worker's condition since the last assessment was conducted.

205. There is no definition of "assessment". This could be an evaluation of the degree of permanent impairment by a trained assessor conducted many years ago and never acted on. It could be an "assessment" in the hands of an insurer or a worker's legal advisor.

206. What it does do is it applies the new test for a further assessment to any worker who would have previously understood that if they had relied upon an assessment to make a claim and

subsequently suffered a deterioration of their condition that resulted in an increase in the degree of permanent impairment they could obtain a further assessment as to the extent of that deterioration.

207. Unexpected and material deterioration is a very stringent test. It will be met by very few workers.

Commentary on Savings and Transitional Regulations

208. Divisions 1 to 4 establish new and restricted processes for the determination of a worker is permanent impairment to operate until such time as SIRA commences Principal Assessments. These processes comprise:

- Pre-reform assessment
- interim assessment

209. Both of these processes are designed to ensure that workers at any time up until the commencement of SIRA's function are restricted by one evaluation of the degree of their permanent impairment conducted by a trained assessor no matter when that assessment took place.

210. For workers injured in the past who had been advised that they could seek further compensation or benefits based on a further assessment where their impairment had deteriorated, those workers will no longer be able to do so unless they meet the extremely onerous test of "unexpected and material deterioration" which includes establishing that they have a greater than 10% additional whole person impairment. That test also relies on the insurer agreeing with the worker.

211. Workers who have an evaluation of impairment are required to make a claim for section 66 lump sum compensation by 1 July 2028 otherwise they lose that right. The ALA is of the opinion that the regulation is beyond power in this respect.

212. Both processes affect the accrued rights of workers injured at any time before the commencement of the amendment Acts.

Recommendation 20

That Interim assessments be abandoned.

213. That pre-reform assessments be abandoned and the status quo remain until such time SIRA commences Principal Assessments. This then permits the existing procedure bound by all of the existing strictures of one claim and one assessment (under the 'Old Acts') to be maintained until the new procedure commences. This would be far smoother, simpler, fairer and easier to operationalise and administer.

214. The savings and transitional regulations use the word 'assessment' so often as to render the word very confusing. It is made apparent by clause 7 of the savings and transitional regulations that the word "assessment" does not only mean a medical assessment under the 1998 Act, Chapter 7, Part 7. In the definition of "pre-reform impairment assessment" there is a reference to a 'medical assessment' and to "assessment undertaken". Elsewhere assessment is used in conjunction with 'interim' and 'pre-reform' to have other meanings.

215. This regulation is largely outside of power in some respects or unduly punitive, specific, prescriptive but for no demonstrated purpose.

216. The Act have not commenced to any great degree and yet the regulations imposes harsh restrictions and conditions on claimants.

217. Every single regulation will in its very nature produce delay, additional disputes and time wasting on dispute resolution. This adds cost to the scheme and therefore cost to employers. In an environment where premiums are frozen until 1 July 2028, this means that in July 28 if these regulations are allowed to come in, the premium increase will be far more than the 30% of the current premiums that was being projected by the business council of New South Wales and in fact the government.

218. The regulations seem to be an opportunistic grab at prevent preventing claims from being made and preventing workers from returning to work or advancing their accrued rights in terms of Claims.

219. No thought seems to have been put into who is going to assist a worker, how does a worker in New South Wales know of these new restrictions on their ability to make claims, pursue Claims or receive benefits, how is this to be operationalised within such a short period of time? How is this not disruptive of a scheme that is already in turmoil and has already gone through one year of intense debate and fury?

Claim Form

220. The ALA notes that the proposed Worker's Injury Claim Form has been expanded to reflect clause 42F, which requires a worker making a claim arising from "relevant conduct" to provide evidence including details of the following:

- the specific nature of each instance of the conduct,
- the date, time and location of each instance of the conduct,
- the persons involved in the conduct, and
- the names of any witnesses to the conduct.

221. These requirements are reflected in the Worker's Injury Claim Form at item 3A. However, while clause 42F provides that the information is to be given "as far as reasonably practicable", the Claim Form appears to state that the worker "must" provide the information. In the ALA's view, that inconsistency is material. It creates uncertainty as to the true threshold for making a claim and risks the form operating more rigidly than the Regulation itself contemplates.

222. Item 3A leaves the reader to assume that all injuries are either just physical or just psychological and instructs the reader to "leave blank if your injury is physical".

Recommendation 21

The ALA recommends that clear instructions be provided at item 3A for workers who have both a physical and psychological injury

223. Item 3A uses language that the average person may not be familiar with. Concepts of 'vicarious trauma' and 'indictable criminal conduct' should not be assumed to be part of the vernacular of the average person completing the form. Going further, to understand if conduct involved indictable criminal conduct would require extensive knowledge of the criminal justice system. The language can only lead to confusion and nothing else. Whilst there is an indication that further details about the relevant event can be found on page 11 (which contains an Addendum providing an outline of the activities which might meet the definition of a relevant event) it is not clear from the form without the addendum being read as to what constitutes the conduct which is considered the relevant offence. The addendum should be relocated so as to provide information to the worker prior to nominating the alleged relevant event.

224. Item 3A also does not provide an option to tick "other" or a free text option to allow an injured worker to describe

Recommendation 22

That Part 3A be reworked in its entirety use plain language with free text options to allow workers to easily understand what is required of them.

Whilst we have objected to the mandatory nature of Regulation 42I, if is to remain, then part 3A of the claim form should provide a warning to seek legal advice before completion of the form.

225. The ALA further notes that the vast majority of workers completing the form will do so without the benefit of legal advice. The level of detail apparently required is akin to that ordinarily found in pleadings or witness material and assumes that a worker has kept a detailed record of every instance of bullying, sexual harassment, racial harassment or excessive work demands. While that level of particularisation may ultimately be desirable in some proceedings, it is unrealistic to require it at the point of making a claim.

226. That difficulty is likely to be exacerbated for workers with limited literacy, limited English proficiency, or those who have experienced conduct of a traumatic nature, including sexual harassment. Many workers will also be unaware of the consequences that may follow from failing to provide the details contemplated by clause 42F, including the possible denial of interim payments under section 280AD of the 1998 Act. In practical terms, this risks undermining the statutory objectives of prompt treatment, effective injury management and the promotion of return to work.

227. Further, although the form indicates that the information is to be provided "as far as is reasonably practicable", it is unclear whether a worker who later obtains legal advice will be permitted to supplement or refine the particulars initially provided. There is a real possibility that the Industrial Relations Commission or the Personal Injury Commission may be reluctant to permit a worker to rely on material that was not included in the claim form. That uncertainty creates a further and unnecessary forensic risk at the very outset of the claim.

228. In our view it would be better to simply require an injured worker to simply provide "*examples of the nature of allegations".* That would be particularly appropriate where the relevant conduct forms part of a broader pattern of behaviour, such as bullying.

Recommendation 23

A more balanced approach should be adopted so that workers are encouraged to provide as much detail as is reasonably available without being required, at the claim stage, to particularise every instance of the alleged conduct with pleading-level precision.

The Workers Compensation Guidelines

229. The 13 April 2026 Workers Compensation Guidelines issued for consultation express that the intention of the Guidelines is to support the administration of the NSW workers compensation scheme, with the stated purpose being "*to support delivery of the objectives of the Acts and Workers Compensation Regulation 2016 by guiding insurers, workers, employers, medical and related service providers and other stakeholders and informing them about certain requirements for claiming workers compensation in New South Wales*." (ALA's emphasis)

230. SIRA states that their objective in developing the Guidelines and Standards "is to improve outcomes in the New South Wales workers compensation scheme by ensuring that **clear, consistent, easy to access expectations are established**." (ALA's emphasis)

231. ALA makes the following observations in light of these statements:

Clarity

232. The Guidelines lack clarity.

233. One only has to turn to Part 1 on page 6, headline green banner and read the following:

> Part 1 requirements relating to primary psychological injuries (as defined by section 8C of the 1987 Act, inserted by the 2025 Amendment Act) do not apply to exempt workers.
> Part 1 does not apply to primary psychological injuries caused by being subjected to bullying, excessive work demands and harassment ('relevant injuries') under section 280AB of the 1998 Act, except for exempt workers.

This banner is anything but clear. The first sentence says that it does not apply to *exempt workers* for certain types of claims.

234. The second sentence says that it doesn't apply to workers who have suffered a particular type of injury given a new description of "relevant injuries" and then it excuses exempt workers again.

235. In order to understand just the very first banner one has to refer to the 2012 amendment Act or the 1987 Act once it has been amended, the version of the 1987 Act that excludes those

provisions not applicable to exempt workers and then look at provisions of the 1998 Act to determine what is now called a relevant injury.

236. This is confusing guidance material for insurers. It is many more times confusing for workers, employers, medical and related service providers and other stakeholders.

237. The guidance material contained in Part 1.1 and Table 1.1 also lacks clarity. Given that part one does not apply to "relevant injuries", why is there a requirement for an initial notification of injury to include the nomination of one or more "relevant events" as the cause of injury?

238. The "if you get injured at work" poster that has been designed to be displayed in every workplace requires notification at Step 1. It says "Tell your employer". Step 2 is "See your doctor". Step 3 is "Recover at work".

239. Why does then the initial notification of injury require nomination of your treating doctor and tick a box nomination of a relevant event?

240. The green banners for the most part are equally confusing.

241. The ALA recommended in 2018 when the Guidelines were rewritten that there be a specific section of applicable to exempt workers. The ALA maintains that request for obvious reasons and for the specific reason that the legislation and Guidelines are now extremely complex. No longer do we simply have two categories of workers to which the Guidelines apply we have subsets of workers who have suffered a psychological injury and we have important processes and procedures that will now apply if the regulations are approved as written to subsets of different categories of workers. This complexity has not been addressed by these Guidelines.

Consistency

242. The Guidelines lack consistency with the legislation, amending legislation and the draft regulation.

243. The Guidelines introduces terminology not used in the regulation or in the amendment Act. The primary example is the use of "relevant injuries" to describe "primary psychological claims caused by relevant conduct" (which is just one of the descriptions used in the Public Consultation draft of the Regulations). The regulation also refers to "relevant conduct claim" for the same purpose.

244. This lack of consistency contributes to confusion and lack of clarity.

Contradictory

245. Elsewhere, the Guidelines are directly contrary to the Public Consultation draft of the Regulations.

246. The green banner header to Part 4 exemplifies where the Guidelines contradict the current draft of the regulations, but not the amendment Acts or the legislation.

> **Part 4.1 does not apply to exempt workers**
> There is no requirement for exempt workers to seek pre-approval for treatment. However, exempt workers are to be made aware that treatment and services may not be payable without insurer approval.
> Payment of treatment and services for exempt workers must be assessed based on whether the treatment or service is required as a result of the injury, is considered reasonable and necessary and on the provision of properly verified costs.

247. The ALA considers that the content of this banner is correct. However, Schedule one of the draft regulation seeks to insert Part 4A which is in direct contradiction. Whilst the ALA considers the banner is correct, if Part 4A is approved (the ALA has expressed concerns with Part 4A) part 41 is incorrect, misleading and will have to be rewritten.

Easy to access expectations

248. The ALA considers that the Guidelines do not set out easy to access expectations.

249. References to the 2021 Workers Compensation Guidelines, the 2025 amendment Act, the 1987 Act and the 1998 Act together with the Regulations throughout the Guidelines complicates the understanding of expectations.

250. This attempt to condense the information within the Guidelines means that the information is not easy to access for insurers but particularly for workers, employers, medical and related service providers and other stakeholders who are not acquainted with or across the nuances of the instruments referred to. This would be particularly relevant to exempt workers making claims and workers with psychological injuries (including relevant conduct claims).

Specific parts

251. The ALA considers that Part 5 Work Capacity Assessment lacks relevant information.

252. There has been no clear and accurate guidance on work capacity assessments since 2012 amendments which introduced the concept. It is high time that concise and clear guidance material was published which identifies the purpose for which work capacity assessments are made, their relevance for workers and ongoing entitlement to weekly payments of

compensation and how they should be conducted by insurers and the assessment decision notified to workers.

253. More attention has been paid in part 6 to the use of injury management consultants and their reports than to work capacity assessments which have a far more relevant effect on a worker's entitlements and the day to administration of a claim and decision-making in relation to ongoing benefits. Similarly, Part 7 does likewise.

254. Part 8 Lump sum compensation used to refer to a form for the making of a permanent impairment claim. That form was particularly useful for workers and their legal advisers in providing the particulars required by section 282 1998 Act. The ALA calls for the form to be reinstated but not mandatory.

255. Notably, Part 8.1.1 refers to the current method of making a claim for lump sum compensation under section 66 1987 Act. The amendment Acts and the Regulation make significant changes to that method particularly with regard to "pre-reform assessments" and "interim assessments". The guidelines are not clear when taking the regulation into account.

256. The ALA's review of the proposed Workers Compensation Guidelines indicates that they are, in several respects, confusing and difficult to reconcile with the Regulation. In some instances, the Guidelines appear to duplicate matters addressed in the Regulation; in others, they appear to proceed on assumptions or adopt formulations that are inconsistent with, or potentially contradictory to, the Regulation itself. That overlap creates unnecessary uncertainty for workers, insurers and practitioners.

257. Given the ALA's significant concerns about the Regulation in its current form, we submit that any substantive review, consultation on, or finalisation of, the Guidelines should not occur until the Regulation has been promulgated in its final form. To proceed otherwise risks embedding confusion and unnecessary complexity across two interdependent instruments and may require further revision once the final content and operation of the Regulation is settled.

Recommendation 24

That a substantive review with consultation of the Guidelines should not occur until the Regulation has been promulgated in its final form.

Conclusion

258. For the reasons set out above, the ALA submits that the draft *Workers Compensation Legislation Amendment Regulation 2026* should not proceed in its current form.

259. The Regulation, as presently drafted, is in many respects premature, unnecessarily prescriptive, and likely to produce significant unintended consequences across the workers compensation system.

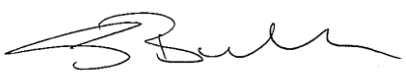
260. A number of provisions appear to go beyond what is authorised by the amending Acts, impermissibly affecting accrued rights, or introducing confusion and inconsistency by duplicating, displacing or contradicting matters more appropriately dealt with in the *Workers Compensation Guidelines* or other instruments.

261. In practical terms, many of the proposed provisions are likely to increase disputation, delay access to treatment and benefits, create further administrative burden for workers, insurers and practitioners, and undermine the stated objectives of the scheme.

262. The ALA remains particularly concerned that these Regulations have been developed and consulted upon within an unreasonably compressed timeframe, notwithstanding their significance to the operation of the broader reform package. The number of drafting errors, incomplete provisions and apparent inconsistencies within the draft materials reinforces the need for caution.

263. The ALA therefore urges SIRA and the Government not to promulgate the Regulation in its current form. Rather, the draft should be substantially revised following further targeted consultation with stakeholders, with proper regard to the statutory objectives of the workers compensation system, the protection of accrued rights, and the practical operation of the scheme for injured workers.

264. We thank you again for the opportunity to provide these submissions and would welcome any further consultation in relation to the draft Regulation, Guidelines and associated forms.



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