

Submission

By the

The Occupational Health and Safety Industry Group
"OHSIG"



To the

Transport and Industrial Relations Select Committee

On the

Injury Prevention, Rehabilitation and Compensation
Amendment Bill (No 2)

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Submission on the Injury Prevention, Rehabilitation and Compensation Amendment Bill (No2)

The Occupational Health and Safety Industry Group (OHSIG) welcome the opportunity to make a submission on the above Bill.

New Zealand and New Zealander's are fortunate to have a comprehensive accident compensation scheme available based on a 24 hour no fault, no liability principle. The Act covers all accident types occurring at work, non work and motor vehicle scenes. The scheme is available to all and is designed to limit litigation around accidents and claims.

The proposed changes in the No2 Bill we believe introduces more uncertainty into the scheme, invites more litigation and creates classes of claimants.

We therefore are not currently able to support the Injury Prevention, Rehabilitation and Compensation Amendment Bill (No2).

We believe that occupational health resources at both regulatory and non-regulatory levels must be improved in terms of skills and available specialists before these proposed changes to the Bill can be effective.

This submission is made in good faith but this Bill has not been able to be fully discussed at our forum as the submission date was very close. We would respectfully request that we be given an extension of time to resubmit a more detailed submission once all our member groups (10) have had the opportunity to consult with their memberships. If we are unable to resubmit I shall inform you accordingly.

Concerns.

1. The proposed introduction of traumatic mental injury.

The concept of mental injury is hard to follow when by definition there has been no injury to the brain. If the only cause was witnessing an event there can be no injury to the brain. We accept fully the concept of post traumatic stress and while the jury is out on the best way to treat this we do not believe it meets the criteria under the existing ACC principles.

The potential scope of events that could fall under the proposed clause is huge and the sequential costs of these claims we believe will be far greater than the explanatory notes would indicate.

Mental harm at any time is difficult to diagnose but to have a compensation scheme acknowledge such a condition and then have no defined boundaries as to what is mental harm is open for massive abuse.

The wording of the clause is very subjective and open to interpretation and legal challenge. We have in the recent years many challenges to the IPRC Act as more and more people seek legal advice. We believe it to be very prudent to not introduce subjective and highly contentious sections into the Act. The current wording of the clause is a lawyers dream.

E.g. close proximity
 Sudden
 Could reasonably be expected
 Is experienced...

All these terms and words are subjective and the Bill has no indication of definitions or interpretations.

2. Gradual process disease and infection.

The proposed changes to Clause 30 introduce uncertainties that are not in the best interests of the claimant, ACC or the employer. While it is claimed that the 3 part test was a barrier to claimants and the proposed changes to Clause 30 remove these it is at the expense of science and reasonable proof of cause.

Removing Clause 30 b ii and introducing the currently worded new Clause 30 c dismisses the valid possibility that non occupational exposure could be the cause of a gradual process injury. It is unscientific to assume (as the Clause allows) that, even if there is evidence of non occupational exposure, all cases of gradual process injury will most likely be caused by work exposures. We would expect this assumption to be proven on the balance of probabilities.

Proposed Clauses (3) (b) (i) and (ii) introduce the concept of prescribed levels of exposure

Quote "that involves exposure, or the prescribed level or extent of exposure...".

This wording fails to define (or point to a definition) of what constitutes the "prescribed level" and by whom that level will be set.

Currently within NZ we have the Workplace Exposure Standards (WES values) used by the Department of Labour and also the Tolerable Dose concept set by HSNO. These two standards are not the same, so which of these (if any) would be the 'prescribed level'? How, in the context of 'prescribed level' would ACC view an "in house" exposure level set in the absence of a WES or instead of a WES?

It is also important to note that the Workplace Exposure Standards currently advised have not been updated since 2002 i.e. they are six years old which in reality means the data on which they were based is older than that.

Without a process by which “prescribed levels” are robustly reviewed, established and frequently updated their relevance is limited in establishing gradual process.

Even using robust prescribed levels as a benchmark would not necessarily prove the origin of a gradual process injury or illness or indeed exposure. This is especially true where cancer or sensitisation are clinical endpoints.

Furthermore there is a poor record throughout New Zealand of workplace exposure measurement. Historically and currently resources are scarce to undertake workplace exposure monitoring. Also examination of the records that do exist will reveal a great number of recorded measurements to be unreliable indicators of exposure as the methodology behind them and/or the competence of those making the measurements is (or has been) highly questionable.

For proposed Clause (3) (b) (i) to be meaningful the whole issue of Workplace Exposure Standards and the competence of those setting them, making measurements and interpreting them must be addressed.

The proposal indicates that Section 57 of the Bill will remain. Under Section 57 ACC must investigate all such claims for gradual process. We believe this must be undertaken by specialists who have demonstrable competence in the relevant discipline of occupational health.

Occupational Hygienists, for example, are trained to measure workplace exposure, assess the possible effects on an individual and offer control solutions. Such specialists will be required to assist ACC in validating a claim, especially where there may be exposures to chemical, physical or biological agents.

We believe that ACC staff at present do not have a sufficiently large skill base to undertake such investigations. Moreover there are so few trained Occupational Hygienists or people with sufficient occupational hygiene skills working in NZ that it will pose a huge logistical problem for ACC to make fair and equitable exposure based assessments under section 57.

For and on behalf of the OHSIG

Chairperson.

Paul Jarvie

The OHSIG member groups.

- NZ Institute of Safety Management,
- NZ Occupational Health Nurses Assoc.
- NZ Occupational Hygiene Society
- NZ Ergonomics Society
- NZ Safety Council
- Institute of Professional Engineers NZ (IPENZ)
- NZ Physiotherapist Occupational group
- NZ Occupational Therapist Assoc
- NZ Risk Management Society
- Australia NZ Society of Occupational Medicine(ANZSOM)

This submission has been endorsed by

- NZ Institute of Safety Management
- NZ Occupational Hygiene Society
- NZ Safety Council
- NZ Physiotherapist Occupational group

No submissions received from

- NZ Occupational Health Nurses Assoc.
- NZ Ergonomics Society
- Institute of Professional Engineers NZ (IPENZ)
- NZ Occupational Therapist Assoc
- NZ Risk Management Society
- Australia NZ Society of Occupational Medicine(ANZSOM)