

About the CompAct



This guide brings together Jackson McDonald's CompAct article series, providing a consolidated and practical reference to the key reforms introduced under the Workers Compensation and Injury Management Act 2023 (WA).

As the legislation has evolved, our team has published a series of insights to help clients understand the changes, their timing, and their practical implications. This guide has been developed to collate those articles in one place, arranged chronologically to make it easier to track how the regime has developed over time.

Readers can use this guide as both a reference tool and a roadmap. Whether you are revisiting specific changes or seeking a broader understanding of the reform journey, the structure allows you to quickly locate relevant updates and consider their impact on your organisation.

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Introducing The CompAct, a fortnightly newsletter to keep you ahead of the curve on the new workers' compensation law

Ashleigh Glasson | October 22, 2024

For this first edition of The CompAct, we are starting at the finish – Settlement Agreements.

We all know the feeling of finally reaching an agreement to resolve a long-running and complex claim, drafting up the settlement documents, arranging for the documents to be executed by both parties, and then sending the agreement to WorkCover for the stamp of approval and thinking “*glad that’s finally done*”.



But of late, that has not been done. More often than we would like, we find ourselves getting ‘invitations’ from WorkCover – not the fun “*come along to our Christmas party*” kind of invite either. They are invitations to rectify errors – errors of all shapes and sizes – from which we have compiled the below list.



Settlement of a compensation claim

- **The approved forms have to be used**
 - The forms cannot be altered, nor can sections be deleted.
- **All pages and sections in the Settlement Agreement, any Permanent Impairment Notice (PI Notice) and in the Application on the WorkCover portal need to be completed**
- **When a permanent impairment lump sum is included in the Settlement Agreement**
 - A PI Notice has to be lodged;
 - The permanent impairment report and certificate in support of a PI Notice have to be lodged; and
 - If the Approved Permanent Impairment Assessor (APIA) calculated the PI incorrectly, the settlement agreement will not be accepted for registration.
- **The current PI item numbers are to be quoted in the Settlement Agreement and PI Notice; however, the prescribed amount/general maximum amount as at the date the injury was sustained is to be used to calculate the permanent impairment compensation.**
- **The Settlement Agreement has to be properly executed by the parties.**





- All information entered into the online form when uploading the Settlement Agreement for registration has to be consistent with what is in the Settlement Agreement, and with any PI Notice lodged with the Settlement Agreement.
- The settlement must relate to a claim and WorkCover must have a record of that claim (by way of the insurer/self-insurer claims data submitted to WorkCover)
- Costs and disbursements are not to be included in the settlement sum given on the Settlement Agreement form, and are not otherwise included in the settlement agreement or other information submitted to WorkCover for registration of a particular agreement.
- A breakdown of the settlement sum must be provided.
- The agreement date (on page one of the Settlement Agreement) must be the same as the date the last party signed the agreement.
- The Settlement Agreement must be uploaded for registration within a reasonable timeframe after signing by both parties.

Settlement agreements: What information is needed?

SETTLEMENT AGREEMENTS: WHAT INFORMATION IS NEEDED?

Statutory settlement agreement

- Worker's title and full name
- Worker's address
- Worker's date of birth
- Employer's name
- Employer's address
- Employer's ABN
- Injury date
- Injury circumstances
- Injury description
- Claim number
- Date claim made
- Date claim given to insurer
- Liability status
- Prior amounts paid for income, medical and health expenses, workplace rehabilitation expenses and miscellaneous expenses compensation
- Settlement total lump sum
- Amount of the settlement apportioned to future income, medical and health expenses, workplace rehabilitation expenses and miscellaneous expenses compensation

WorkCover online

- Worker phone number
- Worker email address
- Worker representative (firm and contact selector)
- Employer name
- Employer ABN
- Employer postal address
- Employer phone number
- Employer contact person – title, name and email
- Insurer
- Insurer contact name
- Date claim form received by insurer

If there is an allowance in the settlement for permanent impairment compensation, you also need:

- Applicable general maximum amount
- Item number
- Item maximum of GMA (percentage and amount)
- Assessed, agreed or determined degree of permanent impairment (percentage)
- Item lump sum
- APIA name
- APIA number
- Date of report

Common law settlement agreements

- Date Plaintiff registered election
- District Court action number
- Costs and disbursements figures

Medicare Notice of Judgement or Settlement

- Worker's representative's case reference
- Worker's representative's address
- Worker's representative's phone number
- Worker's representative's email
- Insurer's ABN
- Insurer's postal address

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A little privacy please! How to effectively investigate, assess and manage claims whilst complying with the Privacy Act 1988 (Cth)

Ashleigh Glasson | November 11, 2024

For many, The Privacy Act 1988 (Cth) has always been on the periphery. We were aware that this important piece of legislation existed and that we were bound by its provisions.

However, we perhaps felt safe in the assumption that those provisions were not too onerous and we largely went about our business without concern that we may be acting contrary to our obligations under that Act. That is, of course, until WorkCover issued two bulletins to spell out exactly what the relevant obligations are.

Collecting and disclosing claimants' private and sensitive information

This brings us to the current situation, where the workers' compensation industry in WA has been left scrambling to ensure that we are all complying with the privacy legislation. Of particular concern is the disclosure of claimants' personal and sensitive information obtained for the purpose of assessing and managing their respective claims.

The bulletins – issued on 9 and 17 July 2024 - provide a detailed overview of the entities to which the consent authority in the prescribed claim form expressly extends. And the most notable absences are (drumroll please...) brokers and employers.



Brokers = significant contributors



There are hundreds of brokers working in the workers' compensation sphere in WA. Many of these brokers have years of industry experience, while others bring to their roles skills and experience from adjacent industries, including workplace health and safety, allied health, injury management, human resources and more. And the collective skills and experience that brokers have is put to good use; they know how to act as an intermediary, supporting employers and their interests; ensuring that those employers have adequate insurance coverage; that they are meeting their statutory obligations; and that they are paying appropriate premiums. They play an important role in the scheme and their duties are not such that they could easily be subsumed into the roles played by other participants.

Returning for a moment to WorkCover's bulletins: it was made clear that employers, also, are not covered by the consent authority... but that was said as more of an aside (a soft whisper that followed the bellowing announcement about brokers).

As the message disseminated by way of WorkCover’s bulletins reverberated through our brains, some questioned why the focus seemed to be so heavily on brokers. We posit that it’s the lack of legislation covering brokers operating in the WA workers’ compensation scheme. Given that the scheme is based around legislation that is designed to benefit workers – we can see why WorkCover needed to step in here: to remind everyone that the private and confidential information of those workers is not to be given out to anyone who is not covered by the scheme, at least without the appropriate consent.

So, what do we do?

While the gold standard is to only use, disclose and collect personal information with express consent, there are some other exceptions in the Australian Privacy Principles (APP) which allow insurers to share personal and sensitive information obtained about a worker with the employer and broker if:

a	that worker would reasonably expect them to do so; and
b	if the disclosure is directly related to the purpose for which that information was obtained by the insurer.

Practically speaking, we interpret this as meaning that an insurer can disclose information to employers (and possibly brokers) without the worker’s express consent, but they have to be careful about what they disclose and why.

An insurer who obtains, for example, a worker’s full pre- and post-injury treatment records, can only disclose to the employer the information in those records that is directly related to the assessment and management of that worker’s claim. This might also extend to the broker if the broker is playing a claim management function and if the worker is aware that the broker is playing that function.

While it may not be particularly convenient to think carefully about the limits of disclosure, it is necessary. Not just for privacy reasons, but also for the efficacy of the scheme. A major aim of the scheme is to get injured workers back to work once they recover capacity. If a worker knows that their employer has seen their entire medical history, they may be less inclined to return to work. It’s all well and good that the compensable knee injury has resolved, but it’s going to be difficult to meet your boss’s eyes during those weekly catch-up meetings, knowing that he has seen records detailing your most embarrassing injuries and ailments.



Of note, the new Workers Compensation and Injury Management Act 2023, prohibits the disclosure of information about a worker's claim for compensation (or claim history) to another person for the purpose of pre-employment screening. So, the two year gap in a worker's employment history that they declined to elaborate on during the interview? Employers will now have to just use their imaginations....and maybe a pre-employment medical examination.

For now, it seems that the easiest way to deal with these privacy issues is for a further, separate form to be issued to workers on each and every claim, current and future, where there is broker involvement.

Ouch I did it again!

Erica Thuijs | November 27, 2024

Recurrence claims. They weren't particularly easy to deal with under the old system, and there is even more to think about under the new system.

Let's start at the very beginning (a very good place to start)

When a worker claims compensation, it is up to the employer and insurer to determine whether the claim is an "incapacity claim" or not. Don't look at the claim form – because you won't find the answer there!

Look at the first certificate of capacity. If the worker has full capacity for work and only requires treatment, then there is no claim for income compensation. It is a bit trickier if the worker has partial capacity (on the face of the certificate) but has actually continued working. If you're confident they haven't actually stopped working, then you can probably assume no claim for compensation.

When you accept liability for the claim, pay attention to the highlighted section of the decision notice. If there is no claim for income compensation, then make sure you indicate that you do not accept that the employer is liable for payment of income compensation.

LIABILITY DECISION

In relation to the above claim we accept the employer is liable to compensate you for the injury.

We accept/ do not accept [delete as applicable] the employer is liable for the payment of the income compensation for the incapacity for the work resulting from the injury.

If you don't have it in your claims system already, insurers and other claim managers might want to implement an easy way of marking a claim as an "incapacity claim" or not to make it easier to identify if there is a recurrence down the track.

The pain strikes back

If a worker does not initially have an incapacity claim, but later receives a certificate of capacity which indicates a downgrade in capacity (i.e. the worker now has some capacity or no capacity), then that is a "subsequent certificate of capacity" as defined in section 33 of the WCIMA 2023 and regulation 21.

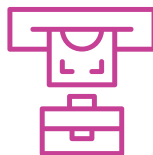
This certificate of capacity automatically amends the claim to become an “*incapacity claim*” and the administrative process (let the fun begin!) under section 28 must be followed:

- The employer has 7 days to give the certificate to the insurer.
- Once the insurer receives the certificate, the claim is amended.
- The insurer then has 14 days to issue a liability decision notice (accepted, deferred, disputed).
- If liability is deferred, then a provisional payments date is set and time starts ticking

Déjà boo boo

But what about if the worker has already received income compensation, returns to work (hooray!) and then later gets a downgraded capacity (boo)?

In this case, section 33 and regulation 21 do not appear to apply. This means that no legislative notices need to be issued.



However, from a claim management perspective, you still need to make a decision about whether or not you are going to start paying income compensation under the open claim for the period of incapacity.

This might require the gathering of additional witness evidence, or arranging further medical reviews and you should communicate with the worker about your intention to investigate and your decision (to accept and pay, or to defer and investigate, or to dispute liability).



This advice does not need to be given in a formal notice under the WCIMA 2023 and we do not recommend that you repurpose the liability decision notices for use with recurrence claims. It just causes confusion.

It is essentially the same process you follow when the worker presents medical & health expenses for consideration throughout the course of their claim, so just make sure you communicate with the worker in the same way.



There may be occasions where you determine that the worker is not entitled to income compensation under the open claim, but might be entitled to income compensation for a fresh claim. For example, if there was a new incident at work that has caused a compensable aggravation or recurrence or a completely new injury.

If you form that view (but the worker has not submitted a new claim form) you will need to decide whether to:

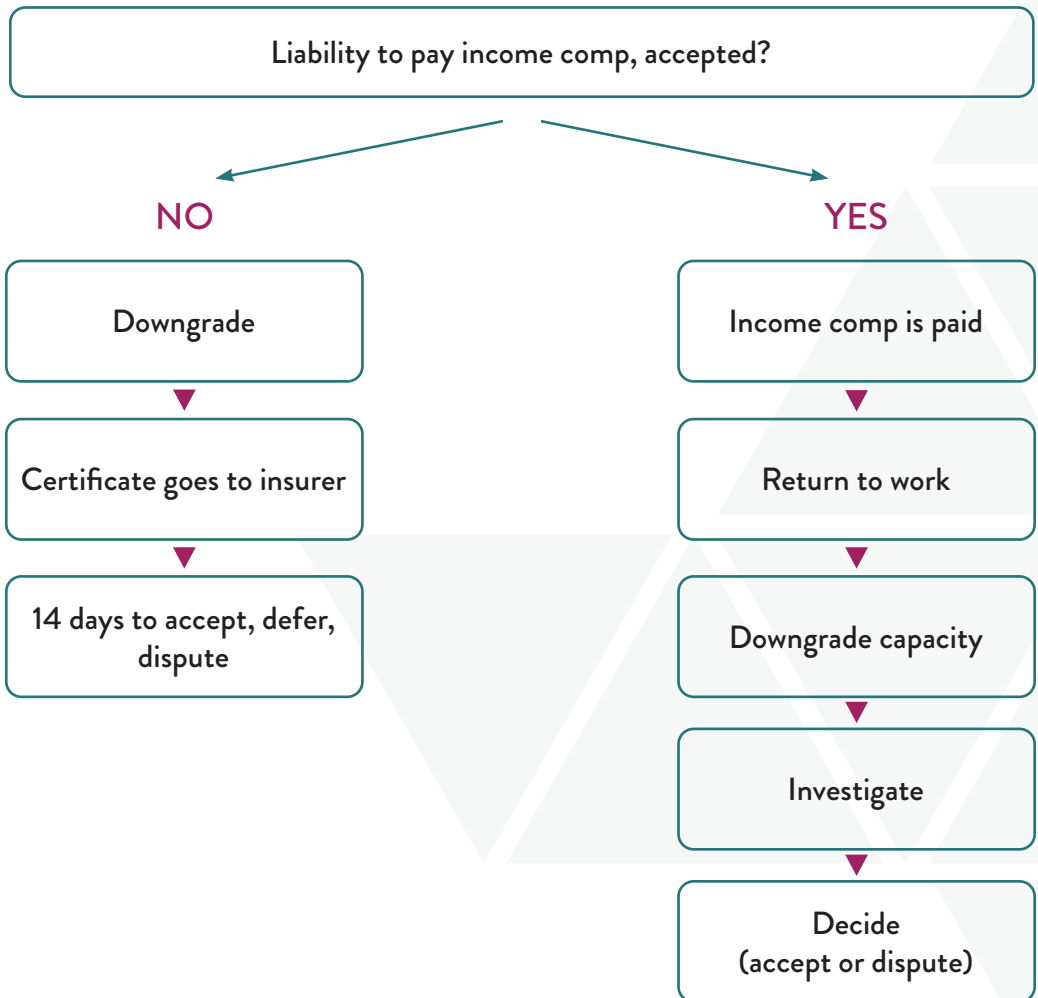
1. dispute liability to pay income compensation under the open claim (and stay silent on the worker’s ability to make a new claim), or
2. invite the worker to submit a new claim form and first certificate of capacity and the administrative process (let the fun begin!) under section 28 must be followed.

But you haven't mentioned the recurrence claim form...

A "recurrence claim form" is not a legislated form. This is a document that insurance companies and employers have created to assist with gathering information and making decisions when circumstances change.

It is a handy tool and you can still use your recurrence claim forms to gather information, but just remember that there is no legal requirement for the worker to complete the form. Having said that, if a worker does not complete the form, you may decide that this means you don't have enough information to accept liability to pay income compensation for the new period of incapacity.

CLAIM MADE?



Stress testing stress claims: what insurers need to know

Ashleigh Glasson | December 9, 2024

With the increasing prevalence of workers' compensation claims made in relation to psychological injuries, and recent the changes to the legislative provisions which provide a potential defence to such claims, we take this opportunity to provide an overview of the statutory regime in relation to stress claims.

Stress claims are on the rise

The number of workers' compensation claims being lodged for psychological injuries are on the rise, with claims being brought across all sectors of the community and across all industries.



Examples of behaviour in workplaces that increase the risk of psychological or psychiatric injury include:

The number of workers' compensation claims being lodged for psychological injuries are on the rise, with claims being brought across all sectors of the community and across all industries.

Examples of behaviour in workplaces that increase the risk of psychological or psychiatric injury include:

a	poor leadership practices and workplace culture;
b	poor or no policies and procedures;
c	work demands;
d	inadequate support;
e	bullying/targeted behaviour;
f	vicarious trauma; and
g	administrative/managerial decisions.

The relevant definitions provided in the legislation

In short, if someone suffers a psychological condition because of their work, then they are entitled to compensation for that condition under the *Workers Compensation and Injury Management Act 2023 (WA) (Act)*.

This is because:

a	Compensation is available for a disease, or the recurrence, aggravation or acceleration of a pre-existing disease (section 6 of the Act).
b	A psychological condition is a 'disease' (which is any ailment, disorder, defect or morbid condition, whether physical or mental and whether of sudden or gradual onset).
c	Compensation is given for diseases that are contracted or recur or are aggravated, in the course of the employment, as long as the employment contributed to a significant degree to the contraction of the disease or the recurrence, aggravation or acceleration of the pre-existing disease.

It is a reasonably low bar to prove that worker is suffering from a psychological condition, especially because the criteria are so subjective. However, it is worth mentioning that mere sadness or grief or anger will not be enough to constitute a psychological condition that is a "disease" under the Act.

Once a worker has proved they have a psychological condition contributed to by their work to a significant degree, there is only one exclusion that applies to "defend" that claim. This is the "reasonable administration action" exclusion in section 7 of the Act.

There is not a "you brought this upon yourself" exclusion for workers who suffer a psychological condition because they are difficult to work with and alienate themselves from their colleagues, causing them to get anxiety about turning up to work because other people don't like them.

Exclusion: reasonable administrative action

The Act excludes claims for psychological and psychiatric disorders which wholly or predominantly result from:

a	reasonable administrative action taken by a worker's employer; or
b	a worker's expectation of administrative action or a decision of an employer in relation to administrative action.

What is administrative action?

The Act gives this phrase an “inclusive” definition. This means that the Act gives examples of things that constitute administrative actions, without limiting the number of things that might be an administrative action. As Lindsay Lohan would say: “*the limit does not exist!*”.

The things that are specifically included are:

a	appraisal of a worker’s performance;
b	suspension, discipline, demotion, dismissal or retrenchment; and
c	not obtaining benefits in relation to the employment such as being promoted, reclassified, transferred or granted a leave of absence.

Examples of actions that don’t appear in the list, but have been found to be administrative actions are:

a	job plan discussions (Buck and Comcare [2012] AATA 327); and\
b	an employer attending at an employee’s home to collect a medical certificate and discuss welfare supports (Kennedy and Comcare [2013] AATA 696.

Some interesting questions arise around when this exclusion will and won’t apply:

a	When the employer’s conduct was not administrative action: Case law in other states suggest that there is a difference between an administrative action and an operational action. An administrative action typically affects (at a higher level) the nature of the relationship between the worker and their employer, whereas an operational action is something that relates more to the granular day to day activities and way that work is performed. Stress caused by operational actions is compensable.
b	When the employer’s conduct in relation to administrative action was harsh or unreasonable: Where the exclusion would otherwise apply but the administrative action is found to have been unreasonable and harsh on the part of the employer, the employer can still be held liable for the worker’s resulting psychological injury. This involves an inquiry about whether due process was followed and if the outcome of the action was reasonable in all of the circumstances. If a person was summarily dismissed for a typing error, that would probably be harsh and unreasonable.



c	When the administrative action is not the whole or predominant cause of the injury: Even if the administrative action is one cause, and even if it is a significant cause of the injury, if there are other contributing factors (work related and non-work related), then the exclusion doesn't apply.
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Denying liability

Even though there is only one exclusion in the Act, that does not mean there is only one bases upon which an employer can question liability for a psychological injury claim.

Other reasons an employer might dispute liability are:

a	If the worker's symptoms are not serious enough to constitute a "disease".
b	If the worker says that their injury was caused by particular events, or duties or actions of others – but there is no corroborative evidence to prove those things occurred.
c	If there are multiple different potential causes of the worker's psychological condition – both work related and non-work related – and it is not clear if the employment is a significant contributing cause or not.

If liability for a psychological injury is denied – what next?

Where an employer/its insurer has declined to accept liability for a psychological injury allegedly sustained in the course of a worker's employer, the worker may choose to ask for WorkCover WA to determine the issue of liability.

The following issues are likely to be aired in the course of arbitration proceedings:

- a. To convince an arbitrator that the employer should be held liable, the worker will need to establish that the employer's conduct was a significant contributing factor to the contraction of the psychological injury. Of note, when the legislation refers to the word "significant", it means "not insignificant". In other words, the contribution must be material: *Mokta v Metro Meat International*.
- b. To an extent, the worker also has to prove that the conduct alleged occurred. However, sometimes it is enough for the worker to prove that they perceived a certain state of affairs and that their perception caused them to suffer a psychological injury. In this context, the worker establishes an entitlement to compensation if they can establish on the balance of probabilities that their subjective reaction was due to objectively proven facts. However, it is not necessary for a worker to prove that their subjective perception of proven facts was reasonable (*Weigand v Comcare*), or that a person of normal fortitude would have



suffered the same reaction: *Pilbara Iron Company (Services) Pty Ltd v Suleski*. For example, if a supervisor raises their voice at a worker to make sure they are heard over other voices in an office, and a worker perceives that their supervisor is angry at them and that causes them to suffer anxiety – that may be enough to establish a compensable injury.

- c. The worker also bears the onus of proving that a potentially excluded matter (or the expectation of a potentially excluded matter), as set out in section 7 of the Act, is **not** wholly or predominantly the cause of the stress is on the worker: *Granitto v Catholic Education Office*.
- d. Similarly, the onus of establishing that the employer's conduct in relation to an excluded matter was unreasonable and harsh also lies on the worker:

“The obvious purpose underlying the exclusion is to prevent the bringing of claims for compensation as a consequence of stress-related diseases that wholly or predominantly arise out of specified incidents of the employment relationship which, by their very nature, are particularly stressful, but which are not harsh and unreasonable on the part of the employer.” *FAI General Insurance v Goulding per Steytler J at [39]*

- e. Where a worker's psychological injury arises out of their **expectation** in relation to an excluded matter or the employer's conduct in relation to an excluded matter, there is no scope for a consideration as to whether or not the employer's conduct was harsh and unreasonable: *McPherson v State Print*.
- f. In *FAI General Insurance v Goulding* it was also held that, where a worker has suffered a recurrence, aggravation, or acceleration of a pre-existing disease which was contributed to by their employment, the employer was unable to rely on a defence pursuant to section 5(4) of the then *Workers' Compensation and Injury Management Act 1981 (1981 Act)*. The reasoning behind that finding was that the disease could not then have been said to have been wholly and predominantly caused by stress.

Wait and see

The reasonable administrative action exclusion provision in the 2023 Act is yet to be considered in any published decisions in WA. We will keep you updated as to relevant determinations as they are published.



Getting Personal: Injury by Accident

Ashleigh Glasson | January 14, 2025

Section 6(1) of the Workers Compensation and Injury Management Act 2023 (WCIM Act) defines ‘injury’ as an injury from employment that is –

- a. A personal injury by accident; **or**
- b. A disease, or the recurrence, aggravation or acceleration of a pre-existing disease.

As the relevant test for causation (i.e. whether the injury is an ‘injury from employment’) depends on whether the subject injury falls under paragraph (a) or (b), the nature of the injury is an important first consideration for employers and insurers when determining liability for any workers’ compensation claim.

Helpfully, except for stress claims, the definition of ‘injury’ has not materially changed in the new legislation, so previous case law should apply to interpreting the new WCIM Act.

In this edition of The CompAct, we provide an overview of the case law surrounding what constitutes a ‘personal injury by accident’ for the purposes of the Western Australian workers’ compensation scheme.



Definition of ‘personal injury by accident’

Whilst ‘disease’ is defined^[1] in the WCIM Act, the terms ‘personal injury by accident’ or ‘accident’ are not. There are, however, numerous decisions which provide clarity as to the indicative factors of a personal injury by accident and we outline some of the leading authorities below.

In *Kennedy Cleaning Services Pty Ltd v Petkoska*^[2] (**Petkoska**), Gleeson CJ and Kirby J described the difference between “*injury*” and a “*disease*”, as “***a sudden and ascertainable or dramatic physiological change^[3] or disturbance of the normal physiological state***” (our emphasis); as compared with the “*underlying pathology*” that constitutes a “*disease*”.

What is the ‘accident’? – specific traumatic causative event/s to be identified

The authorities suggest that a personal injury by accident requires the occurrence of a specific and identifiable, although not necessarily significant, trauma or a series of traumas. The use of the term ‘*accident*’ points to the unexpected nature of the trauma constituting the injury^[4].



Further, the suddenness of the physiological change resulting from that subject accident or trauma/s is of particular relevance when distinguishing between the natural progression of a disease and an event or incident that is an injury by accident.

Applying the above principles in the decision in *State Energy Comm v Van-Zyl*[5] the Supreme Court of WA relevantly distinguished between a condition developed by continuous process and that which was developed by a number of small traumas over an extended period of time.

The Court found that the worker, who had died of a carcinoma of the left lung due to exposure to asbestos in the course of his employment, had sustained a personal injury by accident which resulted in his death. Similarly, in *Rees v Aust Blue Asbestos Pty Ltd*[6] and *Spalding v Cmr for Main Roads*[7] the WA Workers' Compensation Board found that a series of traumas could be regarded as an injury by accident.

A common-sense approach to be used

The common use of the language distinguishing between 'getting hurt' and 'becoming sick' is to be used[8] when considering whether the worker has suffered a 'personal injury by accident' or a 'disease'. It can also be useful to consider whether the worker has experienced any of the following, which might describe a 'personal injury by accident':

- a harmful effect on the body;
- a disturbance of the normal physiological state producing physical incapacity;
- a sudden or identifiable or distinct physiological change and whether there is an event or incident or clinical diagnosis to explain such change.



Physiological change resulting from the progression of a pre-existing disease or condition

Things get tricky when a worker suffers a sudden physiological change during the course of their employment, but the change is a result of a pre-existing disease or condition that is unrelated to work. For example, the rupture of an aneurysm, a stroke or a heart attack.

In *Ansett Transport Industries (Operations) Pty Ltd v Srdic*[9] (**Srdic**), Toohey J discussed the relevant principles of determining when a personal injury by accident has occurred in those circumstances, which included the following:

1. Personal injury by accident may exist where there is no more than an actual internal physical injury such as the rupture of an aneurism or of an oesophagus, not attributable to any external injury but resulting from some force or pressure exerted within the body[10].
 - a. We also note the comment of Higgins J in the earlier determination of the Petkoska matter by the Federal Court[11]:

“...the rupture is due to blood pressure, arteriosclerosis, arteriovenous malformation or any other congenital or diagnostic aetiology, it is nonetheless a rupture – something quite distinct from a defect, disorder or morbid condition, which enables it to occur. An occlusion caused by distinct flaking off of a platelet, and the blocking of an already narrow arteriosclerotic artery is quite distinct from the diseased condition of the artery itself. So also is a rupture distinct from its aetiology, whether progressive or not” (our emphasis).

- b. Where the personal injury by accident relied upon is an internal physical injury, it is no answer to a claim for compensation that there was a predisposing physical condition. The employer must take its workers as it finds them[12].
2. A worker does **not** suffer personal injury by accident arising in the course of their employment where they suffer, at their place of employment, a sudden and distinct physiological change as the product of the inevitable development of a progressive disease from which they are suffering if that change can in no way be attributable to or associated with some incident of his employment[1]. In such circumstances, the disease and the condition in which it culminated is considered to be autogenous (arising from within or from a thing in and of itself). In the absence of any particular incident or activity of the worker accelerating or contributing to the condition, there is no personal injury by accident.

The decision in *Re Lott v Comcare*[14] (**Re Lott**) concerned an airline pilot who had suffered significant employment stressors and who died whilst showering in his hotel room of an acute myocardial ischemia caused by thrombotic occlusion of the right main artery.

The Administrative Appeals Tribunal held that the worker’s coronary artery disease was a mere ailment but that the occlusion of artery was an injury by accident sustained in the course of his employment.

Of note, the worker was found not to have suffered a work-related disease as he could not establish that the work related stress had contributed to the coronary artery disease.

Returning to the Srdic authority, Toohey J referred to the above-mentioned decision in *Re Lott*, stating that the Court applied the following principle in determining that matter:

“A gradually developing morbid condition may or may not answer the description of an “injury” when it reaches a disabling stage. It will do so if, as in this case, the disability or death is a consequence of a distinct step or event, albeit precipitated by, and forming part of, the disease process”.



Can a psychological injury be a personal injury by accident?

Physiological changes can be distinguished from psychological changes, which are ones relating to processes of the mind. The two concepts are linked; however, such as where a worker experiences physiological changes (for example: increased heart rate, digestive issues, higher blood pressure) as a result of psychological stress experienced in the workplace.

A psychological injury can therefore be a personal injury as defined in section 6(1)(a) of the WCIM Act where it:

a	results from an identifiable accident or trauma; and
b	results in “a sudden and ascertainable or dramatic physiological change or disturbance of the normal physiological state” ^[15]

This is in contrast to where a worker suffers a psychological condition – such as major depressive disorder – solely as a result of underlying pathology – such as a deficiency in neurotransmitters - which would constitute a disease.

The above summary of some of the more relevant case law is far from exhaustive; however, we hope it has provided a helpful overview of the relevant principles for consideration as to whether an injury sustained by a worker constitutes a ‘personal injury by accident’ pursuant to the provisions of the WCIM Act.

Next fortnight’s edition of The CompACT will provide a similar summary of the case law relevant to determining whether a worker has suffered a ‘disease’ (or the recurrence, aggravation or acceleration of a pre-existing disease), before we delve into the different causation tests for the two types of ‘injury from employment’ pursuant to the WCIM Act.

[1] ‘Disease’ includes any ailment, disorder, defect or morbid condition whether physical or mental and whether of sudden or gradual development: section 5 of the WCIM Act.

[2] (2000) 200 CLR 286; 174 ALR 626; [2000] HCA 45.

[3] Physiological change relates to the physical and chemical processes of the body.

[4] *Clover Clayton & Co Ltd v Hughes* [1910] AC 242; *Weston v Great Boulder Gold Mines Ltd* (1964) 112 CLR 30 per Windeyer J at 40.

[5] (WASC, SCL 4879, 27 April 1983, unreported.

[6] (1980) 1 WCR(WA) 170.

[7] (1983) 2 WCR(WA) (Pt 2) 83.

[8] *Hume Steel Ltd v Peart* [1947] ALR 477; 75 CLR 242; 21 ALJR 285.

[9] (1982) 66 FLR 41.

[10] *Clover Clayton & Co Ltd v Hughes* [1910] AC 242; and *Kavanagh v Cth* (1960) 103 CLR 547.

[11] *Petkoska v Kennedy Cleaning Services Pty Ltd* (1998) 87 FCR 526; 168 ALR 287.

[12] *Cth v Hornsby* (1959–1960) 103 CLR 588 at 597.

[13] *Cth v Ockenden* (1959) 99 CLR 215 at 224.

[14] (1996) 44 ALD 741.

[15] *Kennedy Cleaning Services Pty Ltd v Petkoska* (2000) 200 CLR 286; 174 ALR 626; [2000] HCA 45

Contracted under contract: Suffering a disease from employment

Ashleigh Glasson | January 28, 2025

Consistent with the now repealed Workers' Compensation and Injury Management Act 1981 (WA), the current legislation[1] defines an injury as:

"...an injury from employment that is –

A personal injury by accident; or

A disease, or the recurrence, aggravation or acceleration of a pre-existing disease"[2].

Our last edition of **The CompAct** provided an overview of the definition of a personal injury by accident; in this edition we will delve into the case law concerning the definition of a disease, or the recurrence, aggravation or acceleration of a disease.

Statutory definition of disease

Unlike *"personal injury by accident"*, *"disease"* is expressly defined in the WCIMA. Section 5 states that *"disease"*:

"includes any ailment, disorder, defect or morbid condition whether physical or mental and whether of sudden or gradual development".

The scope of the above definition is clearly broad, and it is useful to consider the case law authorities which discuss the principles applied when determining whether a worker is suffering from a disease.

The decisions discussed here concern the interpretation and application of the definition of *"disease"* under the former Act. The WCIMA provides a definition that, although slightly re-phased, is essentially consistent, such that the principles outlined in the case law remain relevant.

As a starting point, we again refer to the decision handed down in *May v Military Rehabilitation and Compensation Commission*[3] (**May v Military Rehabilitation**), which highlighted the importance of using common-sense to assess what type of injury has been sustained:



“The place of common-sense lay inference from a clear sequence of events is to be recognised, as long as any such inference is not denied by medical science. In any particular case there may be a consideration of whether there is a harmful effect on the body, a disturbance of the normal physiological state producing physical incapacity, a sudden or identifiable or distinct physiological change, whether there is an event or incident or clinical diagnosis to explain such change, and such considerations will be made against a background of a distinction in the common use of language between getting hurt and becoming sick”.

In *Gallas v Comcare*[4], the tribunal notes that:

a	a disorder meant a “derangement of physical or mental health or function”;
b	ailment was noted to include a “morbid affection of the body or mind; indisposition”; and
c	morbid may mean “affected by, proceeding from, or characteristic of disease”.

In *Burch v SA*[5], it was stated that a particular injury may be accurately described as a “defect” or a “morbid condition”; however, the qualifying words “whether of sudden or gradual development” suggest the need for some progression of a condition, as opposed to one which remains static.

The discussion of the definition of “disease” in *Favelle Mort Ltd v Murray*[6] considered how such an injury can arise:

“Properly used, disease denotes a morbid condition of the body. It may be initiated by some external cause or be idiopathic or autogenous. Quite clearly, when such a condition is idiopathic or autogenous, it will not qualify as an injury in the normal use of language”.

We will be looking more closely into issues of causation, including the requirement for work to have caused or significantly contributed to the occurrence of a disease, in upcoming editions of The CompAct.

Disease vs personal injury by accident

We again refer to the decision *Cth v Ockenden*[7], in which the difference between and personal injury by accident and disease was expressed as follows:

“The worker does not suffer personal injury by accident arising in the course of the employment where he suffers, at his place of employment, a sudden and distinct physiological change as the product of the inevitable development of a progressive disease from which he is suffering.

In *Kennedy Cleaning Services Pty Ltd v Petkoska*[8] it was held that:

“...a long line of decisions in Australia had recognised that an ‘injury’, being a sudden or identifiable physiological change, could nonetheless qualify within the ordinary application of that expression appearing in workers’ compensation legislation, although the change was internal to the body of the worker. It did not have to be external or necessarily produced by external causes...

Secondly, the mere fact that a sudden physiological change is in some way connected with an underlying ‘disease’ process does not, of itself, prevent the classification of such a change as an ‘injury’ within the primary statutory provisions that apply to such a case...”



A review of previous decisions was undertaken in *Szajna v Australian Postal Corporation*[9], and those decisions were noted to establish that it is necessary to consider whether the alleged “injury” is separate to the underlying pathology that constitutes a “disease” that caused, whether directly or indirectly, the relevant physiological change which occurred.

The judgement in *O’Neill v Lumbey*[10] illustrates how the necessary consideration referred to above can be applied to the particular facts of a workers’ compensation claim. The judgement also suggests that identifying the potential treatment for an injury (and the anticipated outcome of such treatment) may assist in distinguishing between a “disease” and a “personal injury by accident”:

“In ordinary language a disease is understood as connoting an ongoing process which is to be distinguished from a structural defect which can be repaired or removed. In the case under discussion the weakness was effectively repaired after the rupture. Once that occurred the problem was eliminated. On the other hand the repair of a ruptured aneurism consequent upon arteriosclerosis would not normally be understood as removing the problem. The mechanical repair to the damaged tissue would not prevent the ravages of the ongoing underlying disease”.

If you're looking for examples of diseases, look no further than Schedule 1 of the Regulations [11]. Here you will find a list of prescribed diseases ranging from anthrax to poisoning or toxicity causing acute damage to the heart, lungs, liver, kidney, nervous system or blood.

A condition outside the boundaries of normal functioning and behaviour



In some instances, a worker will claim incapacity resulting from an injury to which a specific or recognised medical diagnosis cannot be given. *Comcare v Mooi*[12] (**Comcare v Mooi**) is authority for the principle that a claim may succeed even where the “*resultant condition cannot be identified with the label of a recognised medical condition*”.

What, then, is required to establish that a disease has been sustained where there is no diagnosis attached to the reported symptoms experienced or the restrictions in functioning complained of?

In *May v Military Rehabilitation* it was held that even with an ailment, “*there must be more than an assertion by an employee that he or she feels unwell*”. Further, frustration and emotional upset do not constitute injury: *Thazine-Aye v Workcover Authority (NSW)*[13] and *Zinc Corporation v Scarce*[14]. The effect of the injury must be more than transient: *Re Bauduccio v Comcare*[15].

In *Fawkes v Swan Transit Services Pty Ltd*[16] it was held that where a worker is claiming compensation for a disease from employment, that worker will need to give evidence of having stained a condition, regardless of its diagnostic label, that is “*outside the boundaries of normal mental functioning and behaviour*”. By way of example, in *Comcare v Mooi* it was held that the descriptor of “*stress*” will, in most cases, be adequate to ground a claim so long as it can be demonstrated that the condition is outside the boundaries of normal mental or physical functioning and behaviour.

Following the above principle, in *Re Nelson and Comcare*[17] and *Re Chant and Comcare*[18] it was held that the relevant condition suffered by a worker must be more than merely upset or distress, and must be more than an episodic increase in a pre-morbid condition.

By way of example of the application of the above principal, in *Madden v Australian Postal Corporation*[19], the worker was engaged in angry exchanges with his team leader after arguments relating to overtime and completion of work. It was held that the worker’s anger with his employer did not fall outside the normal range of behaviours when the Court took into account the evidence as to the worker’s general personality. As a consequence, it was held that his condition was not compensable.

The recurrence, aggravation of acceleration of a pre-existing disease

Windeyer J in *Ogden Industries Pty Ltd v Lucas*[20]; said:

“... ‘Aggravation’ means, I think, that disease has been made worse, not that it has simply become worse, an existing aggravation includes the failure to diagnose the disease where such failure to diagnose results in a worsening or aggravation of the condition”.

Some guidance as to the meaning of these words was given by the High Court decision in *Federal Broom Co Pty Ltd v Semlitch*[21]. It would appear that the word “**acceleration**” relates to a disease which is progressive in its nature and the acceleration occurs when the rate of progress is increased by some external stimulus. The worker is entitled to claim payments for the resulting incapacity where the acceleration produces some more severe or additional symptoms. Aggravation occurs where external stimuli produces additional symptoms or an intensifying of the existing symptoms which are incapacitating albeit of a temporary nature.

The concept of aggravation of a pre-existing condition was also dealt with in *Asioty v Canberra Abattoir Pty Ltd*[22] which concerned a worker who suffered dermatitis:

“... the existence of some more permanent aggravation is not precluded because those symptoms abate on each occasion that the appellant ceases work. The proper conclusion is that the condition of the appellant’s hands, with their now enhanced susceptibility to dermatitis, has intensified the disease from which the appellant suffers. This enhanced susceptibility constitutes an aggravation of the disease...”.

... [T]here is no reason why a disease which produces susceptibility to some debilitating condition should not be regarded as aggravated when that susceptibility is heightened by a circumstance such as work of a particular type or in particular conditions”.



Conclusion

We hope that this and the previous edition of The CompAct have assisted in clarifying when a particular injury, alleged to be an injury from employment, is a “*personal injury by accident*” and when it is more accurately classified as a “*disease*” (or the recurrence, aggravation or acceleration of same).

In our next edition, we will move onto a discussion of the different tests for causation to be applied for each of the two injury types.

- [1] *Workers Compensation and Injury Management Act 2023 (WA) (WCIMA)*.
- [2] Section 6(a) and (b).
- [3] (2015) 322 ALR 330; [2015] FCAFC 93.
- [4] [2008] AATA 198.
- [5] (1998) 71 SASR 12.
- [6] (1976) 133 CLR 580.
- [7] (1959) 99 CLR 215.]
- [8] [2000] HCA 45; 200 CLR 286.
- [9] (2014) 143 ALD 192; [2014] FCA 1136.
- [10] (1987) 11 NSWLR 640.
- [11] *Workers Compensation and Injury Management Regulations 2024 (Regulations)*.
- [12] (1996) 69 FCR 439; 137 ALR 690.
- [13] (1995) 12 NSWCCR 304.
- [14] (1995) 12 NSWCCR 566.
- [15] [2009] AATA 333.
- [16] [2019] WADC 168.
- [17] [2008] AATA 214.
- [18] [2008] AATA 77.
- [19] (2008) 102 ALD 406; [2008] AATA 411.
- [20] (1967) 116 CLR 537 at 593; 41 ALJR 146.
- [21] (1964) 110 CLR 626; [1964] ALR 1031.
- [22] (1989) 167 CLR 533; 87 ALR 385.



The work/life blur, when is a personal injury by accident an “injury from employment”?

Ashleigh Glasson | February 13, 2025

The previous two editions of *The CompAct* provided an overview of some of the more relevant case law to be considered when determining whether, pursuant to the provisions of the *Workers Compensation and Injury Management Act 2023 (WA) (WCIMA)*, a worker has suffered:

- A personal injury by accident; or
- A disease (or the recurrence, aggravation or acceleration of a pre-existing disease).

There are different causation or connection tests for the 2 types of injuries pursuant to the WCIMA. In the following two editions of *The CompAct*, we will discuss when a personal injury by accident will be found to be an “injury from employment” under the WCIMA, before we move on to a discussion of when a disease (or the recurrence, aggravation or acceleration of a pre-existing disease) will be an “injury from employment”.

Connection with employment - onus of proof

The worker who makes a claim for compensation under the WCIMA bears the burden of having to prove both that he or she sustained a personal injury by accident and that the personal injury by accident was an “injury from employment” under the WCIMA.

Where an employer or its insurer seeks to show that some other event or condition is the cause of the worker’s incapacity, the onus of proof falls on the employer/its insurer.

In *Watts v Rake*[1], Dixon CJ observed that the employer must disentangle and exclude a previously accepted contributory cause of incapacity, in circumstances where there is more than one cause of a worker’s injury or incapacity.

Out of or in the course of the employment – causal vs temporal connections

Section 6(2) of the WCIMA states that a personal injury by accident can be an injury from employment if the injury arises either:

1	out of the employment – meaning there is a causal relationship between the employment and the injury; or
2	in the course of the employment or while the worker is acting under the employer’s instructions – meaning there is a temporal connection between the injury and the employment.

Blurred lines

It is increasingly difficult to determine when “employment” starts and ends. The digital age and flexible working policies mean that work hours and workplaces stretch beyond 9-5 in the office. The offering of employment benefits such as gym memberships, team lunches and retreats, social sporting competitions and even work sponsored vaccinations extend the boundaries beyond what might typically be considered to be an “employment” environment and potential sources of accidents and injuries.



Alternative working arrangements such as fly-in-fly-out, drive-in-drive-out, remote work and being “on call” all create complicated scenarios when determining whether an injury arises in the course of employment.

Incidental to the employment

As stated by Dixon J in *Humphrey Earl Ltd v Speechley*[2]:

“The acts of a workman which form part of his service to his employer are done, needless to say, in the course of his employment. The service is not confined to the actual performance of the work which the workman is employed to do. Whatever is incidental to the performance of the work is covered by the course of the employment. When an accident occurs in intervals between work the question whether it occurs in the course of the employment must depend upon the answer to the question whether the workman was doing something which he was reasonably required, expected or authorised to do in order to carry out his duties”.

Illustrative of the liberal interpretation of what is incidental to one’s employment, the Supreme Court of Western Australia held in *L J Newing & Co v Newing*[3] that the worker, who suffered injury when he was making repairs to a television aerial not owned by his employer and carried out on property not owned by the employer, did suffer an injury from his employment. That worker was a farm hand whose duties required him to observe the weather forecasts. The repair of the television aerial was, therefore, held to be incidental to those duties because it enabled him to observe the weather forecasts as required by his employer.

Personal injuries by accident sustained before work

In *Waterhouse v Bassendean Nursing Home*[4], the worker was injured when she attended the workplace one day prior to her official start date with the employer. The worker’s evidence that her attendance had been for the purpose of familiarising herself with the work which she was to perform was accepted, such that she was found to have sustained an injury in the course of her employment.

The above decision can be contrasted with the facts in *Government Printer v Reeves*[5]. The worker in that matter had arrived at his place of work early (by twenty minutes) and was feeling unwell. As a result, the worker went onto the employer's roof to get some fresh air. The worker was injured when he fell backwards off the roof and onto the ground below. The Court held that the worker's injuries had not arisen out of or in the course of his employment.

Intervals between employment

In *Hatzimanolis v ANI Corp Ltd*[6], the High Court found that the expression arising out of or in the course of the employment included intervals or interludes which occur in the course of **employment where the employer had induced or encouraged the employee:**

1	to spend that interval or interlude at a particular place or
2	to spend that interval or interlude in a particular way.



A West Australian case which has adopted the approach in *Hatzimanolis* is *Sealcorp Holdings v Riddle*[7]. In that case the worker was found to be in the course of his employment, when following a social function at the employer's premises, he left the function took the lift to the lobby. He then realised he had left his keys in his office drawer (on a separate floor to where the function had been held). When he took the lift back up with the intention of getting his keys from his office, he became trapped in the lift and was injured. These events were held to be in the course of the employment.

In *Comcare v Mather and Mitchell*[8] Kiefel J held that two workers, as part of their employment, sent to camp at Darwin Showgrounds. The workers left the camp site, after work hours, to drink and socialise at a nearby hotel. When those workers left the hotel and walked back to the camp site, they were struck by a car and killed. Kiefel J held that, consistent with *Hatzimanolis*, the employees had been encouraged to participate in drinking and socialising at hotels. As they were injured when returning to camp from not distant points, the Court held that they were in the course of their employment when injured:

“To be said to have, expressly or impliedly induced or encouraged an undertaking or presence at some location could refer to, by way of example only, requirements, suggestions, recognition of practices, fostering of participation, or providing assistance and may include the exercise of discretion or choice on the part of the employee...In each case, the question will be whether the attendance at the place at which, or the undertaking in which the employee is involved when injured in an interval falls within the ambit of statements, acts or conduct made by



the employer and what may be said to lodge a clear rise from them, and in each case, importantly, they must be viewed in the background of the particular employment and the circumstances in which the employer is then placed”.

Hatzimanolis was applied in *Ramsay Healthcare Australia Pty Ltd v Wyatt*[9] to deny a worker compensation when she attended her usual workplace on her rostered day off. The worker had fallen and sustained injuries when she attended the workplace:

1	on her rostered day off; and
2	to complete a form, unrelated to her work duties.

As the worker was not performing her usual work duties within scheduled work hours, it was necessary to for her to prove that the employer had required, induced, authorised, expected or encouraged her to spend the particular time in a particular way and to do the very thing when the injury occurred. On appeal, the court found that the Arbitrator had incorrectly applied the test as articulated by Hatzimanolis:

“[The Arbitrator] was in error in focusing on what the [worker] was doing at the time, rather than whether the [employer] had induced or encouraged the [worker] to engage in that activity at the time and place when [the worker] suffered the injury”.

By majority, in *Comcare v PVYW*[10] the Federal Court held that determination of whether an injury sustained in an interlude or interval between work periods occurred in the course of employment required consideration of **both** elements of the “*arising out of, or in the course of*” test. The worker in this matter was injured while engaging in consensual sexual intercourse in her motel room during an overnight work trip.

The Court held that regard must be had to both the worker’s presence at the place the injury was sustained, and the activity being undertaken when the injury was sustained:

“For an injury occurring in an interval or interlude in a period of work to be in the course of employment, the circumstance in which an employee is injured must be connected to the inducement or encouragement of the employer”.



Whilst the worker's presence at the hotel could be said to have been sufficiently connected to her employment, the activity she was engaged in when injured whilst at the hotel was not. Compensation was denied in those circumstances.

But wait, there's more...

*In the next edition of *The CompAct*, we will look at causation of personal injuries by accident in certain specific circumstances, such as when a worker is working from home or when the injury arises from an assault. We will also take a closer look at section 9 of the WCIM and the case law authorities relating to injuries sustained whilst a worker is on a work-related 'journey'.*

[1] (1960) 108 CLR 158; [1961] ALR 333; (1960) 34 ALJR 186.

[2] (1951) 84 CLR 126.

[3] (WASC, SCL 8531, 12 September 1990, unreported).

[4] (1983) 2 WCR(WA) 57.

[5] (WASC, SCL 2112, 25 August 1977, unreported).

[6] (1992) 173 CLR 473; 106 ALR 611; 66 ALJR 365 (**Hatzimanolis**).

[7] (WASC, full court, 53/94, 26 May 1995, unreported).

[8] (1995) 56 FCR 456; 37 ALD 463; 21 AAR 297.

[9] [2017] WADC 145.

[10] (2013) 136 ALD 1; 303 ALR 1; [2013] HCA 41.

You can go your own way...to a certain extent

Ashleigh Glasson | March 6, 2025

The last edition of *The CompAct* discussed the factors relevant to when a personal injury by accident will be found to be an “injury from employment” under the *Workers Compensation and Injury Management Act 2023 (WA) (WCIMA)*, including the consideration of whether a particular worker was “...doing something which he was reasonably required, expected or authorised to do in order to carry out his duties”[1] when injured.

We also discussed the principles to be applied when a worker is injured during an interval between employment and looked at the decision in *Comcare v PVYW*[2], where it was held that you must first look at whether the injury occurred because of the worker’s presence at the place that the injury was sustained, or because of an activity. The next step is to examine whether there is a connection between employment and the place, or employment and the activity (whichever is most relevant).

In this edition of *The CompAct*, we will look at causation of personal injuries by accident in certain specific circumstances, such as when a worker is working from home or when the injury arises from an assault. We will also take a closer look at section 9 of the *WCIMA* and the authorities relating to injuries sustained whilst a worker is on a work-related ‘journey’.

Working from home

The shift to employers permitting work from home arrangements as the norm, or “*COVID-19’s silver lining*” as some may refer to it, has seen a change in the circumstances in which a worker can be found to have suffered an “injury from employment”. In short, despite being at their own residence when the injury was sustained, a worker can still be found to have suffered an “injury from employment”.



The relevant consideration in such matters is what a particular worker was doing at home at the time they were injured, and whether the activity engaged in was something reasonably connected to their employment.

- In *Van Oosterom v Aust Metropolitan Life Assurance Co Ltd*[3] the Victorian Supreme Court considered a worker who primarily worked from home, without any set hours. The court held that all activities undertaken by the worker which were incidental or related to the carrying on of his work would be regarded as being in the course of his employment. In such cases, it is necessary to have regard to the nature of the work and style of business of the employer.
- In *Re Ledwidge and Optus Administration Pty Ltd*[4], a worker was injured when he was at home, on a Sunday, cleaning his work vehicle in preparation for his normal work duties the following day. The evidence showed that the worker was entitled to maintain the vehicle at home and was under instructions from his employer to keep the



vehicle in good repair. The worker was found to be entitled to compensation in those circumstances.

- In *Lauren Vercoe v Local Government Association Workers Compensation Scheme*[5], Ms Vercoe was employed by the City of Charles Sturt (**the Council**) as an Asset Programmer/Operations Programmer. The day before the incident, she received prior approval by her team leader to work from home as she was looking after a colleague's puppy. While working from home, Ms Vercoe was taking a coffee break, and tripped and fell over a metal pet fence that she had erected so that the dog could be kept away from her pet rabbit whilst working. Ms Vercoe injured her right knee and right shoulder. Section 7(5)(b) of the *Return to Work Act 2014* (SA) contemplates that the definition of employment extends to attendance at a worker's place of employment during an authorised break which is compensable. The Council encouraged employees to take regular short breaks from their work stations, which includes employees working from home. The Deputy President, applying the test in *PVYW*, concluded that Ms Vercoe's injuries were compensable because her home was her place of employment on that day, and her injuries were caused by a feature of her place of employment – the pet fence. The fact that her employer knew that this was the reason for her working was home was also taken to be tacit approval or at least knowledge of the general circumstances in which she would be working.



- In *State of New South Wales (Western NSW Local Health District) v Knight*[6] Ms Knight was employed as a case worker in a court diversion program. Due to COVID-19 restrictions, she had worked from home, and conducted her duties at home through phone and video calls. On 8 October 2021, Ms Knight was bitten by a dog on her right hand after she attempted to intervene in dog attack on her daughter's puppy outside her front door. She sustained severe lacerations on her right hand and also sought treatment for post-traumatic stress disorder. This case went on appeal against a decision of the Personal Injury Commission (PIC) constituted by a Member. The ground was that the Member rejected the employer's assertion "*that in leaving her workstation and leaving her house to attend to her daughter's puppy, the worker had taken herself out of employment.*" President Judge Phillips upheld the Member's findings that although Ms Knight ceased performing her duties to investigate and then intervene in the attack, this was a reasonable practical necessity and consistent with what her employer would have



reasonably expected of her in the circumstances and therefore Ms Knight did sustain an injury 'in the course of employment'. Also, that to keep the environment quiet and professional, it was required that her household pet was to be kept outside and that this arose due to being at work and the nature of her employment. Therefore, her employment was a substantial contributing factor to their injury.

- In *Nazar V Hydro Electric Corporation*[7], Mr Nazar was employed by Hydro Electric Corporation as a relief area coordinator. His employer provided him accommodation to stay in Tullah and stayed with his partner and dog. On 25 May 2018, Mr Nazar slipped and broke his leg, whilst on a walk beside a lake. Mr Nazar injured himself whilst on a call. The employer required him to attend the work site within 15 minutes of the notification and he would be paid an allowance of \$68.15 per day for each day he was on a call. The case went up to the Full Court of the Supreme Court, made up of three judges where it was unanimously decided that the injury occurred in the course of his employment. The Chief Justice was satisfied that he was complying with the requirements of his contract of employment, which was to be on Availability Duty and proceed to commence work within 15



minutes of being contacted, and for which he would have been paid. There were also clear restraints on where he needed to be which is Tullah, and that was integral to his performance obligations.

Assaults

Injuries caused by serious or willful misconduct (eg if a worker starts a fight) are excluded, but what if a worker is assaulted by a colleague (and they didn't start the fight)? Is the colleague "in the course of employment" if they are engaging in unlawful conduct?

The case law authorities indicate that, when determining whether a worker injured by way of assault was injured in the course of his or her employment, the following factors need to be taken into account:



1	how the assault occurred;
2	if there was an argument or disagreement preceding the assault, what was the substance of that argument and its relationship with the employment; and
3	whether the assault occurred with or without any warning being given to the injured person.

In *South Maitland Railways Pty Ltd v James*[8], it was noted:

“It would not be in the course of the employment for workers to discuss their private affairs or ventilate their private quarrels in their employer’s time; but it must often be necessary for workmen in the course of their employment to discuss some matter relating to their work. A discussion between Hindle and James in order to ascertain whether Hindle was making charges that James was a favourite with the management who had been given work which he was incompetent to do would be a conversation which the commission could reasonably find was incidental to James’ employment and not to his private affairs”.



- In *Martin v Bailey*[9], the Court of Appeal of Victoria considered a case where a worker was assaulted by another worker, by way of retaliation to a racist slur. The majority held that the particular circumstances in which the altercation arose were not so far removed from the employment contemplated by the employer and the worker as to exclude it from the course of the employment. The minority held that by racially abusing his co-worker, the worker (who was subsequently injured by assault), had abandoned his employment.
- In *Weston v Great Boulder Gold Mines Ltd*[10], the High Court held that a worker was entitled to compensation for injuries he sustained from an assault, even though the disagreement which led to the assault began weeks earlier and involved issues entirely unconnected with the injured person’s employment. It was held that the circumstances of the injury were such that the worker was actively engaged in performing his duties at the time of the accident when he was assaulted by another employee.



Domestic violence risks

A recent decision in NSW raised the question of when an employer might be liable to pay compensation for an injury caused to a worker who is injured by an assault occurring when the worker is working from home.

In *Workers Compensation Nominal Insurer v Hill*[11], the deceased worker and her de facto partner worked in a family company, S L Hill & Associates Pty Ltd, which carried on its business of financial advising from their family home. On 16 June 2010, the deceased was sadly killed by her de facto partner. The partner was charged with murder but pled not guilty on the ground of mental illness, as the attack was inspired by paranoid delusions. Their two children made claims for workers compensation and gave evidence about how their parents worked long and ad hoc hours, and were basically always on the clock. An Arbitrator at the Workers Compensation Commission determined that the deceased had died as a result of injury arising out of and in the course of her employment and ordered payments in favour of the two children, however this was appealed by the Workers Compensation Nominal Insurer (**Appellant**). Basten JA, Payne JA and Simpson AJA from NSW Supreme Court of Appeal unanimously dismissed the appeal. This was based on the finding that the partner's 'paranoid beliefs' related to the way that the Deceased performed her work duties, which thus led him to assault her, and provided the necessary connection between the assault and employment.

Journey claims

The WCIMA has largely retained the wording of the relevant provisions regarding journey claims. Consistent with section 19(2)(a) of the 1981 Act, section 9 of the WCIMA states that, where a worker sustains a personal injury by accident whilst on a journey from his or her place of residence, either to or from work, that injury is not one for which the employer is liable. The basis for that provision is clear - that travel is undertaken outside of work hours and employers generally have little or no control over how a worker travels between work and home.



There are exceptions to the above rule; however, such as where the employer provides the means of transportation (between home and work) and requires the worker to use that transportation. Once the employer takes control over that period of travel, it is harder to separate it from a period of employment.

In *Fagan v Byrne-cut Mining Pty Ltd*[12] it was observed that the facts of each case under section 19 (of the 1981 Act) should be considered on their facts. The facts of that matter showed that the worker was injured in circumstances that arose out of his employment, despite the worker having been injured when he was driving a work vehicle between his place of residence and his place of employment.



Factors that might point to a journey from home to work (or vice versa) being compensable include:

- if employer has supplied the worker with a car or has paid for the worker's transport;
- if the worker is transporting equipment that is necessary for work (eg if they are taking files home that they need to work on later that night, or that they need for work the next day at a different location);
- if the employer also supplies the worker with housing.

When does the journey start and end?

In *Gilbert v JRR Nominees Pty Ltd*[13], the Supreme Court considered where a worker's residence ended, and a journey commenced:

“All that is required for the present purposes is to identify and mark out the “place of residence” ... I take this to mean the building in which the worker eats, drinks or sleeps. The place of residence in my opinion has nothing to do with meters and bounds of the land on which that building stands”.

This becomes important if a worker is injured in a work funded car park, or in the driveway of their home.

More clear cut are the scenarios where a worker is injured when on a 'work journey' - defined as *“a journey arising out of or in the course of a worker's employment”*. Some examples of such work journeys may include:

- a worker taking a taxi or ride-share from their usual place of work to attend a work meeting held at the office of a client;
- a worker being directed by their employer to drive to a supplier's premises to pick up products; or
- a worker having to take a flight from Perth to give a presentation to their colleagues based in the employer's Melbourne offices.

This follows the line of authorities imposing liability on the employers of workers injured through activity which is incidental to their work activities. It then becomes less clear cut if the worker is injured while doing something on that journey that their employer may not have expected. For example, leaving their hotel to go in search of food and ending up drinking slushies in the park with some new friends who rob you.[14]

If a worker is injured while undertaking a task on their journey that is not part of, or incidental to, their work duties, then section 9 of the WCIMA may be held to be irrelevant to that particular matter.



The decision in *Smith v Ranger Camping and Outdoors Pty Ltd*[15] concerned a worker who suffered a post-traumatic stress disorder (PTSD) as a result of an incident which occurred whilst she was on a work journey to collect equipment on behalf of her employer. Whilst on the work journey, the worker stopped and exited her vehicle so that she could assist the victim of a road accident. The worker was with the victim, offering assistance as she could, for about half an hour after the road accident, at which point the victim passed away from the severe head injuries sustained in the accident.

The Arbitrator, referring to case law including *Hatzimanolis v ANI Corp Ltd*[16], noted that the worker was employed as an administration manager and, therefore:

“...providing assistance to people injured in motor vehicle accidents was not part of the contract of employment, and the question then becomes whether the evidence satisfies me the worker’s involvement in providing assistance in the accident, was an act that was ‘reasonably required, expected or authorised to be done in order to carry out her actual duties’.

I am unable to find that the worker sustained an injury as defined in s.5 (a). This being the case, the employer’s argument advanced pursuant to the provisions of s.19 becomes irrelevant”.

- The moral of the story being – if you want to carry out an act of extraordinary human grace, setting a wonderful example of kindness and decency, make sure you do it on your own time, call your employer for permission first, or make sure you work at Jackson McDonald where that kind of behaviour is induced, encouraged or expected.

A personal injury by accident suffered by a worker whilst on a work journey will not be found to be an injury arising out of, or in the course of, that worker’s employment if:

1	that injury is sustained while the work journey is substantially interrupted for a purpose unconnected with the worker’s employment, or after an interruption of that kind; or
2	during a substantial deviation from a work journey for a purpose unconnected with the worker’s employment, or after a deviation of that kind.

Unlike the 1981 Act, the WCIMA does not define ‘substantial interruption’ as including any interruption of a journey for a period of more than one hour. This omission, and a consideration of the extensive case law surrounding claims arising from injuries sustained during a work journey, tells us that it is more pertinent to look at the particular circumstances surrounding the journey rather than simply its duration alone.

As an example, in *Lukatelich v Brambles Manford*[17], a worker who was injured during the course of his 1500 km work journey, was not held to be disentitled to compensation on the grounds there had been a substantial interruption in the journey, notwithstanding that he made numerous stops along the way, for periods of up to three hours.

The decision in *Scobie & Tallar v K D Welding Co Pty Ltd*[18] concerned a pair of workers who left work and went to a hotel for 1.5 hours, before then travelling home by motorbike, that journey including the decision to deviate from a bitumen road onto a gravel road. The worker who was the passenger on the motorbike was held to be disentitled to compensation for injuries he sustained when the motorbike left the road whilst the rider was attempting to avoid a pedestrian.

The High Court took into account that the deviation was substantial and had materially increased the risk of injury; however, in Western Australia, it is not necessary for an employer to show that an interruption to, or deviation from, a journey materially increased the risk of injury.

Next fortnight, The CompAct will move on to a discussion of the relevant causation test for when an injury defined as a ‘disease’, or the ‘recurrence, aggravation or acceleration of a pre-existing disease’ is an “injury from employment”.

[1] As per Dixon J in *Humphrey Earl Ltd v Speechley* (1951) 84 CLR 126.

[2] (2013) 136 ALD 1; 303 ALR 1; [2013] HCA 41.

[3] [1960] VR 507

[4] [2008] AATA 58.

[5] [2024] SAET 91

[6] [2023] NSWPCPD 63

[7] [2022] TASFC 11

[8] (1943) 67 CLR 496; [1943] ALR 173; (1943) 17 ALJR 37.

[9] [2009] VSCA 263

[10] (1964) 112 CLR 30; [1965] ALR 329; (1964) 38 ALJR 208.

[11] [2020] NSWCA 54

[12] (CM(WA), Packington J R, 5/03, 17 December 2003, unreported).

[13] [1985] WAR 209 as per Burt CJ at 212.

[14] *Douthwaite v MEDISERVE Pty Ltd* [2023] WADC 56

[15] [2014] WADC 40.

[16] (1992) 173 CLR 473; 106 ALR 611; 66 ALJR 365.

[17] Unreported, SC(WA), 15/89, 27 October 1993.

[18] (1959) 103 CLR 314

Causation of work-related diseases under the WCIMA:

A not uninteresting review

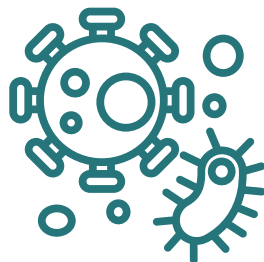
Ashleigh Glasson | April 1, 2025

The previous editions of The CompAct have outlined how injuries pursuant to the Workers' Compensation and Injury Management Act 2023 (WA) (WCIMA) can be either:

- a. a personal injury by accident; or
- b. a disease, or the recurrence, aggravation or acceleration of a pre-existing disease,

with the previous two editions detailing the relevant causation tests for determining when a type (a) injury – being personal injury by accident - is an injury from employment pursuant to section 6 of the WCIMA.

In this edition, The CompAct will provide an overview of the legislation and case law surrounding the causation test for a type (b) injury – being a disease, or the recurrence, aggravation or acceleration of a pre-existing disease.



Causation under the WCIMA

Section 6(3) of the WCIMA states that

“Unless otherwise provided in this Act, a disease, or the recurrence, aggravation or acceleration of a pre-existing disease, is an injury from employment if –

- a. *the disease is contracted, or the recurrence, aggravation or acceleration is suffered, in the course of the employment, whether at or away from the place of employment; and*
- b. *the employment contributed to a significant degree to the contraction of the disease, or the recurrence, aggravation or acceleration of the pre-existing disease”.*

And section 6(4) of the WCIMA helpfully goes on to list the factors that must be taken into account in determining whether particular employment contributed to a significant degree to the contraction of a disease, or to the recurrence, aggravation or acceleration of a pre-existing disease, those factors being as follows:

- a. the duration of the employment;
- b. the nature of, and particular tasks involved in, the employment;
- c. the likelihood of the disease, or the recurrence, aggravation or acceleration of a pre-existing disease, occurring despite the employment;
- d. the existence of any hereditary factors relating to the occurrence of the disease;
- e. matters affecting the worker's health generally;
- f. activities of the worker not related to the employment.



Contributing factor

Whether there was contribution from employment is a question of fact. The courts have held that it is proper to start such an inquiry from a position of common sense, considering the relevant sequence of events leading up to and/or surrounding the contraction of an injury (or its recurrence, aggravation or acceleration).

The burden of proving that employment caused or contributed to a disease falls on the worker and a worker will fail to discharge that burden by only proving that employment might have caused the particular disease in question[1].

Significant contribution

The WCIMA does not define 'significant'; however, in relation to causation of a work-related disease, in *Mokta v Metro Meat International Ltd*[2], the term 'significant' has been held to mean 'not insignificant'. That clarification from the Court cannot, by its own definition, be said to be of 'significant' assistance; however, we can look to decisions in other jurisdictions to provide further (albeit, non-binding) guidance.

In *Re Wesford v Cth Banking Corp*[3], Davies J considered the Commonwealth legislation requiring a worker's employment to have contributed to a material degree and held that:

“The factor is not required to be the real proximate or effective cause of the disease or of its development. In a case where a number of separate factors contribute to the contraction of a disease or its acceleration, aggravation or recurrence all that is required is that one such factor exhibits the necessary connection with the worker's employment”.

The Tasmanian legislation requires employment to contribute to a worker's disease to a “substantial degree”[4]. In considering that phrase, the full court of the Tasmanian Supreme Court noted that same was quantitatively imprecise, but that it would seem to require something which was more than trivial or minimal. It was thought that the term showed recognition that there may be multiple causes of a disease, and that the word substantial was used in a relative sense, such that the employment was not required to be the only substantial cause of a disease.

Recurrence, aggravation or acceleration of any pre-existing disease

In *Federal Broom Co Pty Ltd v Semlitch*[5], the High Court held that:

- “*acceleration*” relates to a disease which is progressive in its nature and the acceleration occurs when the rate of progress is increased by some external stimulus. The worker is entitled to claim payments for the resulting incapacity where the acceleration produces some more severe or additional symptoms.
- “*aggravation*” occurs where external stimuli produces additional symptoms or an intensifying of the existing symptoms which are incapacitating albeit of a temporary nature.

If it can be shown that a worker’s employment has accelerated a pre-existing disease, that resulting incapacity will remain compensable for as long as the evidence shows that incapacity has some causal relationship with the employment. This remains true even after the time by which the disease would have naturally progressed to the point of causing incapacity to the same degree: *Darling Island Stevedoring & Lighthouse Co Ltd v Hankinson*[6]. Medical evidence is to be led to show if and when a work-caused acceleration has or is likely to cease: *Casarotto v Australian Postal Commission*[7].

A psychological response to a compensable physical injury can itself be compensable, depending on the particular circumstances in which the psychological response arises[8], if it can be shown that the compensable injury is a material contributing cause of the condition[9].

Stress claims



The decision in *Sorenson v SA Metropolitan Fire Service*[10] indicates that, when considering causation of a stress related condition allegedly caused by employment, the decision-maker is entitled to take into account all other relevant medical conditions.

A worker having had a pre-disposition to sustain a particular disease does not equate to a worker having a pre-existing disease, but rather that the worker was more likely to eventually suffer the disease.

In *Re Turnley and Comcare*[11], evidence was led to show that the worker’s obsessive personality traits and his work circumstances created a particular vulnerability for that worker to suffer a psychological disease. It was held that whilst:

- the worker’s perception of his work circumstances may not have been (objectively) accurate, and that
- another person in similar circumstances may not have been affected by the circumstances as the worker was,

as the worker was not delusional, his predisposition to the psychological disease sustained was not regarded as relevant.

Relevant to causation of stress conditions, is the defence that can be raised pursuant to section 7 of the WCMIA, for a psychological disorder wholly or predominately resulting from administration action which is not unreasonable and harsh on the part of the employer, or the worker's expectation of administrative action or a decision by the employer in relation to same. We refer to our previous edition of The CompAct "*Stress testing stress claims: what insurers need to know*", for a detailed discussion of that provision.

[1] *Tubemakers of Aust Ltd v Fernandez* (1976) 10 ALR 303; 50 ALJR 720.

[2] [2005] WASC 143.

[3] (1984) 1 AAR 42.

[4] Section 25 of the *Workers Rehabilitation and Compensation Act 1988* (Tas).

[5] (1964) 110 CLR 626, [1964] ALR 1031 (**Semlitch**).

[6] (1967) 117 CLR 19.

[7] (1989) 17 ALD 321.

[8] *Semlitch*.

[9] *Kanowna Belle Gold Mines v Feierabend* [2003] WASC 246.

[10] [2008] SAWCT 10.

[11] [2008] AATA 560.

Rate of pay calculations are gross

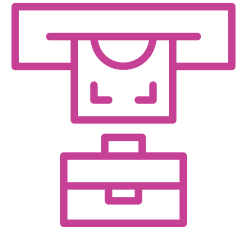
Ashleigh Glasson | April 17, 2025

In this edition of The CompACT, we take a look at the simplified method of calculating a worker's rate of income compensation introduced by the Workers Compensation and Injury Management Act 2023 (WA) (WCIMA), and take the opportunity to note the impact of a recent private ruling in relation to whether a worker is obliged to pay income tax when redeeming certain future WCIMA entitlements.

Calculating Rate of Pay

Step 1: Obtain the worker's pay records

Obtain the worker's pay records for each and every employment role that the worker was employed in on the day that the injury occurred. The records obtained should cover the period over the 12 months preceding the day before the injury was sustained.



If the worker was employed in that position for less than 12 months when the injury occurred — then the period considered starts on the day that the worker was employed in that position and up to the day before the day on which the worker's injury occurred.

If, on the day on which the injury occurred, the worker did not hold a position with the employer who is liable to pay income compensation, then the reference to “the day on which the worker's injury occurred” is to be taken as a reference to the day on which the worker last held a position with the employer before the worker's injury occurred.

Step 2: Calculate the pre-injury weekly rate of income for each role in which the worker was employed as at the date of injury

Calculate the worker's average weekly earnings over the relevant pre-injury period.

If the worker changed positions within that 12 month pre-injury period, the pre-injury weekly rate of income is calculated with reference only to the average weekly rate of earnings in the position that the worker held on the day on which the worker's injury occurred.

If a worker has taken leave without pay during the period over their average weekly rate of earnings is to be calculated, then that time taken as leave without pay must be excluded from the calculation of their average weekly earnings. Note that you only need to discount for periods of “leave without pay”, which is distinct from periods of paid leave or periods that a casual worker did not pick up shifts.

If a worker held two, or more, employment positions on the day the injury occurred, then the worker's average weekly earnings in each of those roles are added together to obtain the pre-injury weekly rate of income.

Step 3: Ascertain the weekly rate of income compensation for the relevant period/s of incapacity

A worker's rate of income compensation for the first 26 weeks of incapacity, is to reflect their pre-injury weekly rate of income.

Following the initial 26 weeks of incapacity, if the worker remains incapacitated for work, then the weekly rate of income compensation drops down to 85% of the worker's pre-injury weekly rate of income.



Step 4: Ascertain the impact of the “maximum” and “minimum” rates of income compensation

If the amount of income compensation payable is higher than the *maximum weekly rate of income compensation* applying at the relevant time (this changes every financial year), the amount of the payment must be reduced to the amount representing a payment at that maximum weekly rate.

Conversely, if the amount of income compensation payable would otherwise represent a weekly rate of payment less than the applicable *minimum weekly rate of income compensation*, the amount of the payment must be increased to the amount representing a payment reflecting that minimum weekly rate. The *minimum weekly rate of income compensation* will depend on whether the worker is an award worker or not.

Step 5: Consider whether there are any additional amounts that need to be included

If an employer provides a worker with board and lodging either during the 12 months leading up to the injury, or subsequent to the injury and during a period when the worker is entitled to receive compensation, section 58 of the WCIMA states that the monetary value of that board and lodging needs to be included in the calculation of the worker's rate of income compensation.

Step 6: Consider whether any discounts should be applied

If a worker is partially incapacitated for work, then pursuant to section 48(2) of the WCIMA, the rate of income compensation is obtained by calculating the amount that would apply if the worker were totally incapacitated for work and deducting from it the amount the worker earns, or is able to earn, in suitable employment.



If the worker has provided particulars of earnings under section 32 of the WCIMA, you could use those earnings to calculate any discount or deduction. Don't forget to issue a CN2 if you are reducing the rate of income compensation from a rate for total incapacity to a rate for partial incapacity.

Example:

Alexandra Ludwig has been employed full-time as a lawyer at JM Pty Ltd for 27 years. On March 1, 2025, she sustained a work-related injury that resulted in total incapacity. Her earnings over the 12 months prior to her injury were as follows:

- Base salary: \$70,000
- Overtime payments: \$5,000
- Allowances: \$2,000
- Bonuses: \$1,000
- Leave without pay: 2 weeks

In the 12 months before her injury, Alexandra took 2 weeks of leave without pay. Therefore, the number of weeks she worked is:

52 weeks (total weeks in a year) - 2 weeks (leave without pay) = 50 weeks

The Pre-Injury Weekly Rate of Income (PIWRI) is calculated by dividing the total earnings by the number of weeks worked. Alexandra's total earnings include her base salary, overtime, bonuses and allowances:

$\$70,000$ (base salary) + $\$5,000$ (overtime) + $\$2,000$ (allowances) + $\$1,000$ (bonus) = $\$78,000$

Now, divide the total earnings by the number of weeks worked:

$\$78,000 \div 50$ weeks = $\$1,560$ per week

Therefore, Alexandra's PIWRI is $\$1,560$.

- First 26 weeks: Alexandra is entitled to 100% of her PIWRI. Therefore, she will receive $\$1,560$ per week for the first 26 weeks of her incapacity.
- After 26 weeks: The compensation rate decreases to 85% of the PIWRI. Therefore, Alexandra will receive: $\$1,540 \times 85\% = \$1,309$ per week

These rates are lower than the current maximum rate of $\$3,079$ per week, so that not does affect the calculations. Alexandra is not paid under an industrial instrument or industrial agreement, so the minimum weekly rate that applies is calculated according to the Minimum Conditions of Employment Act 1993 (ie. minimum wage). Alexandra's rates of pay are not lower than the current minimum wage for award free workers of $\$918.60$, so that also does not affect the calculation.

Tax implications

As the WCIMA rolled in last year, there were mumblings that the change in terminology from “weekly payments” to “income compensation” might also have tax implications for lump sum settlements.

The Australian Tax Office (ATO) has now published a ruling, answering the following questions of whether the:

- a. income compensation component; and/or
 - b. the medical and health expenses, and miscellaneous expenses components –
- of the redemption settlement in question payable under the WCIMA is assessable income under section 6-5, or section 6-10, of the *Income Tax Assessment Act 1997 (ITAA)*.

Without wanting to spoil the ending, in short – yes, an amount paid in redemption of income compensation is subject to income tax, and an amount paid in redemption medical and health expenses or miscellaneous expenses is not.

The basis for the above finding being that:

1. Pursuant to the ITAA, assessable income includes ordinary and statutory income (for example, capital gains) derived directly and indirectly from all sources. The ATO stated that:

“...amounts which compensate for lost income or serve as a substitute for other income are themselves income according to ordinary concepts.

...

The fact that the payment is received in one lump sum does not change its revenue character”.

1. Medical and health expenses, and miscellaneous expenses, pursuant to the WCIMA are rights of a capital nature. Therefore, the money a worker may receive to compensate them for the relinquishment of these rights will similarly be of a capital nature.

The specific facts of the matter to which the ATO determination relates concerned a worker who sustained a personal injury in the course of their employment, liability for which was accepted by the employer’s insurer, such that the worker was in receipt of income compensation and other statutory entitlements pursuant to the WCIMA at the time when an in-principle agreement to settle the claim was agreed between the worker and the employer’s insurer.

This ruling is consistent with, and considered, the decisions of *Brackenreg V Federal Commissioner of Taxation* [2003] AATA 824; 2003 ATC 2196; (2003) 53 ATR 1116 and *Senior v FC of T* 2015 ATC 10-392.

It is currently unclear whether a redemption of potential entitlements to income compensation under the WCIMA would also be held to be taxable income in circumstances where liability for a worker's personal injury was not accepted before the redemption takes effect.

It is also of note that the ATO stated that the amount representing future income compensation in a redemption settlement will be required to be declared in the income year it is received. We note that this could create a situation where a worker ends up paying more income tax than they otherwise would have if the redemption includes an allowance for future income compensation for a period of more than the number of weeks remaining in the financial year.

This ruling has changed the way most workers approach redemption of their workers' compensation entitlements and removes some of the incentives for employers and insurers to agree to a lump sum redemption.

The limit does exist: A closer look at medical & health expenses

Ashleigh Glasson | May 12, 2025

As with the 1981 Act, the Workers Compensation and Injury Management Act 2023 (WCIMA 2023) provides an entitlement to reasonable medical and health expenses compensation incurred or to be incurred by a worker as a result of a worker's work-related injury.

Significant increase in the general limit for medical and health expenses compensation



One of the most significant changes introduced by the WCIMA 2023 was the increase in the maximum entitlement to medical and health expenses from 30% to 60% of the general maximum amount.

This has set the current cap on medical and health expenses at \$158,692, which is almost double the 2023-2024 cap of \$75,817. In addition, a worker can potentially access further increases in that general limit.

The increase to the general limit for medical and health expenses does not, however, extend limits that had already been exhausted before 1 July 2024. So if a worker had already received \$75,817 in medical and health expenses before 1 July 2024, they must apply for a standard increase to be eligible for further compensation.

Increases in the general limit can be sought

A *standard increase* of 40% of the medical and health expenses general limit can be sought pursuant to section 77 of the WCIMA 2023, and an arbitrator may order this increase if the arbitrator –

1	is satisfied that the worker has incurred, or is likely to incur, reasonable medical and health expenses in an amount that is in excess of the general limit; and
2	considers that the increase should be allowed, having regard to the social and financial circumstances and the reasonable financial needs of the worker.

If an arbitrator orders the *standard increase* and the worker then incurs, or becomes likely to incur, “special expenses” in excess of those that can be provided for by a standard increase, an arbitrator can then order a special increase of up to 190% of the medical and health expenses general limit, if:

1	it has not yet been 5 years since the claim for compensation was accepted or deemed to be accepted by the employer;
2	the worker has a degree of permanent whole of person impairment of at least 15% as a result of the worker's injury as determined under section 79;
3	the arbitrator considers that the increase should be allowed, having regard to the social and financial circumstances and the reasonable financial needs of the worker; and,
4	pursuant to the Regulations, that operative intervention and reasonable post-operative treatment are required to substantially alleviate the consequences of serious impairment and improve the worker's physical condition.

Unlike under the 1981 Act, accessing a *special increase* does not prevent a worker from being able to commence common law proceedings.

Unfortunately “special expenses” is not defined in the Act or Regulations, so it is unclear whether that term has been used to refer to a narrower category of medical and health expenses (for example, only operative intervention and post-operative treatment) or not.

Settling claims where a standard increase or special increase has been ordered or agreed

Now that WorkCover is applying greater scrutiny to settlement agreements, it is unclear whether a settlement agreement that provides for redemption of medical and health expenses above the general limit (to accommodate a standard increase or special increase entitlement) will be approved, rejected or referred to an arbitrator for further consideration.

We anticipate that unless there is an order from an arbitrator lodged against the claim approving of the increase, the agreement will be outright rejected.

If you want to avoid the cost of applying for an arbitrator's order, it would be worth at least trying to register a settlement agreement together with extrinsic evidence explaining why the total amount of medical and health expenses exceeds the general limit, and a statement of social and financial circumstances. If that fails, then you may need to consider a formal application.

The requirement for the treatment to be “reasonably necessary”

Consistent with the 1981 Act, medical and health expenses are only compensable if they are “reasonable”. However, the WCIMA 2023 now includes a list of factors that must be considered when determining whether expenses are “reasonable”. This list is set out in section 72 of the WCIMA 2023 and includes:

- it must be reasonably necessary for the worker to incur the expense; and
- the amount of the expense must accord with any applicable WorkCover scale of fees, or if no such scale exists, prevailing market rates and other relevant circumstances

As we await any decisions pursuant to the WCIMA 2023 in relation to the meaning of “reasonably necessary”, we consider that the leading cases under the 1981 Act are likely to still provide useful guidance. In particular, the Court of Appeal decision in *Napier v BHP Billiton (Worsley Alumina) Pty Ltd* [2015] WASCA 230. In the decision, it was held that:

- the relevant treatment must have a connection or relationship with an injury to which the Act applies. Buss JA noted that the factual inquiry in this regard is to involve “...the application of common sense in evaluating the causal chain”;
- the term “reasonable” requires a factual value judgment; and
- a determination as to the reasonableness of the treatment will include, but not be limited to, consideration of matters going to the appropriateness, effectiveness and costs of same. President McLure gave the example that “...a large outlay for a marginal outcome is unlikely to be reasonable”. The benefits of the considered treatment are to be compared with the costs of obtaining it. Illustrative of this principle was the decision given in *Cantone and Telstra Corp Ltd* [2015] AATA 534 that whilst remedial massage treatment was reasonable for the worker in the particular circumstances, the requirement to travel in excess of a 50 km round trip to access that treatment, was not.

In *Re Graham and Comcare* [2007] AATA 1715 it was held to take into account other available treatment, if any can be identified.

It has been held, in *Allen v P & O Ports* (unreported, CM(WA), 49/01, 10 September 2001) that treatment can be held to be reasonably necessary even where a worker will have a capacity for work without the treatment. Similarly, the fact that a worker will remain incapacitated for work despite the treatment is not itself sufficient to find the treatment is not a reasonable expense. In *Smith v WA Plantation Resources Pty Ltd* [2017] WADC 8, it was held that the arbitrator who originally determined the matter had erred in law in having failed to consider as a relevant factor the prospect that the proposed surgery would improve the worker’s sleep and therefore his quality of life.

In *Barrick Gold Aust Pty Ltd v Green* (CM(WA), 98/03, 18 December 2003, unreported) the following factors were listed as ones which a decision maker might take into account when determining whether medical expenses were reasonable:

1	the costs of the treatment;
2	whether the treatment was difficult or simple;
3	whether the treatment was attended with serious risk;
4	whether the treatment was likely to be successful;
5	whether the treatment would put an end to the incapacity;
6	whether there would be much pain and risk in the use of anaesthetic;
7	whether the treatment was advisable;
8	whether all the material facts were known;
9	the appropriateness of the treatment;
10	the alternatives to the treatment;
11	the effectiveness of the treatment; and
12	the acceptance of the treatment by the medical profession.

For your inFORMation...

Ashleigh Glasson | June 5, 2025

Brace yourselves - the WorkCover WA forms have changed (again).

If you have woken up thinking, “I sure could go some light reading about changed workers’ compensation forms” then today is your lucky day! Welcome to the thrilling world of **form updates** - where boxes are checked, fields are filled, and excitement is... well, mostly theoretical.

Yes, the forms you know and love (or at least tolerate) have undergone changes. Again. Because nothing says “*living on the edge*” like a new dropdown menu or a slightly repositioned signature line. So grab your favourite pen, stretch those typing fingers, and prepare to dive into the riveting world of form revision...now with 12% less confusion and 100% more compliance.

Let’s get into it before the forms change again while you’re reading this.

Note: don’t use the new forms yet, you must wait until 1 July 2025.



SF1 - Settlement agreement

The agreement no longer needs to indicate the circumstances of the injury, the date the claim was made, or the date the claim was given to the insurer.

- In relation to the compensation amounts agreed, these no longer refer to ‘future’ compensation.
- Where the worker signs the agreement, it no longer says ‘worker’ signature.
- The position of the employer (or employer’s representative) is to be indicated when signing the agreement.
- The new settlement agreement form indicates as follows:

“In accordance with the Workers Compensation and Injury Management Act 2023, a worker’s entitlement to compensation in respect of an injury to which this settlement agreement relates ceases on the date of registration of the agreement”.

SF3 - Permanent impairment notice

- Employer ABN no longer needs to be indicated.
- The employer is no longer requested, and is instead required, to indicate whether or not the employer agrees with the assessed degree of permanent impairment specified in the notice. In addition, the employer now ticks the correct box to indicate whether or not it agrees with the assessment, rather than crossing out the option that does not apply.
- The form now indicates that, if agreement is reached, this notice may be signed electronically or digitally and must accompany an application to register a settlement agreement together with the APIA report **and settlement agreement**.

CN1 – Intention to Reduce or Discontinue Income Compensation – Consent

The new form now includes the following notice to the employer and insurer:

“Note: This approved form cannot be used to seek a worker’s consent to reduce or discontinue compensation in the following circumstances:

If a worker takes leave. Section 61 of the Act provides the worker’s entitlement is not affected by the worker taking leave

If a worker has returned to work. Section 63 of the Act requires approved form CN2 to be given in these circumstances

On the basis of medical evidence about a worker’s capacity for work. Section 64 of the Act requires CN3 to be given in these circumstances

If a settlement agreement has been lodged for registration. Section 156 of the Act provides that compensation ceases on the date of registration”.

This note has been included to discourage employers and insurers from asking workers to consent to their income compensation ceasing upon agreement or in “4 weeks or until registration, whichever is sooner”. WorkCover has indicated its disapproval of that term, without recognizing that the term is important to encourage workers to return settlement documents without delay and to ensure that compensation limits are not exceeded.

Employers and insurers will also need to consider alternative ways to manage claims if workers who have not returned to work or who do not have medical evidence confirming that they are fit for work request a long period of annual leave (especially overseas leave). In certain circumstances, employers and insurers might consider steps such as:

- i. arranging a medico-legal review before a period of leave to support a CN3 being issued;
- ii. an application under s164 for failing to comply with a return to work program.

CN2 – Intention to Reduce or Discontinue Compensation – Return to Work

Rather than simply being signed by the employer/insurer, the new form requires the following declaration to be completed with by an authorised person, with that person's name and position also be disclosed on the form.

“Declaration

I confirm that you have returned to work in the position described above and that all information provided in this notice and any attachments are correct and complete.

I am authorised to complete and sign this declaration.

Penalties may apply for illegally reducing or discontinuing a worker's income compensation”

The new form also includes the following:

“Note: Prior to making this declaration an employer or insurer must have evidence of the worker's return to remunerated work which may include pay slips, or correspondence from the worker or employer or a notice provided by the worker under section 32 of the Workers Compensation and Injury Management Act 2023. This approved form cannot be used to reduce or discontinue compensation on the basis of medical evidence about a worker's capacity for work. Section 64 of the Act requires CN3 to be given in these circumstances”.

These additional comments and declaration have been included to remind employers and insurers that they require a sufficient level of evidence to substantiate a return to work within the meaning of the Act, before ceasing income compensation payments. It is not acceptable to cease income compensation payments simply because old mate Johnny Smith told a friend of the friend that the worker's younger sister mentioned the worker had been doing a few cashies.



CN6 – Custody or Imprisonment Notice

- No longer need to specify the authority which the notice is addressed to.
- The employer's details are now to be specified on the form.
- The form now includes the following:

“Note: To assist WorkCover WA in this request please ensure the liability decision notice accepting the worker's claim and any other relevant information is attached to this notice when providing it to WorkCover WA”.

- Rather than being issued by the insurer, the form is now to be provided to WorkCover to issue the request for confirmation that the relevant worker is in custody or serving a term of imprisonment.



APIA3 – Permanent Impairment Assessment Requirement to Attend

The form no longer needs to be signed by the approved permanent impairment assessor (APIA).



APIA4 – Permanent Impairment Assessment – Provision of Information

The form no longer needs to be signed by the APIA.

APIA5 – Permanent Impairment Assessment Consent to Provision of Information

- Rather than being issued to “person with relevant information”, the form is now directed to the worker.
- The form no longer needs to be signed by the APIA.

CF2 – NIHL Compensation Claim Form

The form must now specify:

- i. the date the worker's claim form was given to the last employer; and
- ii. the date the worker's claim form was given by the last employer to the insurer.

NIHL1 – NIHL Audiological Test Report

- The form now requires the worker’s reported recreational history, as well as their occupational, past medical and audiological history.
- The form now provides a separate table where the percentage hearing loss at each frequency, and for each ear, is to be specified. This table also requests the worker’s age at the date of the test and the age correction factor to be specified.

NIHL3 – Worker Noise Exposure and Employment History

- The only change made to the form is that the form now specifies that the worker’s period(s) of previous employment are to be entered on the form in dd/mm/yyyy format.

And there you have it - every riveting detail about the latest form changes, from the majestic migration of the “percentage hearing loss” fields to the mysterious disappearance of “Employer ABN required”.

Remember: forms may change, but your ability to forget which section needs initials will remain eternal. So go forth, brave reader, and may your fields always auto-fill and your attachments never exceed 25MB.

Until the next update, stay compliant and caffeinated.

From ambulance trips to artificial limbs:

What's hiding in miscellaneous expenses?

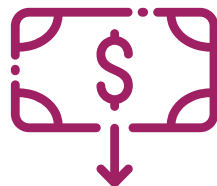
Ashleigh Glasson | June 19, 2025

The **Workers Compensation and Injury Management Act 2023 (WA) (WCIMA 2023)** provides for uncapped miscellaneous expenses compensation, meaning that – unlike income compensation and medical and health expenses compensation, there is no overall compensation limit that applies to miscellaneous expenses.

What's included?

Miscellaneous expenses also now extend to include first aid and emergency transport costs, which were previously part of the capped medical entitlement in the 1981 Act, in addition to the same small number of random additional expenses provided for in the 1981 Act. This is of significant benefit to workers who require transfer to hospital via, for example, a flight provided by the Royal Flying Doctor Service where the injury is sustained in a remote location. Such transfers can cost in excess of \$20,000 and would, under the 1981 Act, use up a substantial proportion of the worker's capped entitlement to medical expenses before the worker has received any actual treatment for their injuries.

Miscellaneous expenses are generally regarded to include aids and appliances, such as wheelchair or similar, as well as surgical appliance or artificial limb, repair or replacement of clothing damaged or destroyed, travel, as well as costs associated with the assessment of degree of permanent impairment.



The “reasonably necessary” test

The miscellaneous expenses item for which funding is claimed must be reasonably necessary and the monetary cost attributed to the item must itself be reasonable. The WCIMA 2023 states that regulations may provide for the principles to be applied in determining whether it is reasonably necessary for a worker to incur a miscellaneous expense.

Aids and appliances

As allowed by the WCIMA 2023, Regulation 34 of the *Workers Compensation and Injury Management Regulations 2024*, applies to limit the amount payable for the provision of a wheelchair or similar appliance and the rate of travel expenses.

In relation to a miscellaneous expense for providing a worker with a **suitable surgical appliance or artificial limb**, this will be considered only if it:

- Is capable of relieving any effect of the worker's injury; and
- Complies with any standard prescribed by the regulations.



The cost of the repair or replacement of artificial aids, such as a hearing aid, artificial limb, artificial teeth, artificial eyes, spectacles or contact lenses, is a miscellaneous expense even if the worker did not suffer any injury as a result of the work accident.

The expense can include the costs of services by way of consultations, examinations or prescriptions that are rendered by medical practitioners, dentists or other qualified persons and reasonably required in connection with the repair or replacement.

Travel expenses

In relation to travel expenses, this can include:

- the running costs of the use of the worker's vehicle for approved travel; or
- any fare or other cost of approved travel; or
- meals and accommodation reasonably required in connection with approved travel.

Further, approved travel includes:

- travel that the worker is required to undertake by the employer; or
- travel that the worker is advised to undertake by a medical practitioner; or
- travel that the worker establishes is necessary in the particular circumstances of the case.

Travel by a worker is also approved travel if it is for the purpose of the assessment of the worker's degree of permanent impairment and the worker establishes that the travel is necessary for that purpose in the particular circumstances of the case.

The Regulations specify the rates at which expenses for:

- vehicle running costs; and
- meal and accommodation reasonably required in connection with approved travel – are taken to be reasonable.

Costs associated with permanent impairment assessments

In relation to the cost of an **assessment of the worker's degree of permanent impairment**, this is a miscellaneous expense if it is for any of the following purposes:

- establishing eligibility for permanent impairment compensation;
- for a worker seeking to elect to commence common law proceeding against their employer in respect of the work injury;
- obtaining a special increase in the medical and health expenses general limit amount.

Only one assessment for each purpose is compensable (together with any assessment for any previous attempt at obtaining the assessment if the previous attempt resulted in a finding that the worker's condition had not stabilised to the extent required for the assessment to be made).



Dependency claims pursuant to the WCIMA

Ashleigh Glasson | July 3, 2025

When a worker dies - either as a result of a work-related injury, or while they are in receipt of compensation for a work related injury - a claim for compensation can be made by the worker's dependant(s) under the Workers Compensation and Injury Management Act 2023 (the WCIMA).

If a worker dies from a work related injury

The following compensation entitlements may be claimed by dependants who were wholly or partly dependent upon the earnings of the worker at the time of the worker's death:

1	a lump sum entitlement.
2	a regular allowance for dependent children.
3	funeral expenses up to a statutory maximum amount (also available to non-dependants).
4	the worker's reasonable medical and health expenses resulting from the workplace injury prior to the worker's death (also available to non-dependants).

If a worker dies while in receipt of compensation

If a worker dies from a non-work related cause while they are receiving income compensation (and if they have received income compensation for at least 6 months immediately preceding their death), dependants who were wholly or partly dependent upon the earnings of the worker at the time of the worker's death can claim a lump sum entitlement.

The entire amount available is equivalent to 1 year of income compensation payments, and is split among the eligible dependants according to a formula prescribed by the WCIMA.

Who can make a dependency claim?

Compensation can be paid to financially dependent family members, including:

- a **current or former partner** of a worker;
- **child** of a worker; and

- **extended family member/s** of a worker. However, an extended family member can only make a claim where there is no dependent partner or children.

Usually, a claim must be made within 12 months after the date of the worker's death.

What information is required to be lodged by a claimant?

To make a claim the Workplace Fatality Compensation Claim Form must be completed and lodged, along with supporting documents, with the worker's employer who, in turn, will lodge the claim with its insurer within 7 days of the claim having been received.

There are several documents that insurers need to be provided with to enable them to assess liability for the claim. The required documents include:

Information about the worker: birth certificate, death certificate, marriage certificate (where applicable), bank statements, payslips, tax returns or other proof of the worker's income, receipts, invoice and/or quotations for funeral expenses incurred or likely to be incurred.

Information about the dependent spouse or partner making a claim: birth certificate for the spouse or de facto partner, statement from the de facto partner, a supporting particulars, about the status of their relationship with the worker, including:

- shared bank statements, expenses and other proof of how the spouse or partner was dependent on the worker
- payslips, tax returns or other proof of the spouse or partner's income.

Information about dependent children making a claim: birth certificate for dependent children, evidence of school, vocational or university enrolment if the child is aged between 16 and 21 years, evidence of guardianship or adoption, if the worker or the person claiming on behalf of any child is not the parent.

Information about an extended family member making a claim: evidence the person is an extended family member, a Statutory Declaration to the effect the worker died leaving no dependent partner or children.

Information about financial dependency: records of income received from employment, investments or business over a two year period prior to the death of the worker, for the worker and claimant(s), tax returns for the two year period prior to and including the worker's death, for the worker and the claimant(s), bank/ financial statements that show the worker provided monetary support to the claimant(s), copies of any relevant legal order or voluntary arrangement setting out the amount to



be paid for child support or spousal/de facto maintenance; and details of any distribution or profit paid to the worker or claimant(s) from any family trust.

Information about medical and health expenses: invoices that relate to the worker's medical attendance, transportation and treatment incurred for the workplace injury prior to their death.

Documents to provide if the death did not result from the injury: documents to show the worker had been in receipt of income compensation for a continuous period of at least six months; and documents to prove the claimant's relationship to the worker and dependency (same as documents listed above).

Information about the circumstances of the worker's death and their employment may also be required. This can include a police report, a coroner's report and other evidence about what happened and how it was relevant to the worker's employment.

The supporting documents assist to determine:

- the cause of death and whether that cause was related to work
- the dependant's relationship to the deceased worker
- the dependence on the deceased worker's earnings.

Dependency claim determination and applications to WorkCover WA

The employer's insurer will assess the claim and notify the claimant if it is accepted or disputed, or if additional details are required.

If a liability decision is not made within 30 days of making the claim, and the claimant believes a decision should reasonably have been made in that time, the claimant can lodge an Application with the Arbitration Service without a liability notice.

If the insurer accepts the claim, an Application for Arbitration – Workplace Fatality Compensation will need to be lodged with WorkCover WA's Arbitration Service for an order for payment of compensation.

If the insurer does not accept the claim, the claimant must be advised of the reason. If the claimant disagrees with the determination, that claimant can still apply to WorkCover WA's Arbitration Service for the insurer's decision to be reviewed.



Dependant lump sum entitlement amount (for work related deaths)

If the worker's death is determined to have resulted from the workplace injury, a dependant lump sum entitlement amount (**DLSE**) is payable to any partner or child who is accepted as having been dependent on the earnings of the worker at the time of death.

If there is more than one dependent partner and/or child, the DLSE is shared between them in accordance with the formula described in Table provided in section 133 of the Act.

Where there is no dependent partner or child, the DLSE is payable to an extended family member who was dependent on the earnings of the worker at the time of death.

Child's allowance

A regular child's allowance is payable for the care and maintenance of each child who was dependent on the worker's earnings at the time of the worker's death. This amount is additional to the child's proportionate share of the DLSE. This allowance is paid into a trust account managed by WorkCover WA and paid to each dependent child weekly or at intervals determined by an arbitrator.

The allowance is payable to each dependent child:

- until the child attains the age of 16; or
- until the child attains the age of 21 and is in full time study.

Funeral expenses

There is a maximum amount payable for funeral expenses which is indexed each financial year. The amount is payable to the person who has incurred the costs of the worker's funeral.

Medical and health expenses

The cost of the worker's medical and health expenses incurred in relation to the injury prior to their death can be claimed by the person incurring the expenses.

This may include emergency transportation (e.g. ambulance), hospital accommodation expenses, surgery and medical treatment.

Arbitrator orders about the lump sum

The arbitrator's orders will specify who gets what portion of the lump sum with reference to the table in the Act.

The powers of an arbitrator provide flexibility for the entitlement to be paid to dependants as the arbitrator sees fit. Generally, the arbitrator's compensation orders will specify whether the lump sum is to be paid directly to the dependant or not. This usually depends on whether the dependent is an adult or a child.

Discharging common law liability

Statutory payments made to dependants under the WCIMA do not discharge common liability.

And settlement of a common law claim does not necessarily prevent the dependants from making a separate statutory claim.

It is important to ensure that the appropriate steps are taken to procure the necessary releases if you are concerned about future liability.

Show me the meaning of being on light duties

Ashleigh Glasson | July 21, 2025

As with the former legislation, the **Workers Compensation and Injury Management Act 2023 (WA) (WCIMA)** places a number of injury management obligations on employers.

Injury Management

Pursuant to the WCIMA, an employer must ensure that -

- an injury management system is established and implemented in accordance with the regulations in relation to workers employed by the employer; and
- the injury management system is described in a document that is available to the workers.

An injury management system means a process setting out the steps to be followed when there is an injury from employment.

The *Workers' Compensation and Injury Management Regulations 2024* (the Regulations) state that an injury management system is to include:

- a description of a worker's right to claim compensation if they suffer an injury from employment;
- a description of an employer's obligation to comply with the claim and injury management process set out in the Act when a claim is made;
- a description of the steps the employer will take if an injury from employment occurs;
- information about the person who has day-to-day responsibility for the injury management system and their contact details.



Compensation for workplace rehabilitation expenses

An employer's liability to pay workplace rehabilitation expenses compensation arises when it is reasonably necessary for an approved workplace rehabilitation provider to provide a workplace rehabilitation service in accordance with the Regulations.

Such expenses are payable to the workplace rehabilitation expenses compensation limit, being the amount that is 7%, or a greater percentage, if any, prescribed by the Regulations, of the general maximum amount. The limit for the 2025/2026 financial year is \$19,125.

Return to work program

The WCIMA dictates that an employer must establish and implement a return to work program (RTWP) with the object of assisting the injured worker to return to work in a timely, safe and durable way, with a potential penalty of up to \$5,000 to apply if the employer fails to meet this obligation.

If an insured employer requests the insurer to assist the employer to either comply with, or discharge, any of the employer's duties in relation to establishing a RTWP, the insurer must take reasonable action to assist and ensure that the employer complies with, or to otherwise discharge, the employer's duties that are the subject of the employer's request.

A RTWP is required after the earliest of the following:

- the day on which the worker's treating medical practitioner issues a certificate of capacity to the effect that the worker is partially incapacitated for work;
- the day on which the worker's treating medical practitioner advises the employer in writing that a return to work program should be established for the worker;
- the day on which, in proceedings under Part 6, an arbitrator determines, or the parties agree, that the worker has suffered an injury in respect of which compensation is payable and is partially incapacitated for work.

A RTWP is required after the earliest of the following:

- give the worker an opportunity to participate in the establishment of the RTWP;
- take reasonable steps to ensure that the worker agrees with the content of the RTWP established for the worker; and
- give a copy of the RTWP and any amended RTWP to the worker and their treating medical practitioner.

If the treating medical practitioner of a worker on a return to work program amends a certificate of capacity or modifies in writing the restrictions on the work that the worker is considered capable of doing, the employer must, as soon as practicable after becoming aware of the amendment or modification, amend the worker's return to work program as required to take account of the amendment or modification.

The employer of a worker on a return to work program must ensure that the program is implemented in a timely manner.

Pursuant to section 161 of the WCIMA, a worker may apply for an order of an arbitrator, requiring the employer to either establish and implement a return to work program for the worker, or to alter the terms of a return to work program for the worker (if the arbitrator is satisfied that any of the obligations placed on the worker under the RTWP are unreasonable).

Workplace rehabilitation providers

A workplace rehabilitation provider may apply, in the approved form, to WorkCover WA for approval for the purposes of the WCIMA.

The Regulations state that a request to an approved workplace rehabilitation provider for the provision of a workplace rehabilitation service may be made by a worker, an employer, an insurer (or self-insurer) or a treating medical practitioner. A worker may choose which approved workplace rehabilitation provider is to provide the workplace rehabilitation service and, in the circumstances where an insurer recommends a particular provider, the insurer must inform the worker of his or her right to choose a different provider.

The Regulations also specify when it is reasonably necessary to provide workplace rehabilitation services, such as if assistance is required to:

- to identify and address risk factors that may impact on a worker's successful return to work;
- to assess a worker's functional capacity and provide recommendations to translate functional gains into meaningful work; or
- to help a worker identify their vocational strengths, skills and abilities if they are unable to perform their pre-injury work and assist with identifying steps that can be taken to transition into a different type of work.

Case conferences

Pursuant to the WCIMA, an injured worker who has an incapacity for work may be required to attend a conference (*a return to work case conference*) - arranged by the worker's employer, the employer's insurer, the worker's treating medical practitioner or an approved workplace rehabilitation provider - for the purpose of supporting the worker's recovery and enhancing opportunities for the worker's return to work.

The following matters may be discussed at a return to work case conference:

- the workplace, the worker's duties and the worker's return to work opportunities;
- the types of duties the employer can provide while the worker has work restrictions and the workplace support the worker will need to fulfil those types of duties;
- any modifications which may be required to the workplace or work equipment;
- any barriers that are, or may be, impacting a worker's return to work;
- whether to develop or modify a return to work or injury management activity or goal specified in a certificate of capacity or return to work program.

The following matters must not be discussed at a return to work case conference:

- matters relating to the treating medical practitioner's diagnosis, the medical assessment findings or the certified capacity for work;
- matters relating to liability for the claim.

This includes the following;

- how the injury happened;
- whether the injury is a new injury or the recurrence, aggravation or acceleration of a pre-existing injury;
- challenging a fact stated by the worker or treating medical practitioner;
- matters relating to a worker's injury that may be dealt with by requiring the worker to undergo an examination by a medical practitioner under section 180(1) of the WCIMA.

This means that a return to work case conference is not an opportunity for the employer or insurer to query why a medical practitioner has certified partial instead of total incapacity, or request an increase in hours or changed restrictions.

The Regulations state that the maximum frequency that a worker may be required (by an employer or insurer) to participate in a return to work case conference is not more than once every 4 weeks. This, however, does not apply if the return to work case conference is arranged by the worker's treating medical practitioner.

Not optional:

worker and employer duties in the return to work process

Ashleigh Glasson | August 19, 2025

The Workers Compensation and Injury Management Act 2023 (WA) (WCIMA) creates particular obligations for workers and employers to comply with.

Worker obligations

An injured worker must:

1	In cooperation with the worker's employer, make reasonable efforts to return to work.
2	A worker must also participate and cooperate in the establishment of the return to work program, if a return to work program is required to be established.
3	The worker must comply with any reasonable obligations placed on the worker under the worker's return to work program, including any obligation to undertake workplace rehabilitation.
4	The worker must comply with any requirement to attend a return to work case conference under section 165 and must participate and cooperate in the conference.
5	The worker must give each progress certificate of capacity issued to the worker to the worker's employer or the employer's insurer within 7 days after the certificate is given to the worker (unless the medical certificate is provided to the employer by the medical practitioner who issued it directly).

If a worker refuses or fails to comply with their return to work obligations, an employer may apply to an arbitrator for:

- An order that the worker comply with the duty;
- An order that the payment of income compensation to the worker be suspended.

If, after an arbitrator makes an order, the worker continues to refuse or fail to comply with their return to work obligations for 1 month (or for another particular period of time specified by the arbitrator), an arbitrator may order that the worker ceases to be entitled to income compensation in respect of the injury in relation to which the duty arose. An arbitrator must not make such an order if the worker is held to have had a reasonable excuse for refusing or failing to comply.

Employer obligations

The employer of an injured worker must, for a period of 12 months from the date of the worker's first incapacity:

1	Provide to the worker the position the worker held immediately before having an incapacity for work; or
2	Ensure that the worker is provided with a suitable position if -

- if it is not reasonably practicable to provide to the worker the pre-injury position; or
- if the worker does not have capacity to work in the pre-injury position.

A suitable position is defined to mean a position:

- for which the worker is qualified; and
- that the worker is capable of performing; and
- that is most comparable in status and pay to the position the worker held immediately before having an incapacity for work.

If an employer is held to have contravened its obligation to provide an injured worker with their pre-injury or a suitable position during that initial 12 month incapacity period, the employer can face a potential fine of \$10,000.

During that initial 12 month incapacity period, the employer of an injured worker must not dismiss the worker solely or mainly because the worker is totally or partially incapacitated for work.



In considering whether a worker has the capacity to work, the employer is entitled to take into account factors (other than the compensable injury) which may render the worker unfit to return to his or her pre-injury role. By way of example, in the South Australian decision *Seal v Transfield Services (Australia) Pty Ltd* [2010] SASCFC 44 it was held that the worker was neither ready nor able to exploit his partial capacity to work because there was no realistic opportunity in the labour market for a worker with the handicap of his alcohol and drug dependence.

If the employer does intend to dismiss the injured worker during that 12 month period, then the employer is obliged to provide that worker with a notice of intention in the approved form (at least 28 days before the dismissal takes effect.)

If an incapacitated worker is employed by a labour hire organisation, the host employer must, to the extent that it is reasonable to do so, cooperate with the labour hire organisation in respect of action taken by the labour hire organisation in order to comply with its obligations to facilitate the worker's return to work.

Worker must not be prejudiced by resuming work

The WCIMA has retained the provision stating that, if a worker who has an incapacity for work resulting from an injury resumes or attempts to resume work, and is unable, on account of the injury, to perform or continue to perform the work, the resumption or attempted resumption of work does not prejudice any entitlement to compensation under the WCIMA that the worker would otherwise have.

It is interesting to note that neither the WCIMA, regulations or the form allowing for a cessation of income compensation payments on the basis of a return to work specify how long a worker needs to have been back at work for and there is no set notice period before payments can cease.



Return to work

The WCIMA defines a return to work, in relation to a worker who has an incapacity for work, as meaning:

- a. the worker holding or returning to the position that the worker held immediately before becoming incapacitated if it is reasonably practicable for the employer who employed the worker at the time the incapacity occurred to provide that position to the worker; or
- b. if the position is not available, or if the worker does not have the capacity to work in that position, the worker taking a position, whether with the employer who employed the worker at the time the incapacity occurred or another employer -
 - i. for which the worker is qualified; and
 - ii. that the worker is capable of performing.

The leading authority regarding when a worker will have “*returned to work*” in the WA workers’ compensation system is the decision in *Department of Education v Kenworthy* (1990) 3 WAR 1, in which the Court held that a return to work is not simply a return to any activity that may be called work, but rather means a return to remunerated work with the employer who is liable to make the weekly payments.

Notwithstanding the above, the WCIMA now specifically states that returning to work with “*another employer*” is possible.

As indicated by the second limb of the definition of return to work, an injured worker can be seen to have made a return in circumstances where they have returned to a new role, different to that in which they were employed in at the time of becoming incapacitated. As stated in the obiter comments of Sweeney DCJ in *West v BGC Australia Pty Ltd* [2019] WADC 20:

“The reference in the definition of ‘return to work’ in s 5 to: ‘or if the worker does not have the capacity to work in that position’, clearly contemplates that returning to work and yet remaining partially incapacitated are not inconsistent scenarios, but an employer may well be able to employ the worker in another role which justifies ceasing the weekly payments”.

In *Atkinson v Nipper Cleaning Services P/L (t/a Burrells Hi-Tec Cleaning Service)* (unreported, SC(Tas), No FCA 99/92, 10 December 1993), the Supreme Court of Tasmania considered a worker who had been able to return to work in her pre-injury role with one employer, but remained incapacitated from returning to work in her concurrent pre-injury role with another employer. In those circumstances, it was held that it was still open for payments of compensation to be paid at the reduced rate, despite there having been a (partial) return to work.

The specifics of a particular return to work with a new employer will remain relevant however. We note the decision in *Westswan Formwork Pty Ltd v Pretorius* (CM(WA), 133/03, 25 February 2004, unreported), where the worker had returned to work on a paid work trial.

It was held in that decision that there was not a proper return to work, as the worker was not considered to have been re-established as a wage earner who was no longer in need of weekly payments of compensation.

In *Dept of Education v Azmitia* [2015] WASCA 246 it was held that the particular qualifications or conditions placed upon a worker’s return to work will be relevant in determining whether that worker has made a proper return to the kind of work he or she performs, under the conditions in which he or she is expected to perform it.

From a practical perspective, payments should not be ceased or reduced unless the worker is performing a “real job” that would be available on the open labour market, as opposed to a work trial or work hardening role specifically sourced for the purpose of assisting a worker to gradually return to the workforce.



An employer should also have sufficient evidence of a “return to work” before ceasing or reducing payments unilaterally under section 63 of the WCIMA. While that should be easy enough if the return to work occurs with the pre-injury employer, if a worker has returned to work with another employer, then particulars of that role, hours and remuneration would ordinarily be required before an employer could be satisfied that there had been a total or partial “return to work”.

One and Done: the Lump Sum Question

Ashleigh Glasson | September 8, 2025

When a single payment closes the book on permanent impairment claims

A worker who has suffered a compensable injury pursuant to the *Workers Compensation and Injury Management Act 2023* (WA) (**WCIMA**) may be left with a permanent impairment or incapacity for work which entitles the worker to a lump sum payment. Pursuant to section 97(3) of the WCIMA, permanent impairment compensation is only payable at the time the worker settles their claim. It cannot be paid out without an agreement being registered.

An assessment of permanent impairment does not determine the question of liability for a claim and can be requested even though aspects of a worker's claim may be in dispute.

According to WorkCover WA's Permanent Impairment Guidelines (**the Guidelines**):

“Assessing permanent impairment involves clinical assessment of the claimant as they present on the day of assessment taking account of the claimant's relevant medical history and all available relevant medical information in order to determine:

- *whether the condition has reached Maximum Medical Improvement (MMI);*
- *whether the claimant's compensable injury/condition has resulted in an impairment;*
- *whether the resultant impairment is permanent;*
- *the degree of permanent impairment that results from the injury; and*
- *the proportion of permanent impairment due to any previous injury, pre-existing condition or abnormality, if any, in accordance with diagnostic and other objective criteria as outlined in the Guidelines”.*

A worker may need to seek an assessment of the degree of permanent impairment or permanent whole person impairment (**WPI**) sustained as a result of a compensable injury in order to access:

- Permanent impairment compensation;
- An increase for special expenses in the medical and health expenses general limit amount (WPI assessment required); or
- A claim for common law damages (WPI assessment required).



An assessment can only be made by an approved permanent impairment assessor (APIA), who is a medical practitioner registered by WorkCover WA who has been trained to evaluate impairment using the Guidelines and the *American Medical Association Guides to the Evaluation of Permanent Impairment, fifth edition*. A register of APIAs is maintained by WorkCover WA and accessible via its website here.

The process

Step 1: Arranging the assessment and obtaining a report

A 'Form APIA2: Permanent Impairment Assessment – request' must be submitted to the APIA who, following assessment of the worker, will provide either a:

- 'Form APIA1: Permanent Impairment Assessment – report and certificate' if the worker's condition has stabilised; or
- 'Form APIA7: Permanent Impairment Assessment – Psychiatric Impairment Rating Scale Form' where the impairment assessment involves a psychiatric injury; or
- 'Form APIA6: Permanent Impairment Assessment – condition not stabilised notice' if the worker's condition has not stabilised.

The employer of the injured worker is obliged to pay for the first impairment assessment, including the costs of any subsequent assessment required because the worker's condition had not stabilised at the time of the first assessment.

Impairment assessments are only to be conducted when the APIA considers that the degree of permanent impairment of the worker is unlikely to improve further and that the worker has attained MMI. This is considered to occur when the worker's condition is well stabilised and is unlikely to change substantially in the next year with or without medical treatment.

If the worker's condition has not yet stabilised, there are circumstances in which an APIA may provide a special evaluation of the worker's degree of permanent impairment.

A special assessment can be done where:

- 18 months have passed since the worker made the relevant claim for compensation claim; and
- A request is made for a special assessment in the approved form; and
- The purpose of the special assessment is for an assessment of the degree of permanent impairment in order to make an election to pursue common law damages, or for an increase in medical and health expenses beyond the standard limit under section 78 of the Act.



Step 2: Negotiating agreement of the level of impairment

Pursuant to section 105 of the WCIMA, upon receipt of an assessment of a worker's permanent impairment, the worker can provide the employer with an 'SF3 – Permanent Impairment Notice' (SF3), by which the employer must indicate, *within 28 days after being given the notice*, whether or not it agrees an assessment of the worker's impairment provided by an APIA. A copy of the APIA report and certificate is to be provided with the SF3.

If the employer and insurer agree with the level of impairment reflected in the notice, the employer/insurer sign the SF3 to indicate their agreement. The parties must then negotiate the terms of settlement (i.e. whether any additional compensation should be paid). A copy of the SF3 must be filed with the APIA report and settlement agreement when the parties apply for the settlement agreement to be registered.

If the employer **does not** agree with the assessed degree of permanent impairment specified in the SF3, the employer must request a further assessment of the worker's degree of permanent impairment by an APIA (with the cost of that assessment to be paid by the employer).

If an employer does not:

- Indicate whether or not it agrees with assessed degree of impairment specified in the SF3, sign the SF3 and return it to the worker; **and**
- Where the employer indicates it does not agree with the assessed degree of permanent impairment, does not request a further assessment of the worker's degree of permanent impairment by an APIA –

within the 28-day period, the employer is taken to agree with the assessed degree of permanent impairment as specified in the SF3 notice.

Where the employer does seek a further assessment of the worker's degree of permanent impairment by an APIA, the employer is to then serve a copy of that report on the worker together with a 'SF4 – Permanent Impairment Notice Further Assessment' (SF4).

The parties then negotiate to agree the level of impairment. The agreed degree of permanent impairment must be based on either:

1	The APIA original assessment; or
2	The APIA further assessment; or
3	It must fall within the range of the APIA original and further assessments.

For example, if the worker obtained an assessment at 20% and the employer obtained an assessment at 15%, the parties could agree at 15%, 20% or anywhere in between.

If agreement is reached, the parties record the agreed permanent impairment on page 2 of the SF4 and sign it. A copy of the SF4 must be filed with the application to register the settlement agreement, together with the APIA's reports (both original and further assessments), SF3 and settlement agreement.

Step 3: If the parties can't agree on the degree of impairment

If agreement cannot be reached as to the worker's degree of permanent impairment following consideration of the original and further assessments, the worker should not sign the notice.

A worker may apply for an arbitrator to determine the worker's degree of permanent impairment.

Pursuant to section 106(2) of the WCIMA, an arbitrator may determine the worker's degree of permanent impairment and is not prevented from determining a degree of permanent impairment that is outside the range of the original assessment and the further assessment. However, section 106(3) of the WCIMA states that, where the degree of permanent impairment determined by an arbitrator is not less than the degree of permanent impairment indicated in the original assessment obtained by the worker, the arbitrator may order that the employer pay all or any of the costs and expenses connected with the dispute.

From a practical perspective...

The preceding steps can be found in the WCIMA, however in practice this is rarely how the parties actually approach settlement of the claim and payment of permanent impairment compensation. The most common way these discussions occur is as follows:

If permanent impairment is agreed according to a single assessment

1	The parties negotiate to settle the claim, and at that time agree the level of permanent impairment according to the available report.
2	The employer/insurer or their lawyer prepare the settlement agreement and the SF3 and send them to the worker to complete.
3	The documents must be completed in the following order to ensure that the agreement is accepted by Workcover:

- The SF3 must be dated and signed by the worker. The “Date of Notice” on page 1 is the date the worker signs the notice.
- The employer/insurer indicates on page 2 that they agree with the degree of assessment and then signs and dates the notice. This must occur at least 1 day after the worker has dated the notice or all dates and signatures must be time stamped to clearly indicate the order in which the document was signed.
- The worker then signs and dates the settlement agreement. Again, this must occur at least 1 day after the SF3 was signed and dated by the employer/insurer.
- The employer then signs the settlement agreement. This must occur at least 1 day after the worker has signed and dated the agreement or all dates and signatures must be time stamped to clearly indicate the order in which the agreement was signed.

4. The documents can then be lodged with Workcover for registration of the agreement.

If permanent impairment is negotiated following multiple assessments

1	The parties negotiate to settle the claim, and at that time agree the level of permanent impairment according to the available reports.
2	The employer/insurer or their lawyer prepare the settlement agreement, the SF3 and the SF4 and then send them to the worker to complete.
3	The documents must be completed in the following order to ensure that the agreement is accepted by Workcover:

- The SF3 must be dated and signed by the worker. The “Date of Notice” on page 1 is the date the worker signs the notice.
- The employer/insurer indicates on page 2 that they do not agree with the degree of assessment and then signs and dates the notice. This must occur at least 1 day after the worker has dated the notice or all dates and signatures must be time stamped clearly indicate the order in which the document was signed.
- The employer then completes the SF4, also recording the agreement reached. The “Date of Notice” on page 1 should be at least 1 day after the employer signed the SF3. The employer should be able to sign the SF4 at the same time.
- The worker then signs and dates the SF4.
- The worker then signs and dates the settlement agreement. This must occur at least 1 day after the SF4 was signed and dated by the employer/insure
- The employer then signs the settlement agreement. This must occur at least 1 day after the worker has signed and dated the agreement or all dates and signatures must be time stamped to clearly indicate the order in which the agreement was signed.



4. The documents can then be lodged with Workcover for registration of the agreement.

**There are some open questions as to whether the second process will be accepted by WorkCover in circumstances where the date of the “responsive” report obtained by the employer either pre-dates the SF3, or pre-dates the report obtained by the worker. We are unsure of the answer to these questions but will update this newsletter when we find out.

WorkCover by numbers

Erica Thuijs & Narika Wicks | October 13, 2025

WorkCover WA has released its annual report covering the first year of operation of the Workers Compensation and Injury Management Act 2023, which came into effect on 1 July 2024. Also released was the Claims Experience Status Report for the quarter ending June 2025.

Key takeaways

The headline numbers are that:

1	29,072 claims were lodged for the year. This was only 201 more than the year prior, but...
2	An additional \$240 million (more than 10%) was made in total claim payments (\$1.64 billion, up from \$1.40 billion the year prior).

The increase in claim payments was driven by:

1	A 20% increase in medical expenses for quarter 4 compared with the same time the year prior; and
2	A 30% increase in income compensation for quarter 4, which WorkCover considers to be the principal factor in the jump in total payments.

But why?

Looking at the data released by WorkCover and our own professional experience, the increase in total claim payments can likely be explained by:

1	Despite the modest increase in new claims for the year, quarter 4 had a 6.2% increase in active claims. That is, it would seem that fewer claims are being finalised. WorkCover also reported 12% decrease in the number of completed conciliations and 15% decrease in completed arbitrations for the year.
2	The return to work rate within 3 months dropped from 84.5% to 71.2%.

3	Lost-time claims with 60+ days lost increased from 46.3% to 48.5%. Put another way, almost half of the workers who had any time off work had more than 60 days off work (i.e. assuming a 5 day work week, 12 weeks).
4	Income compensation is paid at a higher rate for 26 weeks instead of 13 weeks under the new Act.
5	The medical & health expenses compensation limit doubled for the 2024/2025 financial year.
6	Provisional payments are now required to be made while decisions are deferred. Claimants are allowed to not sign consent authorities, making it difficult to investigate claims during the deferral period which lengthens the period of time that provisional payments are made and can lead to claims that may not be compensable being accepted for lack of essential evidence which is unable to be obtained without either consent or an arbitrator's order.
7	Backlogs with lodging settlement agreements resulted in drawn out processes and claimants who had notionally settled their claims receiving ongoing payments for longer periods of time whilst awaiting registration.
8	Claimants are now looking to negotiate settlements on a gross basis, rather than a net of tax basis.
9	Uncertainty around how to use the new forms introduced by WorkCover for ceasing and reducing payments has drawn out disputes and lengthened the time within which claimants are in receipt of income compensation.

Some broader thoughts

The latest data on claims by type of injury has not been released yet. The annual report does record that (consistent with other jurisdictions) **psychological injury claims** have increased in cost and number, and likely provide a further reason for the increase in overall costs.

The report also recorded an increase, from 15 to 34, in substantiated complaints against insurers. In the context of the overall number of claims made, this number remains extremely low. However, the upward trend also reflects a national increase in complaints against the insurance sector. If this trend continues, ultimately insurers may also be looking at an increase in legal/compliance costs to respond to complaints.

What's next?

Look out for our update on the state of psychological injury claims pending the release of further data from WorkCover and the Office of the Auditor General's audit into injury management in the public sector for detailed data on the current prevalence and cost of psychological injury claims in both the private and public sector, both expected before the end of the year.

Last month Chris White and Kevin Gillingham from WorkCover WA presented their "report card" to members of the Australian Insurance Law Association. Some key points from that presentation were:

1	An acknowledgment that the permanent impairment notice process might need improving.
2	An acknowledgment that there might need to be a mechanism for registering a settlement agreement in circumstances where the parties have agreed (or there are orders) for extensions to compensation caps.
3	Non-payment of income compensation by an employer or insurer (if liability to pay compensation has been accepted) is not a "dispute" under the Act. It is a regulatory matter.
4	A CN2 cannot be used to retrospectively justify cessation or reduction of income compensation.
5	WorkCover is going to be:

- reviewing the permanent impairment guidelines again.
- developing a set of standards/principles for APIAs .
- focussed on gig workers, psychological injury and privacy in the future.

Section 34 WCIMA 2023:

What Insurers Need to Know When Liability Questions Remain

Erica Thuijs & Narika Wicks | November 25, 2025

So you've received yet another claim for a 50 year old with a back injury who has only been employed for a short period of time. It is clear that their duties have caused a recent flare up in pain and liability should be accepted, but their clinical records show that they were reporting symptoms while working for their ex-employer, and didn't make a claim.

So what do you do?

When the Workers Compensation and Injury Management Act 2023 (WCIMA 2023) commenced, it brought with it a modernised structure for managing complex liability scenarios - especially claims involving multiple employers or insurers. Section 34 plays a central role in this new framework.

For insurers and self-insurers, the section matters because it imposes clear obligations when a claim is accepted **“with liability questions”**. Understanding those obligations and the consequential risks ensures compliance, reduces dispute exposure and supports orderly contribution recovery.

Why section 34 exists

Section 34 is designed to ensure that the worker receives compensation without delay, even when there is uncertainty about which employer or insurer is ultimately liable.

The WCIMA 2023 addresses this by:

ensuring the worker is paid promptly by the last employer's insurer, and enabling contribution, apportionment and indemnity issues to be resolved in parallel rather than upfront.

This aligns with the objects of the Act and the policy intent reflected in the Explanatory Memorandum — namely, reducing friction and inefficiency in multi-employer claims.

When section 34 applies

1	The worker makes a section 25 claim against the last employer, being the employer who last employed the worker in the relevant employment; and
2	The insurer accepts liability (or potential liability) but raises one or more “liability questions” in its liability decision notice under sections 28 or 29.



Section 34 is triggered only when two conditions are met:

Liability questions include:

- whether another employer may be wholly or partly liable;
- how liability should be apportioned; and
- which insurer is ultimately required to indemnify.



These questions commonly arise in gradual onset injuries, aggravation cases, or situations where workers have multiple relevant employment periods.

Key obligation: the last employer's insurer must pay

Once section 34 applies, the last employer's insurer must:

- **deal with the claim as if the last employer were wholly liable**, and
- **indemnify the employer for all payments made**; and
- **reserve the right to pursue the previous employers for contribution** (by raising a liability question in the liability decision notice).

This obligation is immediate and is not impacted by contribution disputes, indemnity disputes, or uncertainty regarding prior employment.

The Explanatory Memorandum emphasises that this mechanism prevents workers from becoming caught in liability disputes between employers or insurers. For insurers, this creates a clear operational rule: **pay now, dispute later**.

Contribution and indemnity: how disputes are resolved

Section 34 provides a structured pathway for resolving contribution disputes.

If contribution is disputed, the last employer (or the worker) may apply for determination by an arbitrator. The arbitrator may then:

- apportion liability between employers;
- order reimbursement of compensation already paid; or
- order any relevant employer to pay compensation directly.

Where insurers dispute which policy responds, an arbitrator may:

- determine which insurer must indemnify the employer;
- apportion indemnity; or
- order reimbursement between insurers.

This creates a more predictable and workable dispute-resolution environment, with the Arbitrator empowered to make comprehensive multi-party orders.

Worker obligations: information sharing

The worker must provide reasonable information requested by the last employer to help identify earlier or later employment periods relevant to the claimed injury. This assists insurers in identifying potential contribution targets and streamlining the dispute process.

But what if you receive information after accepting liability that suggests there might be prospects of contribution from an earlier employer – but didn't raise a liability question? The ability to ask an arbitrator to determine contribution between employers appears to be contingent on a liability question having first been raised in the liability decision notice.

It is not clear, but it is certainly possible, that if the liability notice does not raise a liability question, this will present a jurisdictional barrier to the employer/insurer seeking a contribution from an earlier employer.

What section 34 does not apply to

Section 34 is expressly excluded from:

- noise-induced hearing loss claims; and
- claims captured by section 35 (primarily specific multi-employer disease claims with their own statutory scheme).



Practical guidance for insurers and self-insurers

- Decide whether you should raise a liability question before you issue your decision notice & document your liability questions carefully
- Clear articulation of liability questions in the notice is essential. The wording should support later contribution or indemnity recovery.
- Proactively gather employment history evidence. Early evidence gathering - particularly employment records, prior claim history, and medical chronology - supports efficient contribution recovery.
- Given that the last employer's insurer must act immediately, workflows should ensure:
- early strategic consideration of apportionment prospects.
- identification of the liability question before the liability decision notice is issued (if further information is required, consider reserving rights by raising the question anyway); and
- prompt acceptance where appropriate.



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