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Accidents and Compensation

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Liability for injury or damage

[3.10] This section deals with the legal responsibilities of various people for injury or damage caused by accidents on private and public property, including owners and occupiers of land, other people who control buildings and land, and people who keep animals (owners and others).

Liability for injury to people

[3.20] On private property
The law of negligence provides that each person owes each other person a duty of care. In Donoghue v Stevenson [1932] AC 562 Lord Atkin described the duty in the following terms:

You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. (at 580)

In the legal context, “your neighbour” is broader than the usual context of a person who lives near another. Lord Atkin said “neighbours” in law are “persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question.” (at 580)

The general duty of care under the law of negligence (laid down in the case of Donoghue v Stevenson) applies to occupier’s liability.

This means that an occupier of private property has a duty to take reasonable care to prevent foreseeable risks of injury to those who may come onto the land or premises.

Who is the occupier?
The occupier is the person who has possession of the land, building or premises; that is, the person who has the right to decide who to admit and who to exclude. This is not necessarily the owner. An occupier can be a tenant, for example, or an independent contractor who has control of a building site.

How is the occupier’s liability determined?
The liability of the occupier for injury on private property is determined by considering whether the risk of injury is real and what a reasonable owner or occupier would have done in the circumstances to prevent injury.

What if the injured person is trespassing?
The way in which the person came onto the land does not determine whether there is a duty of care (see Hackshaw v Shaw [1984] HCA 84; (1984) 155 CLR 614 and Australian Safeways Stores Pty Ltd v Zaluzna [1987] HCA 7; (1987) 162 CLR 479); for example, someone injured while trespassing may be able to claim.

However, the circumstances under which a person came onto land may still be relevant. For example, it would be negligent for a shopping centre not to have a path properly illuminated for late-night shoppers, but it may not be negligent to have the same path in darkness when the shopping centre was closed and a trespasser using the path as a short cut was injured in those circumstances.

Responsibility of tenants
A tenant may be responsible for injuries caused by defects in their rented premises
even if the owner is responsible for maintenance. All tenants should therefore take out appropriate insurance (see Chapter 29, Insurance) and ensure that the policy provides cover for liability for dangerous premises.

Most property insurance and business insurance packages include insurance cover against liability to third parties for personal injury or property damage caused by an insured’s negligence. You should carefully check whether any current insurance policy includes this cover. If it does not, this insurance is not expensive, and can be taken separately from home and contents insurance or other relevant insurance if required.

The Civil Liability Act

The Civil Liability Act 2002 (NSW) has modified the way in which liability for negligence is determined in many cases. The Act is complex. Briefly, some of the main changes are:

• the Act contains statements of general principle on matters that the court has to take into account and that may excuse someone who might otherwise have been liable
• there may be no liability where:
  - the risk of injury was obvious
  - an injury occurred as a result of “the materialisation of an inherent risk of injury” (that is, something happened that could not be avoided by the exercise of reasonable care and skill)
• there may be no liability where the person was involved in a recreational activity and:
  - the risk of injury in the activity was obvious, or
  - a warning of the risk was given.

There are a number of other provisions in the Act that may be relevant in deciding whether someone can be sued for negligence in a particular personal injury case.

[3.30] On public property

The principles of general negligence also apply to accidents in public places. For example:

• a local council may be liable for a dangerous structure in a park or for failing to have warning signs at a council swimming pool
• Sydney Water may be liable for a health hazard posed by the condition of drains that it controls
• State Rail may be liable for an injury caused by the condition of a railway station that was not properly maintained.

Shopping centres are covered by the law dealing with occupiers (see How is the occupier’s liability determined? at [3.20]). The owner of the centre would normally be liable for a hazard in a common area, although a company managing the centre may also be liable.

Liability of public authorities

The Civil Liability Act has provisions about the liability of public authorities, including road authorities that protect them from liability in some circumstances. While it is sometimes possible to sue these authorities, legal advice is required to determine if a case can be brought.

Injury or damage caused by animals

[3.40] Obtaining compensation

A person may be able to obtain compensation if they are injured or their property is damaged, by an animal owned or controlled by someone else.

Civil proceedings can be brought against the owner or person keeping the animal if that person has been negligent.

The Companion Animals Act 1998 (NSW) provides that owners and people who keep companion animals may be liable in certain circumstances even if they were not negligent. All dogs are treated as companion animals, including working dogs on rural
properties, guard dogs, police dogs and corrective services dogs.

Proving negligence
It can be hard to prove negligence. The best evidence may be the animal’s previous behaviour. For example, if a dog causes an accident by chasing a car it will be useful if neighbours can give evidence that the dog had often chased cars.

The court looks at the circumstances of each case. For example, fences and gates that are adequate on a farm may not be enough in the city.

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**Where the owner was liable**

In one case, a dog ran from the owner’s yard through a partly open gate and chased a motorcycle, causing a collision. The owner knew his dog sometimes tried to get out, and was found negligent because he did not make sure the gate stayed closed. The motorcyclist was awarded a large sum for the serious personal injuries he suffered (Eadie v Groombridge (1993) 16 MVR 263).

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Insurance

Owners and other people who keep animals should be insured against claims for injury and damage caused by their animals if there is any real chance of this happening.

Household insurance policies often provide public liability cover for domestic animals. The written terms of any policy should be checked.

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**[3.50] Dogs**

A person who has been injured or has suffered damage caused by a dog may be able to obtain compensation either:

- in the course of any criminal proceedings against the dog’s owner or keeper, or
- by taking civil action against the owner or keeper.

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**Who is a dog owner?**

“Owner” is defined in the Companion Animals Act to mean not only the registered owner but also:

- the person by whom the dog is ordinarily kept, and
- the owner of the dog in the sense of being the owner of the animal as personal property.

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More than one person can be the owner of a dog under one or more of the definitions.

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**Civil proceedings**

A dog owner can be held liable for the dog’s actions even if the owner was not negligent. Under s 25 of the Companion Animals Act, the owner is generally liable if a dog attack causes:

- bodily injury to a person; or
- damage to a person’s clothing.

However, it is necessary to prove that the dog was attacking or causing an element of aggression against the injured person.

Section 25 does not apply if the attack occurred:

- on property or in a vehicle occupied by the owner or where the dog is ordinarily kept, and:
  - the injured person was not lawfully there, and
  - the dog is not a dangerous or restricted dog (see below);
- in response to intentional provocation of the dog by someone other than the owner or a person authorised by the owner; or
- in connection with a police dog or a corrective services dog.

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**Dangerous and restricted dogs**

**Dangerous dogs**

A dog may be declared dangerous by the local council or the court under the Companion Animals Act. Owners of dangerous dogs must meet special requirements relating to the control of their dogs. Failure to do so constitutes an offence and may result in the dog being seized.

**Restricted dogs**

Certain breeds of dog, including pit bull terriers, Japanese tosas, and Argentinian and Brazilian fighting dogs are restricted dogs with stringent control requirements (ss 55–56). Failure to meet such requirements constitutes an offence, and may result in the dog being seized.

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**Criminal proceedings**

The owner of a dog that rushes at, attacks, bites, harasses or chases any person or animal, whether or not injury is caused, can generally be prosecuted for an offence under s 16 of the Companion Animals Act.
Exceptions
It is not an offence if the incident occurred:
• because the dog was being teased, mistreated, attacked or otherwise provoked
• because the person or animal was trespassing on the property where the dog was kept
• as a result of the dog acting in reasonable defence of a person or property
• in the course of lawful hunting
• in the course of the dog working stock or training to work stock, or
• in connection with a police dog or a corrective services dog.

Compensation
A person who suffers injury or loss through a dog attack may make a claim for compensation (damages) from the owner. Damages are assessed under the Civil Liability Act and can include compensation for pain and suffering, wage loss, expenses and domestic assistance.

Penalties for dog attacks
There are substantial penalties under the Companion Animals Act 1998 for owners guilty of offences in which their dog attacks someone or causes property damage.

Injury to animals
The Companion Animals Act also applies in limited circumstances if another animal is injured as a result of a dog attacking or chasing it (s 27).
Other laws relating to injuries to animals are discussed in the next section.

[3.60] Claims for compensation
There are a number of ways in which the owner of an injured animal can claim compensation. It may also be possible to bring a criminal prosecution against the person responsible.

Intentional injury
An action for trespass can be brought if the injury was both wrongful and intentional. The kind of action depends on the circumstances:
• trespass to property applies where the injury is caused directly as a result of someone’s conduct (for example, shooting the dog)
• an action on the case (a very old common law action) applies where the damage occurs indirectly (for example, through someone leaving a poison bait).
Either way, the owner should get legal advice.

Unintentional injury
If an animal is injured unintentionally the owner may be able to claim negligence, although this can be difficult to prove, especially if the animal was hit while on a road. However, each case depends on its circumstances. For example, if the driver of a car was travelling at high speed and ignored “stock crossing” signs and injured cattle, the owner of the cattle may claim damages for the injuries.

[3.70] Seizing or destroying a dog
Preventing damage to property
Anyone may lawfully seize a dog if the action is “reasonable and necessary” to prevent damage to property (Companion Animals Act, s 22(1)), unless the dog is engaged in stock work.

Preventing injury or death
Anyone may lawfully seize, injure or destroy a dog if the action is “reasonable and necessary” to protect a person or animal (other than vermin) from injury or death (s 22(2)), unless the dog is engaged in stock work.
If the dog is engaged in stock work, the action is only lawful if it is necessary to protect a person, not an animal.

Preventing injury to farm animals
If a dog approaches a farm animal on enclosed land, the occupier or a person authorised by the occupier can lawfully injure or destroy the dog, if they reasonably believe that the dog will molest, attack or cause injury to the farm animal (s 22(5)).

[3.80] Criminal liability

Stealing an animal
A person who steals a dog or other animal may be guilty of an offence under the Crimes Act 1900 (NSW), ss 126, 132, 503, 505.

Destroying or injuring an animal
It is a serious offence to intentionally or recklessly destroy or damage domestic animals or wild creatures that have been tamed or are ordinarily kept in captivity (ss 194, 195).

Cruelty to animals

A person who mistreats an animal may face criminal penalties and may have to pay compensation to the animal’s owner. Even where there is a power to seize, injure or destroy a dog under the Companion Animals Act 1998 (see Seizing or destroying a dog, [3.70]), ill-treatment or cruelty is not permitted.

Reporting incidents of cruelty
Incidents of cruelty can be reported to the police, who will take action under the Prevention of Cruelty to Animals Act if a complaint is made. Otherwise you can contact the Royal Society for the Prevention of Cruelty to Animals, New South Wales (RSPCA) or the Animal Welfare League (NSW), who can send an inspector to investigate the complaint and will, in many cases, take the appropriate criminal proceedings. The Animal Welfare Unit of the NSW Department of Primary Industries may also be contacted in some cases.

Motor vehicle accidents

[3.90] This section discusses the legal obligations of a driver involved in a road accident, as well as how to make an insurance claim and how to claim compensation for personal injury and property damage. The section includes a number of sample letters to assist in pursuing such claims.

What to do after an accident

[3.100] Legal obligations
The legal obligations of a driver involved in a crash in NSW are covered by r 287 of the Road Rules 2014 (NSW).

Exchanging information
Under r 287, the driver of a vehicle involved in a crash must give certain particulars to:
• other drivers involved in the crash or representatives of such drivers
• anyone injured in the crash
• the owner of property (including any vehicle) damaged in the crash (or the owner’s representative).

There is an exception, in that it is not necessary to give the particulars to the owner of another vehicle or the owner’s representative if the particulars have been given to the driver or the driver’s representative.
The required particulars
The information that must be given (the required particulars) is as follows:
• the driver’s name and address
• the name and address of the vehicle’s owner
• the vehicle registration number
• other details needed to identify the vehicle.

Reporting to the police
Under r 287, the required particulars must be given to a police officer if:
• anyone is killed or injured, or
• the particulars are not given to drivers, injured persons and owners and/or representatives of drivers and owners as set out above, or
• a vehicle is towed or carried away, or
• a police officer asks for any required particulars.
Where particulars are required to be given to a police officer, in addition to the required particulars, an explanation of the circumstances of the crash must be given.
Where these details are required to be given to the police, this must be done as soon as possible after the crash but, except in exceptional circumstances, within 24 hours.

Requirement to stop and give assistance
Under s 146 of the Road Transport Act 2013 (NSW), the driver of a vehicle involved in an accident that causes death or injury must stop and give all possible assistance.

Practical steps
A driver involved in an accident should first meet the legal requirements described above; ie:
• exchange the required particulars with other drivers
• report the accident to police if necessary
• assist accident victims if necessary.
The driver should also, if possible:
• take the names and addresses of witnesses
• make notes of any conversation with other people involved in the accident
• make a sketch plan of the scene, including distances, width of street, lane markings and other relevant details
• take photographs of the scene
• find out whether the other vehicle is insured, and if so with which company
• make no admissions about liability for the accident. This may invalidate insurance claims
• remove debris from the road. If an injured driver cannot do this, the person who removes the vehicle should clear the road.
Drivers should take all precautions necessary to prevent any other motorists colliding with the crashed vehicles.

Motor vehicle insurance

[3.110] Types of damage
A motor vehicle accident may cause:
• personal injury (such as cuts, bruises and broken bones)
• property damage (such as damage to cars, clothing or luggage).
Property damage and personal injury are usually covered by different insurance policies, and a separate claim should be made for each. It is possible to sue first for property damage only, and later for personal injury (or vice versa).

[3.120] Types of insurance
The most common types of motor vehicle insurance are:
• compulsory third party (CTP)
• comprehensive, and
• third party property.

Compulsory third party insurance
Compulsory third party (CTP) insurance covers claims against the owner of a vehicle for compensation for personal injury. The premium is paid to a licensed insurer when the vehicle’s registration is renewed. The
certificate of insurance – a green slip – must accompany the registration payment.

There are a number of licensed insurers, including most well-known insurance companies.

For a list of licensed insurers, contact the State Insurance Regulatory Authority (SIRA).

**Comprehensive insurance**

Comprehensive insurance generally only covers claims for property damage. It covers:

- claims made by other people for damage to their property, and
- damage to the policy holder’s own property.

**Additional cover**

Some comprehensive policies also cover hospital and medical expenses, and some give a benefit if the policy holder is killed or injured in the insured vehicle.

**Third party property insurance**

Third party property insurance covers damage to someone else’s property. It is usually taken out by people who consider their vehicles are not valuable enough to warrant comprehensive insurance, or simply do not wish to pay for comprehensive insurance.

Every motor vehicle owner should have at least this type of insurance.

**Proving negligence**

To succeed in an insurance claim it is necessary to prove that the other person was negligent – that is, that the damage was caused wholly or in part by the other person’s lack of reasonable care in the driving, control or maintenance of their vehicle.

The fact that the other driver has been found guilty of a criminal offence (such as negligent driving) arising from the accident does not mean that the court will come to the same conclusion in a civil case. Having said that, the standard of proof for criminal proceedings is higher than for civil proceedings, so if the driver of the other vehicle has been convicted of an offence in relation to the accident, there is a very good chance that the insurer will admit liability for your claim and/or a court will find in your favour.

**Suing for damages**

Because a third party property policy only provides cover for damage to the other party’s property, there is nothing to stop the policy holder from suing the other party for damage to their own property.

If the other party counterclaims; the counterclaim can be defended by the insurance company.

**Notifying the insurer of claims**

Policy holders must, of course, notify their insurance company of any accidents and resulting claims made against them.

[3.130] **Losing insurance cover**

Insurance policies should be read carefully – most comprehensive and third party property policies have conditions that must be met before the insurer will accept a claim. Some of these are described below.

**Reporting an accident**

Most policies require the insured person to report any accident or damage as soon as possible. Even a person who does not intend to claim on their policy should notify the insurer (indicating that the notice is not a claim).

**Ensuring that the driver has a licence**

Under most policies, the insurer can refuse to cover a claim if the vehicle was being driven by an unlicensed driver, including a person to whom the owner has lent their car.

Owners who wish to lend their car should always check that the other driver has a valid licence. This protects the owner, the driver and anyone suffering damage in an accident.

**Giving the insurer accurate information**

The application for insurance (the proposal) normally includes questions about the
owner’s driving record. These (and all other questions in the proposal) must be answered fully and honestly. Otherwise the company may refuse to honour a subsequent claim.

Ensuring that the driver is not intoxicated
Under most policies, there is no cover if the driver was under the influence of alcohol or a drug.

Note that under cl 34 of Sch 3 of the Road Transport Act 2013 (NSW), a conviction for alcohol-related driving offences, and the tests related to them, are not admissible as evidence of:

• intoxication while driving, or
• being incapable of driving or exercising effective control over a vehicle.

Alcohol related driving offences are discussed in more detail in Chapter 20, Driving and Traffic Law.

Property damage

[3.140] Uninsured vehicle owners
When property is damaged in a motor vehicle accident, an owner who is not insured can either:
• claim payment from the other party and sue if necessary (see Suing for damages at [3.170]), or
• pay for their own repairs.

[3.150] Insured vehicle owners
If the damaged vehicle is insured, the owner can:
• make a claim on their insurance policy (see Claiming on insurance at [3.160])
• pay the cost of repair themselves
• demand payment from the other party and sue them if necessary (see Suing for damages at [3.170]).

Making a decision
In deciding what to do, insured owners should consider a number of issues, including:
• the type of policy
• the excess payable
• the effect of the claim on their no-claim bonus
• whether the other person is insured
• how the amount of damages they may receive will compare with legal costs.

[3.160] Claiming on insurance
If an owner has comprehensive insurance, it is generally best to let the insurance company handle an accident claim, although owners sometimes decide to handle their own claim rather than claim on their insurance. Either way, the issues discussed below should be considered.

Matters to consider
The excess
The excess is the amount stated in the insurance policy to be payable by the insured person when a claim is made. The amount depends on:
• the insurance company
• the driver’s age – all insurance companies insist on an age excess for drivers under 25
• driving history – if the driver has had a previous claim, the excess may be increased.

The standard excess for all drivers is around $350; for drivers under 25, it may be as much as $1,000. A person should find out what the excess is before making a claim.

It is possible to pay an increased premium to remove all or part of the excess.

Effect on the no-claim bonus
Insurance companies have adopted a principle of rewarding owners who have not made claims during a particular year by offering a lower premium for the following
year. Someone who has made a claim must usually pay a higher premium the following year.

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**No-fault claims**

Some insurers allow a person who has made a claim to keep their no-claim bonus if:
- the accident was not their fault, and
- the other accident party was insured.

The company will normally also try to recover the excess from the other driver in these circumstances.

This is only possible, of course, if the other driver was identified.

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**Is the other party insured?**

Going to court is expensive. Before suing someone for damages it is important to check:
- whether the other party is insured, and
- if the other party is not insured, whether they can afford to pay damages.

There is no point in paying legal costs then finding that the other person simply cannot pay any damages ordered by the court. If this seems likely, the best course, for an insured person, is to claim on their own insurance.

**Advantages of claiming**

**Immediate repair**

A major benefit of immediately making a claim on an insurance policy is that the vehicle will, usually, be repaired with a minimum of delay.

**Legal action by the insurer**

Another advantage is that if a person makes a claim, the insurance company can commence an action against the other driver in their name. This is called subrogation. In this case, the company will pay all the costs of the action. Actions by subrogation are common, and many drivers find themselves suing another driver in this way.

If the company recovers more in damages than it paid, it will generally give the balance to the insured person after deducting its legal costs.

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**[3.170] Suing for damages**

**Legal costs**

Taking a case to court can be expensive, so the likely legal costs should be considered carefully.

**Should a solicitor be used?**

It is possible to minimise costs by handling all or part of a damages claim personally (see Handling a claim yourself at [3.190]). However, this is often not advisable, especially if the claim is defended. It is worthwhile to at least discuss the matter with a solicitor before going to court.

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See Chapter 4, Assistance with Legal Problems, for information about getting an estimate of charges from a solicitor and for other possible sources of advice.

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**Recovering costs**

If a lawyer handles a claim, legal costs for the work done in pursuing the claim may be recovered from the defendant if it is successful. However, this may depend on the amount of the claim. The solicitor’s charges may also exceed the amount awarded.

**Arbitration**

If the matter is in the Local Court, either party can request the court to refer defended motor vehicle property damage claims to an arbitrator.

**Repair costs**

If the repair cost is small (say, under $250), it may not be worth claiming on insurance or using a solicitor. However, it may be worth handling the claim personally to try to recover some of the cost (see Handling a claim yourself at [3.190]).

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**Working out the cost**

Barbara sues Alan for damage to her car. The court decides in Barbara’s favour and orders Alan to pay $3,000 for repairs to Barbara’s car and $1,000 in costs. Barbara’s solicitor charges $1,600, which Barbara has to pay whether or not Alan actually pays the court order for the total amount of $4,000.

Of course, if Alan does pay the full amount, Barbara retains $2,400 after paying her legal fees – which is $600 less than the cost of repairs to the car.
If Barbara had lost the case, she would have had to pay not only for her repairs and legal costs, but also Alan’s legal costs, and probably the cost of his repairs.

Apportioning damages
Deciding whether or not a driver was at fault can be quite difficult. Clearly, a driver who has a collision while drunk is driving negligently. Driving over the speed limit is probably also negligent, as is failing to stop at a red light. But many situations are not so clear.

If the court cannot say that one driver was entirely at fault, it can apportion (share) damages between each driver according to each driver’s degree of responsibility (see Effect of contributory negligence below).

**Contributory negligence**
A driver who shares responsibility for an accident is guilty of contributory negligence. For example, in an accident at an intersection the driver with right of way may be held 25% responsible because every driver should drive safely in all circumstances. Likewise, a driver who did not take reasonable steps to avoid an accident may be held partly responsible for it.

An award of 100% of damages is possible (for example, if a legally parked car was hit by another car), but the possibility of apportionment must be considered.

**Effect of contributory negligence**

**Example 1**
Alan’s car and Barbara’s car collide at an intersection.
Each suffers damage worth $5,000. Alan sues Barbara for $5,000 and Barbara counterclaims (sues Alan) for the same amount. The court finds Alan 20% responsible and Barbara 80% responsible. Alan gets 80% of $5,000, or $4,000. Barbara gets 20% of $5,000, or $1,000.

The net result, before considering costs, is that Barbara has to pay $3,000 to Alan for repairs.

Alan also gets $1,500 that the court has ordered Barbara to pay Alan for his legal costs. However, this does not pay all Alan’s legal costs, which have run to $2,500.

Once he has paid the balance, Alan is left with $2,000 to cover the damage to his car.

Barbara is already down $4,500 (the $3,000 she has paid to Alan for repairs plus his legal costs of $1,500), and has to pay her own legal costs of $1,500. She is out of pocket by $6,000 and still has a $5,000 repair bill.

**Example 2**
Alan’s car and Barbara’s car collide at an intersection.
They claim and counterclaim. Alan’s repairs cost $2,000. Barbara’s cost $8,000. The court finds Alan 20% responsible and Barbara 80% responsible. Alan gets 80% of $2,000, or $1,600. Barbara gets 20% of $8,000, or $1,600.

Alan’s damages and Barbara’s damages cancel each other out.

Alan has to pay solicitor’s costs and $2,000 for repairs. Barbara also has to pay solicitor’s costs of $2,000 as well as $8,000 for repairs, so she is no better off than if she had settled out of court and paid for Alan’s repairs in the first place.

**[3.180] Which court?**
The first step before deciding whether or not to personally handle a property damage claim is to establish which court will hear the claim.

Claims over $100,000
If damages are more than $100,000, legal action must be commenced in the District Court.

In this case, it is usually best to claim on an insurance policy and leave it to the insurer to handle the matter; or, if for some reason a person decides not to do this, to instruct a solicitor.

Legal costs in the District Court are higher than costs in the Local Court.

**Claims under $100,000**
For claims under $100,000, legal action is commenced in a Local Court.

**Claims under $10,000**
Small Claims Divisions have been introduced into some Local Courts for claims involving less than $10,000. Proceedings are informal, and conciliation is encouraged, where appropriate.

Legal representation is allowed, but there are limits on the costs that can be recovered by either party. If the damages are substan-
tial (say, over $1000) and court proceedings are involved, it is wise to seek legal advice.

**Using a solicitor**

Court proceedings are often complicated and stressful. Anyone needing to go to court should carefully consider whether to instruct a solicitor, particularly if the other party has one.

### [3.190] Handling a claim yourself

If the repair bill is around $500, there is nothing to prevent a person handling all or part of the claim personally without involving a lawyer. The procedure is as follows.

**Get details of the other party**

Find out who to sue and whether they are insured. If the other party’s name and address were not noted at the scene of the accident but the registration number is known, the owner may be traced through the Roads and Maritime Services (RMS). There is a free registration check that can be done on the RMS website, otherwise for more comprehensive information, a Vehicle History Report is $21.

It will be about a month before the registry advises the result.

**Obtain quotes**

Get a written quote for the cost of repairing the vehicle from a reputable repairer. It is advisable, but not essential, to get two quotes. If two quotes are obtained, the claim should be based on the lower quote.

**If the other party is insured**

If the other party is insured the person should:

- send them a letter of demand (see sample (1) Letter of demand – other party insured at [3.290] for what this should contain), and
- send their insurance company:
  - a copy of the letter of demand, and
  - the repair quote, and
  - a letter like sample (2) Letter to insurance company at [3.300].

If the insurance company:

- does not reply, or
- refuses to accept liability (because, for example, the other driver was drunk or unlicensed when the accident occurred) another letter of demand must be sent to the other party as if they were uninsured (see sample (3) Letter of demand – other party uninsured at [3.310]).

If the other party is not insured

If the other party is not insured, the person should send them:

- a letter of demand (see sample (3) Letter of demand – other party uninsured at [3.310]), and
- the quote for repairs.

**If the other party accepts liability**

If the other party accepts responsibility for the damage bill, payment details can be finalised.

If the other party disputes the quote, another should be supplied.

**If the other party denies liability**

If the other party denies liability, a statement of claim should be issued against them (see below).

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**Claiming the insurance excess**

A person who has to pay an insurance excess (see The excess at [3.160]) may be able to recover it from the other party. A letter of demand should be sent to the other party (see sample (5) Letter of demand – insurance excess at [3.330]). Or the insurance company may do it – check with them first.

If there is no reply, it is necessary to decide whether to commence proceedings in court, bearing in mind the costs involved. If the insurance excess is small, it might be better to let the matter lapse and go no further. If it is substantial, court proceedings should be commenced.

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**If the other party does not reply**

If the other party does not respond to the letter of demand, a second letter of demand should be sent in the terms of sample (4) Second letter of demand – other party uninsured at [3.320].

If the second letter of demand produces no result, proceedings may be commenced in a court (see If the other party does not respond below).
Taking action in court

Is it worth it?
First, the question of whether the claim is worth taking to court should be seriously considered. Remember that a statement of claim against the other party may provoke a counterclaim, and everyone may lose (see Effect of contributory negligence at [3.170]).

How to proceed
If a decision is made to go to court, the first step is to go to the Civil Claims section of the nearest Local Court (see Chapter 14, Criminal Law, Contact points for a list of these) and request a statement of claim. If necessary, the clerk will help fill out the claim and arrange for it to be served on the other party.

Fees
For claims up to $10,000, the fees are:
• $93 for lodging the statement of claim, plus
• $39 for a service fee
If the claim is for more than $10,000 the fees will be higher, and legal assistance is strongly recommended.

Action in the Small Claims Division
Consideration should be given to starting the case in the Small Claims Division, if possible, especially if a solicitor is not being used. (For more on the Small Claims Division, see Claims under $10,000 at [3.180].)

The other party’s response
Once the statement of claim is served, the other party (the defendant) has 28 days to file a defence.

Moving the claim to another court
The defendant can apply to have the claim transferred to:
• another Local Court in the area where the defendant lives or works, or
• the District Court (by making an application in the District Court).
When a case is transferred to the District Court, legal advice should be obtained.

Action by the court
After the defence has been filed, the magistrate either:
• lists the matter for mention in court, in which case a notice of the mention date and a copy of the defence are sent to the person claiming (the plaintiff), or
• refers the matter to arbitration.

If the other party does not respond
If the defendant does not file a defence within 28 days of the statement of claim being served, it is necessary to go to the court again and apply for a default judgment from the court office. This is a judgment made by the court in the absence of any defence or explanation from the other party.

To obtain a default judgment, it is necessary to have the affidavit of service back from the bailiff (see Chapter 15, Debt, for what this is) and to complete a form called a statement and affidavit for default judgment at the court.

Enforcing the judgment
After the court gives its judgment ordering a person to pay, that person must do so.
If they do not, the chamber magistrate at the Local Court should be approached for advice on how to enforce the judgment.

See Chapter 15, Debt, for more about enforcing a judgment against a debtor.

[3.200] Defending a claim
A person against whom a claim is made (the defendant) will receive a letter of demand. This letter should not be ignored.

Owners who are insured
An insured vehicle owner who receives a letter of demand should notify their insurance company as soon as possible, giving full details of the accident, if this has not already been done.

Owners who are not insured
If the defendant disputes the claim
An uninsured person who receives a letter of demand may want to dispute the claim.
In this case, they should write to the other party (the plaintiff) denying liability. If the defendant’s vehicle has been damaged, the letter should state that if legal action is started, a counterclaim for repairs to their vehicle will be made. The amount of damages claimed by the other party can also be disputed.

The defendant is entitled to request copies of repair quotations and invoices and receipts for the damages claimed by the other driver.

**If the defendant accepts liability**

If there is no dispute about responsibility for the accident and the defendant is uninsured or does not wish to claim on their insurance policy, and the amount claimed is reasonable, the defendant should pay as soon as possible. This will avoid further expense, such as court costs, solicitor’s fees and so on. If responsibility for damages is not clear, seek legal advice (see Chapter 4, Assistance with Legal Problems).

The defendant may offer to pay by instalments. If the other party does not accept this, the defendant should seek advice from a chamber magistrate at the Local Court or from a solicitor, or apply to the court for a decision on what is a reasonable amount to pay.

**Action by the insurer**

After an insurance company has paid out a claim, it is entitled to take legal action in the name of the person insured to recover the amount from the other party. This is called the right of *subrogation* (see Advantages of claiming at [3.160]).

Drivers of uninsured vehicles often face such claims, and they may seek to pay the repair costs by instalments if they can’t afford a lump sum.

**Settlement of the claim**

The party seeking compensation (an insurance company or private individual) will often accept a lump sum payment for an amount less than the total amount of the repair costs in preference to instalments. This is called *settlement of the claim*.

**Obtaining a release**

When a claim is settled and payment is made, the defendant or their insurer must obtain a signed release from the party who made the claim. This document releases the defendant from further responsibility.

A defendant should not pay any money without getting the signed release. The release should be in terms such as the following:

Between [name of plaintiff]
and [name of defendant]

The plaintiff hereby agrees to and accepts the amount of $...................... paid by the defendant in full and final settlement of all claims for property damage arising out of the accident on the ........... day of [month] [year] at [place]

Signed ................................ [Plaintiff]
.......................................... [Defendant]

Dated ..............................................

**Signing a release**

People who are asked to sign a release by the other party should ensure that it does not prevent them from taking action for physical injury. If in doubt, they should approach a solicitor or a chamber magistrate for advice.

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**Other expenses that can be claimed**

**Hiring a vehicle**

Generally, the owner of the vehicle damaged in an accident can claim the cost of hiring another vehicle only if the damaged vehicle was essential for earning income. It is up to the person making the claim to show that the hiring charges were reasonable and was for a vehicle comparable to the one damaged.

**Lost wages or profits**

In some cases, lost wages or profits may also be claimed (for example, a taxi driver’s net income during the period the taxi was being repaired if no replacement vehicle could be obtained).

Anyone wishing to take action for this type of loss (called a *demurrage claim*) should seek legal advice.
[3.210] Claims contested in court

Witnesses
In any court action for damages that arises from a motor vehicle collision, evidence is given orally by people who:
- were directly involved, or
- witnessed the accident.

The drivers and their passengers
The driver of each vehicle and their passengers can give evidence of what they saw and heard.

Independent witnesses
Courts tend to give more weight to the evidence of independent witnesses such as drivers of other vehicles or pedestrians who saw the accident.

Police witnesses
The police officer who attended the accident is often a very useful witness. To obtain their name and contact details, and a statement as to who the police believe was most responsible, a police accident report should be applied for. Applications are made to the Accident Information Unit at the Police Centre, Parramatta. This will cost about $75.

What must be proved in court?

Proving negligence
Responsibility for proving that the other party was negligent rests on the person making the claim.

Proving that the accident caused the damage and that the claim is reasonable
If someone wants to claim damages following an accident, they must prove that the damage was caused by the collision. It is necessary, therefore, to obtain a detailed quotation for repairs to the vehicle, and it is advisable to obtain at least two quotations as evidence of the reasonableness of the claim.

Sometimes, of course, the vehicle will be so badly damaged that the repair costs will exceed the market value of the vehicle and repair will be uneconomical.

Police prosecution
Sometimes a police prosecution is commenced against one of the drivers concerned.

Police proceedings (that is, criminal proceedings) are quite separate from civil proceedings for damages. Regardless of the outcome of any criminal case, in a civil case the court looks at all the circumstances of the accident before deciding which party or parties are at fault and, as indicated earlier, can decide that both parties are at fault in varying degrees.

How much can be claimed?
Claims cannot exceed the value of a vehicle at the time of the accident. This value can be established by getting a certificate of valuation from a vehicle repairer or some other qualified person.

The duty to mitigate damages
It is a general rule of law that anyone who has suffered damage must try to minimise that loss. This is called the duty to mitigate damages.

Check the repair work
After repairs have been carried out, the owner should take the vehicle to the NRMA for an inspection and test if possible. If this is not possible, they should check the vehicle carefully, especially the paintwork and chassis alignment. If the work is not up to standard, the repairer should be asked to fix it. If they refuse, a complaint can be made to the Department of Fair Trading or the Motor Vehicle Repair Industry Council (see also Chapter 10, Consumers).
Personal injury

[3.220] Legislation
This section deals with claims for personal injury and death arising out of motor accidents that occurred on or after 5 October 1999. These claims are dealt with under the provisions of the Motor Accidents Compensation Act 1999 (NSW).

The Act applies whether the accident occurred on a public road or on private property. The Act can also apply to some accidents occurring at work.

Time limits
There are strict time limits for giving notice, doing certain other things and bringing an action. It is sometimes possible to get an extension, but delay should be avoided, and legal advice should be sought as soon as possible.

[3.230] Who can claim for personal injury?
Simply being injured in an accident does not give a person a right to compensation. Someone claiming damages for injuries or death caused by a motor vehicle accident must prove that the accident was due to the fault of the owner or the driver of a vehicle involved in the accident, subject to five main exceptions.

Fault means negligence or some other tort (wrongful act). The vast majority of claims for injury and death are based on negligence.

The five main exceptions where compensation can be recovered by a person injured in a motor accident who cannot prove anyone else (such as another driver) was at fault are:

1. All people who are injured as a result of a motor vehicle accident are entitled to claim up to $5,000 for treatment and loss of income, regardless of whether they were responsible for the accident or not. In order to access this compensation an Accident Notification Form must be lodged within 28 days of the date of the accident (see Claiming compensation at [3.240]).
2. A person who is “seriously injured” in a motor accident may be entitled to have treatment and care provided to them under the Lifetime Care and Support Scheme. For example, even a person who is injured when he or she simply drives into a tree may be provided with treatment and care if they are “seriously injured”. “Seriously injured” covers a specific range of injury-related major disabilities and in the scheme there are procedures to determine if a person is eligible to participate.
3. A person injured on certain work-related journeys is eligible to claim workers’ compensation.
4. If a person is injured in a motor vehicle accident that is not caused by the fault of anyone (ie, a “blameless accident”) then it is deemed that the driver/s of the motor vehicles involved in the accident were at fault, and a claim can be made in the usual way.
5. Children who were aged under 16 at the time of the accident are entitled to no-fault compensation for their treatment and care expenses. These claims must be made against the CTP insurer of one of the vehicles involved in the accident, and are made in the usual way (ie, following the procedures outlined at Claiming compensation at [3.240]).

Proving negligence
Proving negligence involves proving that:
• the defendant owed the injured person a duty of care, and
• the defendant breached that duty, and
• the person suffered loss or damage as a result.

Whether or not the defendant has been negligent depends on all the circumstances of the accident.
**A driver’s duty of care**

Drivers owe a duty of care to all road users, including their passengers and pedestrians. Some common breaches of the duty to take care are:

- driving too fast in the circumstances
- failing to keep a proper lookout for other traffic and road users
- entering an intersection without regard for other traffic that may also be using it
- driving with insufficient control – for example, because the driver is under the influence of alcohol or drugs.

**What is a motor vehicle?**

A motor vehicle is defined in the Motor Accidents Compensation Act as a motor car, motorcycle, bus, truck or any other vehicle powered by any means other than human or animal power. An accident caused through the fault of a bicyclist, for example, is not covered by the Act. “Vehicles” such as forklifts and other motorised vehicles on a work site can also be motor vehicles for the purpose of the Act.

**Is breaking traffic regulations negligent?**

The fact that a driver has committed a breach of the traffic regulations does not necessarily mean that they have been negligent. It is only one of the factors which must be considered.

**[3.240] Claiming compensation**

Three ways of dealing with the claim

Depending on the nature of the claim and the seriousness of the injuries, the claim can be:

- settled with the third party insurer of the party alleged to be at fault, or
- decided by an Assessor at the Claims Assessment and Resolution Service (CARS), or
- the subject of a common law action for damages against the party alleged to be at fault (through their insurer). In this case, the claim can be either:
  - settled during the proceedings, or
  - decided by a judge.

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**Get legal advice**

A person claiming compensation for personal injuries arising out of an accident should seek legal advice as soon as possible.

**Procedure**

If the registration number of the vehicle at fault is known, the Motor Accidents Compensation Act requires a person wishing to make a claim for compensation for personal injuries to take certain steps.

**If the registration number is not known**

If the registration number of the vehicle at fault is not known, such as in a hit-and-run accident, legal advice should be sought immediately. A claim can still be made against what is known as the nominal defendant.

**At the scene of the accident**

For what should be done at the scene of the accident, see What to do after an accident at [3.100].

**Reporting the accident**

The accident must be reported to the police within 28 days. Failure to report the accident to the police within this timeframe can result in the claim being rejected. If this happens, the injured person will have to provide a full and satisfactory explanation for the delay in reporting the accident. The claim will only be allowed if the application is accepted by the insurer or by an Assessor/Judge.

**Accident Notification Forms (ANFs)**

All people who are injured as a result of a motor vehicle accident are entitled to no-fault benefits of up to $5,000. These benefits cover medical and treatment expenses, and loss of income.

In order to access these no-fault benefits, the injured person must lodge an Accident Notification Form with the CTP insurer of one of the vehicles involved in the accident, within 28 days of the date of the accident. The Accident Notification Form must be accompanied by the prescribed Medical Certificate, which must be completed by the injured person’s treating doctor.
If the injured person’s losses exceed $5,000, or if the injured person is seeking compensation for losses other than medical expenses and loss of income, then a full personal injury claim must be made.

**Time limits**

A personal injuries claim must be made within six months of the accident, using the prescribed form.

A claim in relation to a person’s death must be made within six months of the date of death, also using the prescribed form.

If a claim is made after the six-month period, the insurer can reject it. If this occurs, the injured person must provide a full and satisfactory explanation for the delay in lodging the claim.

**Delivering the claim**

The Personal Injury Claim Form (which can be obtained from the third party insurer of the party at fault or the Motor Accidents Authority) must be completed in full and served on the driver of the vehicle and their third party insurer within six months of the accident.

It is recommended that the claim form be completed with the help of a lawyer.

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**Finding the other party’s insurer**

The Roads and Maritime Services (RMS) will release the name of the third party insurer if they are given the registration number of the vehicle and the date of the accident.

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**Assessing the claim**

Third party insurers have a statutory duty to try to resolve claims as quickly as possible.

To help the insurer assess the claim, the person making the claim may be required to:

- provide information such as:
  - details of loss of earnings, and
  - details of medical and hospital expenses
- produce documents, including medical reports from hospitals and doctors
- provide a photograph or other evidence of their identity
- undergo a medical examination, vocational assessment or rehabilitation assessment.

It usually takes an insurer six months to assess a claim after the form has been received.

**Settling the claim**

After the claim has been lodged with the third party insurer, it may be possible to negotiate a settlement without going to court.

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**Settling out of court**

If injuries are minor and there is no continuing disability, it is usually advisable to try to settle without going to court. This is likely to be much quicker. Sometimes this can be done by negotiating directly with the third party insurer. However, it is advisable to seek legal advice before settling a claim. Most motor accident claims can be dealt with by referral to the Claims Assessment and Resolution Service (CARS), which is part of the State Insurance Regulatory Authority. Often claimants accept awards by CARS assessors and decide not to go to court.

It is very important to remember that once a claim is settled it is finished forever. It is not possible to claim further compensation at a later date if your injuries deteriorate if you have an unexpected problem.

Therefore, before a claim is settled you should:

1. Wait for your injuries to stabilise.
2. Get a medical opinion about your prognosis, your future treatment and care needs, and whether you will have any loss of earning capacity in the future.
3. Be assessed to determine whether you are eligible for compensation for non-economic loss (see What can be claimed at §3.260).

Again, it is advisable to seek legal advice before settling a claim and terminating your rights.

If a claim is made in court, there will be some time before it is heard and decided. (However, see Where court proceedings should be commenced below.)
3.250 Taking the case to the Claims Assessment and Resolution Service or court

Most motor accident cases do not go to court. Instead, they are assessed by the Claims Assessment and Resolution Service (CARS). CARS is administered by the State Insurance Regulatory Authority, who appoints a panel of assessors (experienced solicitors and barristers) to assess motor accident claims. The CARS process is relatively informal and is much quicker and cheaper than going to court.

All claims that are not settled will be assessed by CARS unless they are entitled to be exempted from the CARS process. There are only limited cases that can be exempted from CARS, notably claims where the insurer has denied liability, claims involving children or people who lack legal capacity and claims where the insurer has alleged a significant amount of contributory negligence.

The decision of the CARS assessor is binding on the insurer (unless there has been an allegation of contributory negligence) but is not binding on the injured person. The injured person is entitled to have their case reheard in court if they are unhappy with the decision of the CARS assessor. However, costs penalties can apply, and legal advice should be sought.

There are complicated procedures that must be carried out before a claim can be referred to CARS. It is advisable to seek legal advice if it has been more than two years since the accident and your claim has not yet been settled.

Going to court

Court proceedings can only be commenced in relation to a CTP claim if:

1. The claim has been assessed by the Claims Assessment and Resolution Service and the claimant is unhappy with the assessment and applying for a judge to hear their case.
2. In a case where contributory negligence has been alleged, the claim has been assessed by the Claims Assessment and Resolution Service and the insurer refuses to pay the amount assessed by an assessor of the Claims Assessment and Resolution Service.

3. The case has been exempted from the Claims Assessment and Resolution Service.

Before bringing a court case, it is necessary to consider:

- whether negligence or some other tort can be proved, and
- the amount of damages likely to be awarded, which has been substantially decreased by the Motor Accidents Compensation Act (see Is it worth going to court? below).

Use a lawyer

Anyone intending to claim for personal injury in court should instruct a solicitor.

Which court?

The District Court can hear claims for personal injuries under the provisions of the Motor Accidents Compensation Act regardless of the amount claimed.

However, if the claim is clearly in excess of $1,000,000, there may be advantages in bringing the claim in the Supreme Court (although restrictions apply to bringing motor accident cases in the Supreme Court).

Non-jury hearings

All actions for personal injury or death arising from motor vehicle accidents, are now heard by a judge without a jury.

Time limits

Proceedings cannot be commenced more than three years after the accident (or date of death) except with the leave of the court. If a claim is referred to CARS prior to the three years following the accident then time stops for the purpose of the three year time limit to issue court proceedings until two months after a claims assessor from CARS has issued a certificate as to the assessment or exemption.
Is it worth going to court?

The damages that can be awarded under legislation have been modified from the position at common law, and the full measure previously recoverable can no longer be claimed. Often, however, the final amount will not be very much less. It is in the case of less serious injuries that difficulties are encountered.

Where going to court may not be worthwhile

In the past, a person injured through a driver’s negligence was likely to recover an amount that made court action worthwhile. For accidents on or after 5 October 1999, however, it is often not possible to establish the necessary degree of impairment to claim for non-economic loss [see Damages for non-economic loss, [3.260]]. In cases where the injured person is not entitled to compensation for non-economic loss, consideration should be given to what entitlements they have to claim for other heads of damage (such as loss of income, treatment expenses and care) before deciding whether to commence court proceedings. This is particularly important in cases where liability is denied and the injured person runs the risk of losing their case.

Where court proceedings should be commenced

An injured person should get legal advice before settling a claim, especially if he or she has some continuing disabilities from the motor accident. Often injuries take some time to settle down and the final disabilities may not be immediately apparent. Once a claim has been settled, the injured person cannot claim any further amounts or take any further action.

The person making the claim should be guided by medical and legal advice before settling a claim or signing a release that will prevent future action.

The advice will help the injured person to make the best decision about starting court proceedings or accepting a settlement or the amount awarded by a CARS assessor.

Get legal advice

Anyone in doubt as to whether or not to make a claim should seek legal advice without delay.

[3.260] What can be claimed?

Damages for non-economic loss

For accidents occurring on or after 5 October 1999, general damages for non-economic loss (i.e., pain and suffering) are restricted to a maximum of $511,000 (as at 1 October 2015 – the amount is adjusted on 1 October every year). Damages are not awarded on a scale, and if the court decides to make an award it may fix any amount it considers fair and proper compensation provided it does not exceed the maximum.

The 10% threshold

Before damages for non-economic loss may be awarded the claimant must establish that they have suffered more than 10% permanent whole person impairment in accordance with certain guidelines. Whether this test can be passed is generally determined by a medical assessor, appointed by the State Insurance Regulatory Authority.

What is non-economic loss?

Non-economic loss includes:

• pain and suffering
• loss of amenities of life
• loss of expectation of life
• disfigurement.

Other amounts that can be claimed

Damages under a number of other categories can be recovered in motor accident claims.

Hospital and medical costs

The injured person can recover all hospital, medical, ambulance and similar expenses resulting from the accident. It is advisable for the person to keep a record of all such expenses, and to keep receipts. Unpaid accounts should be kept to either give to the insurance company or produce in court as proof of the amounts claimed.

An amount can also be claimed for future treatment.

Nursing and domestic care

If nursing or domestic care has been provided, the cost can be claimed, even if the services were provided by members of the injured person’s family or a friend without payment.

There are, however, restrictions on the circumstances in which such a claim can be made, and how much can be claimed. In order to claim past domestic assistance provided gratuitously by a family or friend without payment the care must have been
provided for more than six months following the accident and for more than six hours per week.

Economic loss
Loss of wages up to the date of hearing can be claimed as past economic loss. However, there is a maximum amount per week that may be claimed. The amount is indexed annually. As at 1 October 2015, the maximum amount of economic loss that may be claimed is $4,688 net per week.

The injured person can also claim a lump sum amount for future loss of earnings, or for a general reduction in earning capacity. It is necessary to adduce evidence as to the injured person's likely future circumstances but for the accident.

Other claims
Other types of claims can also be made, including the cost of fund management, particularly when the injuries suffered are very serious. Advice should be sought from the solicitor acting for the injured person as to additional claims that can be made in particular circumstances.

[3.270] Amount of the settlement
The solicitor handling a settlement can advise how much an injured person should receive.

Deductions
Sums that may have to be deducted from the settlement amount include:

- the solicitor's costs and disbursements, above the regulated costs payable by the insurer
- repayments for medical or hospital expenses
- repayments of workers' compensation or sickness benefits paid to the injured person while they were unable to work
- repayments to the Health Insurance Commission for treatment expenses paid by Medicare or for nursing home care
- repayments to Centrelink.

These factors must be investigated and considered before a claim is settled.

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**Compensation to relatives**

Under the Compensation to Relatives Act 1897 (NSW), relatives of a person who has died as a result of injuries received in a motor vehicle accident may be entitled to recover damages against the person responsible. Relatives covered are spouse or de facto partner (including same-sex partner), brother, sister, half-brother, half-sister, parent and child.

Any sum awarded will be for the benefit of all the deceased's dependants and will be apportioned as the court directs.

The same procedural requirements and time limits apply as for making a claim for personal injuries arising from a motor vehicle accident.

A claim can only be made in cases where the wrongful act, neglect or default which caused the death would, if death had not occurred, have entitled the deceased to sue for damages for negligence.

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**[3.280] Defences**

**Denial of liability**

The insurer may defend a claim by denying that their insured driver was negligent. In these circumstances, the onus rests on the injured person to prove that the driver was responsible for the accident.

**Contributory negligence**

An injured person succeeds in their action by proving that the defendant was negligent. Sometimes, however, it is alleged that part of the reason that the person was injured was because of their own lack of care. The most common allegations of contributory negligence in motor accident cases are:

- the injured person was not wearing a seatbelt
- the injured person was a passenger in a car where the driver was affected by alcohol or other drugs
- the injured person was a pedestrian and failed to take care for their own safety when crossing the road.

If the court decides that the injured person has contributed to the accident, it will apportion the liability by reducing the injured person's award of damages by the percentage amount of the contributory negligence (see Apportioning damages at [3.170]), and the damages the person would
otherwise recover will be reduced by the same percentage that the injured person is found to have contributed to the accident. The onus of proving contributory negligence rests on the insurer.

**Voluntary assumption of risk**

The defence of *voluntary assumption of risk* (for example, knowingly getting into a car with a driver who is grossly affected by alcohol) is no longer available, but the facts that would give rise to such a defence are treated as matters relating to contributory negligence.

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**Fraudulent or false claims**

Provisions have been introduced to help third party insurers to identify fraudulent or false claims, and offences have been created for people who knowingly make a false or misleading statement for a claim.

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### Sample letters

**[3.290] (1) Letter of demand – other party insured**

................................................................................................................ [claimant’s name]
................................................................................................................ [claimant’s address]
................................................................................................................ [date]

Dear ................................................ [name of respondent]

I am the owner of motor vehicle number .......... [registration number] which was involved in an accident with a vehicle driven by .......... [if the owner was not the driver] on the above date.

I am holding you responsible for the damage to my vehicle. The damage has been assessed at $ .......... A copy of the quotation is enclosed. I believe that your vehicle is insured with .......... [name of insurance company].

Please forward this letter to your insurers as soon as possible. I look forward to hearing from you shortly.

Yours faithfully,
................................................................................................................ [signature]

**[3.300] (2) Letter to insurance company**

................................................................................................................ [claimant’s name]
................................................................................................................ [claimant’s address]
................................................................................................................ [date]

Dear ................................................ [name of respondent]

I am writing about the accident on .......... [date] at .......... [place of accident].

The motor vehicle involved was .......... [registration number] and was owned by .......... [name of owner].

I enclose a copy of the letter of demand sent to .......... [name of other party] together with a quotation for the damage I will be happy to arrange a second quotation if required. I look forward to hearing from you shortly.

Yours faithfully,
................................................................................................................ [signature]

**[3.310] (3) Letter of demand – other party uninsured**

................................................................................................................ [claimant’s name]
................................................................................................................ [claimant’s address]
................................................................................................................ [date]

Dear ................................................ [name of respondent]

I am writing about the accident on .......... [date] at .......... [place of accident].
I am the owner of vehicle number .......... [registration number] driven by me on the above date. I am holding you responsible for the damage to my vehicle, which has been assessed at $ .......... A copy of the repair quotation is enclosed.

Please inform me within 10 days of today's date whether you admit liability for the accident and whether you will pay, and in any case whether you regard the assessment as reasonable.

Yours faithfully,
........................................................................ [signature]

[3.320] (4) Second letter of demand – other party uninsured

........................................................................ [claimant's name]
........................................................................ [claimant's address]
........................................................................ [date]
Dear ................................................................... [name of respondent]
I am writing about the accident on .............. [date] at ............ [place of accident].
I refer to my letter to you dated ............... [date] wherein I gave you until .............. [10 days after the first letter] to contact me regarding compensation for my losses suffered as a result of the accident.
As I have received no offer or money in satisfaction of my claim, I now inform you that unless I receive payment of my damages of $ .......... within seven days of today's date, I will commence court proceedings without further notice.

Yours faithfully,
........................................................................ [signature]


........................................................................ [claimant's name]
........................................................................ [claimant's address]
........................................................................ [date]
Dear ............................ [name of respondent]
I am writing about the accident on .............. [date] at ............ [place of accident].
I am the owner of motor vehicle number .......... [registration number] which was damaged as a result of a collision with a vehicle owned by you [and driven by .......... if the owner was not the driver] on the above date.
I am holding you liable to compensate me for the damage to my vehicle. Under my comprehensive insurance policy, I am required to pay the first $ .......... [amount of excess] of my claim for the cost of repairs to my vehicle.
I hereby claim payment of the sum of $ .......... [amount of excess] of my claim for the cost of repairs to my vehicle.
I expect payment within ten days of today's date. If I do not hear from you within this time, I will commence court proceedings without further notice.
Yours faithfully,
........................................................................ [signature]

Workers' compensation

New South Wales scheme

[3.340] In New South Wales, a worker who suffers an injury that results in incapacity for work, the need for medical treatment and/or permanent impairment of a limb may be entitled to workers' compensation benefits.

If a worker dies as a result of a work injury, any persons dependent for support upon the worker at the time of his or her death may be entitled to workers' compensation benefits.
[3.350] Legislation
The workers’ compensation scheme in New South Wales is established by legislation. There are two important New South Wales Acts: Workers Compensation Act 1987 (NSW) (1987 Act) and Workplace Injury Management and Workers Compensation Act 1998 (NSW) (1998 Act). The 1987 Act sets out the benefits payable to workers and their dependants in the event of a work-related injury and compulsory insurance requirements for employers. The 1998 Act sets out broader scheme administration, injury management and dispute resolution procedures. Both Acts are supported by regulations and guidelines. The primary regulation supporting the workers’ compensation legislation is the Workers Compensation Regulation 2016 (NSW) (2016 Regulation). There are various guidelines and practice directions, which are issued by the Workers Compensation Commission (WCC) and the State Insurance Regulatory Authority (SIRA) (formerly WorkCover NSW) and are available on WorkCover’s old website (www.workcover.nsw.gov.au) and the WCC’s website (www.wcc.nsw.gov.au).

[3.360] Entitlement to workers’ compensation benefits
The entitlement to workers’ compensation benefits is set out in s 9 of the 1987 Act. Section 9 provides that a worker who has received an injury (and in the case of the death of a worker, his or her dependants) shall receive compensation from the worker’s employer. While statutory workers’ compensation schemes have existed in Australia since the turn of the 20th century, the simple concepts of “worker”, “injury” and “compensation” have resulted in extensive legislative amendments and judicial determinations.

The amendments to the workers’ compensation scheme in 2012 produced some profound changes to the way workers may assert their right to entitlements under the legislation. The Workers Compensation Legislation Amendment Act 2012 (NSW) (the 2012 amending Act) introduced fundamental changes to the 1987 Act and the 1998 Act, applying certain limitations and new processes to the way workers’ compensation entitlements are determined and provided in some areas. The amendments had the underlying aim of reducing a $4.1 billion deficit in the workers’ compensation scheme. Changes to specific benefits, including for permanent impairment and pain and suffering compensation, weekly payments compensation, and medical treatment expenses, impact on both new and existing claims, except where particular groups of workers are excluded, such as the police service, paramedics, firefighters, coalminers, emergency service volunteers and workers falling under the Workers Compensation (Dust Diseases) Act 1942 (NSW). The specific amendments to the entitlements are detailed throughout this chapter, where relevant.

Another impact of the 2012 amendments on the scheme is the abolition of the power of the Workers Compensation Commission to make an order for costs and the curtailment of its jurisdiction in certain circumstances in relation to weekly payments.

In 2015, further amendments were introduced to the scheme, leading to major structural changes, and which allowed workers to continue to make a claim for certain entitlements, despite the limitations that came into effect in 2012. The major structural change occurred with the abolition of the WorkCover Authority as a single, merged entity and its breaking down into three separate entities with specific functions within the scheme. The State Insurance and Governance Act 2015 (NSW) created these separate agencies with the view to replacing the functions of the WorkCover Authority and to distinctly separate its insurance and regulatory functions. The three new agencies that are in operation as at 1 September 2015 are:

- The State Insurance Regulatory Authority (SIRA), an independent agency that regulates the functions of the WorkCover Authority in relation to workers compensation insurance and the Motor Accidents Authority in relation to Compulsory Third
Party (CTP) insurance, and that regulates the functions in relation to Home Building Compensation

- Insurance & Care (NSW) (iCare), an insurance and care service provider, the Workers Compensation Nominal Insurer, and service provider for claimants under the Lifetime Care and Support Authority, the Dust Diseases Authority, SICorp and the Sporting Injuries Compensation Authority.

- Safework NSW, an independent workplace health and safety regulator.

In conjunction with these changes, certain court and tribunal decisions in 2015 also impacted on an injured worker’s entitlements to workers compensation benefits. In a decision made on 27 August 2015 in Cram Fluid Power Pty Ltd v Green [2015] NSWCA 250, the NSW Court of Appeal confirmed the provision first introduced by the 2012 amending Act that an injured worker is limited to only one claim for permanent impairment lump sum compensation (s 66(1A) of the 1987 Act) and that a worker who had made a claim for permanent impairment prior to 19 June 2012 (the operational date of the 2012 amending Act) could not make a claim for further or additional permanent impairment lump sum compensation. The impact of the court’s decision simply means that an injured worker, at any stage of a claim and regardless of the date of injury, will only be entitled to one claim for permanent impairment lump sum compensation under s 66 of the 1987 Act.

The court judgment’s impact appears to be slightly diluted by the introduction of changes to the Workers Compensation Regulation 2010 (NSW) where, through the Workers Compensation Amendment (Lump Sum Compensation Claims) Regulation 2015 (NSW) (the 2015 amending Regulation), a provision now operates that allows workers to make a further permanent impairment lump sum compensation claim, despite Cram Fluid v Green and the 2012 amending Act. The 2015 amending Regulation allowed a worker who has made a claim for permanent impairment lump sum compensation before 19 June 2012 to make one (and only one) further claim for the same entitlement after 19 June 2012. For the purpose of the further claim, the worker does not need to have at least 11% whole person impairment (WPI), despite the 2012 amending Act’s requirement under s 66(1) of the 1987 Act of a degree of permanent impairment of greater than 10% WPI. This means, the worker only needs to prove that there is at least 1% WPI deterioration since the previous percentage or degree of permanent impairment received before 19 June 2012 in order to pursue the further permanent impairment lump sum compensation claim.

Both the 2015 amending Regulation and the Workers Compensation Amendment Act 2015 (NSW) (the 2015 amending Act) have also introduced minor changes to certain entitlements, and these will be set out in the following discussion, where relevant.

Worker

[3.370] Who is a worker?

To be entitled to workers’ compensation benefits you must be a worker (or, in the case of death of a worker, a dependant of a worker), as defined by the workers’ compensation legislation. “Worker” is defined in s 4 of the 1998 Act. Section 4 states that a worker is a person who has entered into or who works under a contract of service or a training contract with an employer. The type of work undertaken is not restricted. The important aspect is the existence of a contract that can be categorised as a contract of service. A contract of service involves a relationship between an employer and a worker where, in return for the payment of wages or equivalent, a worker performs duties as directed by the employer.
A contract of service is distinct from a contract for services. A contract for services typically involves an independent contractor, often a tradesperson, who is contracted to perform a specific task. A person working under a contract for services would not be a worker for the purposes of the workers’ compensation legislation and therefore could not claim workers’ compensation benefits. Independent contractors usually take out personal injury insurance to cover them in the event that they have an accident while working.

The onus is on a claimant to establish the existence of a contract of service and therefore that they are a worker for the purposes of entitlement to workers’ compensation benefits. The contract does not need to be in writing, however, oral contracts often give rise to disputes regarding precise terms and the nature of the relationship. Whether in writing or orally, a claimant must establish the essential features of a contract: an offer of employment, acceptance of that offer, consideration (being the value of the contract), and an intention to create legal relations. In most cases, consideration will be in the form of money paid (wages) in exchange for a person’s labour, although consideration can include anything with a value, such as the provision of food and accommodation in exchange for a person’s labour.

In most cases an employment relationship will be obvious. If, however, it is unclear whether the relationship is a contract of service, it is necessary to look at all the features of the relationship. Indicia that weigh in favour of or against a contract of service include:

Control
Clearly the most important feature of an employment relationship is the right of direction and control by an employer over an employee. Control includes the right to direct what work is to be performed and how it is to be performed, the right to approve or not to approve whether a person may take leave and the right of dismissal of the person.

Hours of work and method of payment
The right to determine a person’s hours of work and days of attendance is a classic feature of an employment relationship (for example, requiring a person to commence work at 9.00am, take a lunch break between 1.00pm and 2.00pm, and finish work at 5.00pm, from Monday to Friday). The method of payment is also a feature. Workers will usually be paid an hourly rate and have tax deducted from the payment whereas an independent contractor will usually perform a specific job for a fixed fee and will usually include GST in addition to the fee.

Provision of tools, material and plant
It is usual in an employment relationship that the employer provides and maintains all tools, equipment and premises that are necessary to perform the work. By contrast, independent contractors usually supply and maintain their own tools and equipment.

Entitlements other than remuneration
Another feature of an employment relationship is the accrual of holiday leave, sick leave and extended leave entitlements.

Right to exclusive use of services of the person engaged
A requirement of an employment relationship is that the person engaged cannot work for other employers, at least not without the consent of the employer.

No right to employ other workers or to delegate the work
A feature of an employment relationship is that a worker cannot employ other persons to do the work or sub-contract the work.

The above examples are not exhaustive and each indicium will not usually of itself establish whether a contract of service exists or not. It is a question of balancing the indicia to determine whether an employment relationship exists.

[3.380] Volunteers
A volunteer who is injured at work premises is not entitled to claim workers’ compensation benefits. Volunteers are unable to establish the essential elements of a contract,
particularly the absence of consideration (value for labour) and the absence of an intention on the part of the parties to enter into a legal relationship.

There is, however, specialist legislation (Workers Compensation (Bush Fire, Emergency and Rescue Services) Act 1987 (NSW)), which provides that volunteer bushfire fighters, volunteer surf lifesavers and SES volunteers are entitled to workers’ compensation benefits if those persons are injured in the course of volunteer activities.

[3.390] Deemed workers
The 1998 Act deems certain persons to be workers for the purposes of entitlement to workers’ compensation benefits, even though those persons do not meet the definition of “worker” under the workers’ compensation legislation. Categories of deemed workers are many and varied and are set out in Schedule 1. They include taxi drivers, jockeys and harness drivers, ministers of religion, entertainers and performers such as professional boxers, wrestlers and referees.

[3.400] Excluded workers
A number of categories of workers are specifically excluded from entitlement to claim workers’ compensation benefits under the New South Wales workers’ compensation scheme. The following persons are excluded from cover under the New South Wales workers’ compensation scheme:

• New South Wales police officers employed before 1 April 1988 – those officers are covered under a separate compensation scheme
• miners who suffer a dust disease – miners who suffer dust diseases are covered for workers’ compensation by the Workers’ Compensation (Dust Diseases) Act 1942 (NSW)
• registered participants of sporting organisations who receive remuneration for participating in authorised activities and training
• casual workers, defined as persons performing work for one period only of not more than five working days and the work performed is not related to the employer’s trade or business (for example, a babysitter)
• a person who is employed by the Commonwealth or by a Commonwealth authority or licensed corporation – Commonwealth employees must claim under the Commonwealth workers’ compensation scheme (Comcare).

The workers listed above, in addition to emergency service volunteers, are also excluded by the amendments to the legislation in 2012 and 2015.

[3.410] Illegal employment
If the contract of service or training contract under which an injured worker was engaged at the time the injury happened was illegal, the workers’ compensation legislation provides that the matter may be dealt with as if the injured worker had at the time been a worker under a valid contract (s 24 of the 1987 Act).

It arises from time to time that an injured person does not have a valid work visa and is therefore prohibited from working in Australia. Despite the illegality of their employment, the courts have consistently held that those workers are still entitled to workers’ compensation benefits if they suffer an injury arising out of or in the course of that employment (see for example Nonferal (NSW) Pty Ltd v Taufa [1998] 43 NSWLR 312 and Singh v TAJ (Sydney) Pty Ltd [2006] NSWCA 330). In these cases regard is given to the nature and circumstances of the illegality to determine whether the person should still be entitled to workers’ compensation benefits.
Injury

[3.420] What is an injury?

Once it is established that the person claiming workers' compensation is a worker, it is necessary to establish that the person suffered an injury as defined by the workers' compensation legislation. “Injury” is defined in both s 4 of the 1987 Act and s 4 of the 1998 Act. Despite the two definitions, they are in similar terms and nothing turns on whether reference is to the definition in the 1987 Act or the 1998 Act.

Essentially, there are three categories of injury which entitles a worker to workers' compensation benefits. The three categories are:

• a personal injury arising out of or in the course of employment

• a disease which is contracted by a worker in the course of employment and to which employment was a contributing factor, and

• the aggravation, acceleration, exacerbation or deterioration of any disease, where the employment was a contributing factor to the aggravation, acceleration, exacerbation or deterioration.

Establishing that a worker has suffered a work injury is a simple task when there is an identifiable incident or traumatic event, such as a fall at work resulting in a broken arm. An injury may cause either internal damage to the body (such as a hernia or disc lesion) or external damage to the body (such as cuts or abrasions).

The task of establishing that a worker has suffered a work injury becomes more difficult when there is no identifiable event or when a worker suffers from a disease or condition that could equally be attributed to non-work factors. It is not uncommon in workers' compensation claims for an injury to arise as a result of repeated and often unnoticed trauma which has the cumulative effect of producing a pathological change. The mechanism of injury in these cases is the nature and conditions of the worker's employment over a period of time, rather than any single incident.

What is required for the purposes of entitlement to workers compensation is a sudden, identifiable pathological change (Castro v State Transit Authority (NSW) [2002] NSWCC 12; (2002) 19 NSWCCR 496).

In 2012, the changes to the legislation further defined a “disease injury” in s 4 of the 1987 Act to mean:

• a disease that is contracted by a worker in the course of employment but only if the employment was the main contributing factor to contracting the disease, and

• the aggravation, acceleration, exacerbation or deterioration in the course of employment of any disease, but only if the employment was the main contributing factor to the aggravation, acceleration, exacerbation or deterioration of the disease.

The effect of this is that a worker now faces a higher test of proving that the employment, among other relevant factors, was the main cause of the disease.

[3.430] Work relationship of personal injuries

Once it is established that a worker has suffered a personal injury, it is also necessary to establish that the personal injury arose out of or in the course of employment. “Arising out of employment” suggests a causal connection between the worker’s employment and the injury, while “in the course of employment” suggests a temporal connection between the injury and employment.

“Arising out of employment” has a fairly wide import and can establish an injury even though a worker was not doing his job at the time of the injury. For example, a personal injury to a worker that arose out of a verbal exchange between a worker and his
supervisor about the work to be performed may be said to arise out of employment.

In general, all injuries that occur during work hours will be found to arise in the course of employment. Personal injuries will be held to be in the course of employment even though they occur during meal breaks and other authorised breaks.

Personal injuries occurring outside the normal period of work may in certain circumstances be considered to arise out of or in the course of employment. This may occur where an employer induces or encourages an activity outside of work, such as attending a work function. However, mere authorisation by an employer to engage in an activity outside of work will not usually be enough; inducement or encouragement by the employer needs to be established.

[3.440] Features of disease injuries

A disease injury has broad implications and encompasses any form of illness, including mental illness (Federal Broom Co Pty Ltd v Semlitch [1964] HCA 34; (1964) 110 CLR 626). In the legal sense, an injury might be described as a disease even though it might not be considered a disease by medical practitioners. A disease injury at law has been described as “the failure of an area of the body to cope with repeated stress imposed upon it and reacts to that stress by developing swelling, pain and loss of function as a consequence” (Perry v Tanine Pty Ltd t/as Erminston Hotel [1998] NSWCC 14; (1998) 16 NSWCCR 253). The wide interpretation of what constitutes a disease at law can be applied to many injuries that may result from the nature and conditions of employment.

Certain types of occupations increase the risk of contracting certain diseases. The 2016 Regulation contains a Schedule which lists the kinds of employment for which certain diseases are taken to have been contracted in the course of that employment (refer to cl 4 and Sch 1 of the 2016 Regulation). For example, brucellosis, leptospirosis and Q fever are taken to be work-related, if the worker was employed in activities in an abattoir. While not prescribed in Sch 1 of the 2016 Regulation, it is common for shearers to contract Q fever and it is unlikely that an employer or insurer would question the work relationship.

Where the injury is the “aggravation, acceleration, exacerbation or deterioration of a disease”, the original disease need not have been contracted in the course of the employment; it is enough that the aggravation, acceleration, exacerbation or deterioration of the disease happened in the employment. So, if a worker has a pre-existing disease, which is made worse by the employment, the worker would be entitled to claim workers’ compensation benefits.

Following the 2012 amending Act, new claims for disease injuries must be supported with sufficient evidence to show that the employment was the main cause of, or contributing factor to, contracting the disease injuries.

[3.450] Employment as a substantial contributing factor

It is not enough that the injury arose out of or in the course of employment. Before workers’ compensation is payable, it must also be established that the worker’s employment was a substantial contributing factor to the injury (s 9A of the 1987 Act). Disputes often arise as to whether employment was a substantial contributing factor to an injury, for example, whether employment was a substantial contributing factor when a worker suffers a heart attack at work or when a worker is injured when not actually undertaking work duties at the time of the injury.

Section 9A provides six examples of matters to be taken into account in determining whether employment was a substantial contributing factor:

1. the time and place of the injury
2. the nature of the work performed and the particular tasks of that work
the duration of the employment
4. the probability that the injury or a similar injury would have happened anyway, at about the same time or at the same stage of the worker’s life, if he or she had not been at work or had not worked in that employment
5. the worker’s state of health before the injury and the existence of any hereditary risks, and
6. the worker’s lifestyle and his or her activities outside the workplace.

Employment is not required to be a substantial contributing factor for injuries suffered while a worker is on a journey to or from work, while on a recess break or while carrying out trade union duties. It would otherwise make it impossible for a worker, so injured, to be entitled to workers’ compensation benefits.

Whether employment is a substantial contributing factor to an injury is a question of fact and is a matter of impression and degree that requires analysis of the causal factors which resulted in the injury and an evaluation of the importance of the employment factors.

[3.460] Psychological and psychiatric injuries

Stressful and traumatic events at work may cause a range of emotional and psychological reactions. If those reactions result in a physiological effect, rather than a mere emotional impulse, a worker will be entitled to claim workers’ compensation benefits. Mere emotional impulses are strong feelings, however, they do not cause a person to become dysfunctional (Yates v South Kirby Collieries Limited [1910] 2 KB 538). What is required is a recognisable condition, not merely an emotional impulse; for example, a medical diagnosis of post-traumatic stress disorder. The worker’s condition must also arise out of real events and not merely the worker’s perception of events (Townsend v Commissioner of Police (1992) 25 NSWCCR 9 and Yeo v Western Sydney Area Health Service (1999) 17 NSWCCR 573).

A defence to a claim for psychological or psychiatric injury is that the injury was wholly or predominantly caused by the reasonable action taken or proposed to be taken by or on behalf of the employer (s 11A of the 1987 Act). The action by an employer can relate to transfer, demotion, promotion, performance appraisal, discipline, retrenchment or dismissal. Whether the injury is caused by the action taken or proposed to be taken and whether the employer’s actions are reasonable or not are questions of fact and degree, which involve consideration of all the factors that produced the worker’s psychological or psychiatric condition (Manly Pacific International Hotel Pty Ltd v Doyle [1999] NSWCA 465; (1999) 19 NSWCCR 181). An employer bears the onus of proving that their actions or proposed actions were reasonable.

[3.470] Hearing loss

Hearing loss may arise out of a traumatic event at work, such as a loud explosion, or by gradual onset caused by the general noise in a workplace over a period of time. In the latter case, where hearing loss is caused by repeated and multiple micro traumata over a period of time, the workers’ compensation legislation deems the date of injury to be the date of the claim or, if the worker is no longer in noisy employment, the date the worker last worked in noisy employment. In effect, the last noisy employer is deemed to be liable for the hearing loss, even though there may have been significant periods of noisy employment before the worker worked for the last noisy employer.

[3.480] Journey claims

In New South Wales, a worker who suffers a personal injury while on a daily or other periodic journey between the worker’s home and work is entitled to workers’ compensation benefits (s 10 of the 1987 Act). Section 10 uses the expression “personal injury” and therefore the disease aspects of injury are excluded from cover if received while on a journey. By operation of s 10, an injury
received on a daily periodic journey is deemed to arise out of or in the course of employment. The journeys to which s 10 apply also include journeys to educational institutions which the worker is required or expected by the employer to attend and journeys to attend a doctor for the purposes of obtaining a medical certificate or treatment in relation to a work-related injury.

It is important to note that a journey commences from, and ends at, the boundary of a worker’s home, that is, at the front gate not the front door.

If a worker suffers a personal injury during an interruption or deviation from a journey, the worker will still be entitled to claim workers’ compensation benefits unless the deviation or interruption materially increased the risk of injury (s 10(2) of the 1987 Act). Each case depends on its own set of facts. For example, sometimes the arrival of darkness following an interruption to a journey home from work has been held to materially increase the risk of injury whereas in other cases the later journey time has been held not to.

The journey provisions do not apply if the personal injury was caused by the worker’s serious and wilful misconduct. In the case of a worker being under the influence of alcohol or some other drug, a personal injury will be taken to be attributable to the serious and wilful misconduct of the worker unless the worker can demonstrate that the alcohol or other drug did not contribute in any way to the injury or that it was not consumed or taken voluntarily.

For journey claims made on or after 19 June 2012, the amending Act imposed a limitation by adding a new requirement that a “journey” as defined in s 10(3) will apply only if there is a real and substantial connection between the employment and the accident or incident out of which the personal injury arose (s 10(3A)). This new provision now requires more particularised evidence in order for a worker to prove a more substantial connection of the journey with the employment, rather than a mere estimation or anticipation that a journey was or will be involved in the course of that worker’s employment. The term “substantial” must carry the meaning, “real and of substance” (Badawi v Nexon Asia Pacific Pty Limited trading as Commander Australia Pty Ltd [2009] NSWCA 324), but “real” should mean “actual” and “connection” should take the meaning of “association” or “relationship” or “link” (Mitchell v Newcastle Permanent Building Society Ltd [2013] NSWWCCPD 55). In applying the test under s 10(3A), there must be a determination in a common-sense and practical manner (Bina v ISS Property Services Pty Limited [2013] NSWWCCPD 72).

### 3.490 Recess claims

If a worker has first attended at his or her place of employment and is temporarily absent from the workplace during any ordinary recess or authorised absence, such as a tea break or a lunch break, the worker will be covered for workers’ compensation benefits if injured while on that recess or absence. Workers’ compensation law deems the injury to have arisen out of or in the course of the worker’s employment, despite it occurring during a temporary absence from work (s 11 of the 1987 Act). An ordinary recess denotes a break in the actual execution of work, during a period of time when the worker is in the course of employment. It is unlikely that a short period of time between shifts (eg, two hours), during which the worker was free to do what he or she liked, would be classed as an ordinary recess. Each would more likely be defined as a separate period of employment.

There is a restriction on injuries received while on a temporary recess or absence from work where a worker voluntarily submits to an abnormal risk of injury while on the break. For example, a worker who crosses a busy highway on foot during a lunch break, rather than using an overhead pedestrian bridge or traffic lights, may be found to have voluntarily submitted to an abnormal risk of injury. While the risk of injury is a risk faced by every pedestrian, it is the fact of the worker exposing him or herself to an abnormal risk.
[3.500] Serious and wilful misconduct of worker
If the injury suffered by a worker is solely attributable to the worker’s serious and wilful misconduct, workers’ compensation is not payable unless the injury suffered by the worker results in death or serious and permanent disablement (s 14(2) of the 1987 Act). Intoxication during work, leading to an injury, may constitute serious and wilful misconduct by a worker.

Compensation

[3.510] Workers’ compensation benefits can be classified into two categories:
• economic loss, such as loss of wages and the incurring of medical and related expenses
• non-economic loss, being compensation for permanent impairment to limbs and for pain and suffering.
While non-economic loss may impact on economic loss, it is not always the case. Often a worker may suffer a non-economic loss but no economic loss, and vice versa. In addition, workers’ compensation is payable in respect of a worker who dies as a result of a work injury.

The most significant change effected by the amending Act in 2012 is to a worker’s entitlement to weekly payments compensation, where a new claims structure has been introduced with additional dispute resolution processes established. Prior to 1 October 2012, weekly payments were made over two entitlement periods: the first 26 weeks and a second period of another 26 weeks.
Following the changes in 2012, weekly payments are now spread out over four entitlement periods:
• the first entitlement period up to the first 13 weeks
• the second entitlement period from week 14 up to week 130
• the third entitlement period from week 131 up to week 260
• the fourth entitlement period after week 260.
While the periods of entitlement have been set out over four distinct timeframes, a worker may only access those entitlements, particularly after the second entitlement period (s 40 of the 1987 Act), if certain requirements are met. The amendments also capped the weekly payments to five years before the entitlement ceases to be paid, except where a worker is certified to have a degree of permanent impairment of more than 20% whole person impairment (defined as a worker with high needs in s 32A of the 1987 Act). The 2015 amendments provided that a worker with high needs, who has been assessed by the insurer as having current work capacity, is no longer required to work at least 15 hours per week in order to receive weekly payments at the expiration of the second entitlement period.
For a worker with highest needs (a worker with a degree of permanent impairment of more than 30% whole person impairment, s 38A of the 1987 Act), the minimum weekly payment amount is $788.32 per week. If the worker with highest needs earned below that amount, the insurer will increase the payment to the minimum weekly payment amount per week. The minimum weekly payment amount is indexed in April and October of each year.
Under the new regime, all injured workers will be paid according to rates that are calculated on the basis of that worker’s capacity for work. New concepts have been introduced – such as a work capacity assessment and a work capacity decision – that compound the difficulty of determining a worker’s entitlement to the benefits.
Workers who were receiving the weekly payments on or around 1 October 2012 will need to be “transitioned” under the new regime by undergoing an assessment of their capacity for work. Once the assessment has been performed, the insurer is expected to make a work capacity decision, setting out the worker’s entitlements under the new regime and formally notifying the worker of that decision. The insurer has an obligation under the law to give the worker at least three months’ notice before the decision or its impact on the weekly payments entitlement takes effect.

It is important to note that if a dispute arises out of a work capacity assessment or a work capacity decision of the insurer, a lawyer will not be entitled to legal costs if that dispute is pursued on behalf of the worker (s 44(6) of the 1987 Act). At this stage, however, there have been movements to introduce some form of legal costs funding for this purpose. Until the proposals are accepted and passed, the preclusion of legal practitioners from claiming legal costs for this purpose remains in effect. The avenues for a worker who is not satisfied by a work capacity decision of the insurer include an internal review by the insurer, a merit review or a procedural review (see Merit review at [3.645] and Work capacity decision review at [3.650]).

If a work capacity decision is subject to the review process, the 2015 amending Act comes into effect in that the decision is stayed during that period of the review process and any reduction or decrease in the weekly payments does not operate.

There are guidelines and regulations issued by the SIRA to administer the new weekly payments regime and further information may be obtained on the former WorkCover Authority’s website at www.workcover.nsw.gov.au.

If a worker has not been “transitioned” and the old provisions for weekly payments still apply, the relevant principles, concepts and methodology for this entitlement are set out in the following paragraphs.

The 2015 amendments further provided that weekly payments for claims made on or after 1 October 2012 will continue to be available for up to 12 months after reaching retiring age (see s 52 of the 1987 Act).

### [3.520] Weekly compensation benefits prior to the 2012 amending Act

If as a result of a work injury a worker is incapacitated for work, the worker will be entitled to weekly payments of compensation for that incapacity. “Incapacity” is measured in terms of a worker’s reduced earning capacity in the open labour market reasonably accessible to the worker. If a worker has no earning capacity, as a result of the work injury, then the worker is deemed to be totally incapacitated for work. If a worker has a reduced earning capacity as a result of the injury, then the worker is deemed to be partially incapacitated for work.

**Total incapacity**

A worker who is totally incapacitated for work is entitled to his or her current weekly wage rate for the first 26 weeks of total incapacity, subject to an overall cap on the amount of compensation payable. The overall cap on the amount of weekly compensation payable is set by s 35 of the 1987 Act, which is currently $2,058.10 per week (as at 1 October 2016). The maximum amount is usually indexed twice a year, on 1 April and 1 October.

A worker’s currently weekly wage will usually be the award that the worker is being remunerated under, including any industrial agreement or enterprise agreement. If a worker is not employed under an award, the current weekly wage rate will be calculated as 80% of the worker’s average weekly earnings. A worker’s average weekly earnings is to be computed in such manner as is best calculated to give the rate per week at which the worker was being remunerated and includes regular overtime and allowances. Special legislative provisions apply to calculating the current
weekly wage rate for part-time workers (refer to ss 42 and 43 of the 1987 Act).

After the first 26 weeks of total incapacity for work, the maximum weekly compensation payable is 90% of average weekly earnings or a statutory rate, whichever is the lower (s 37(1) of the 1987 Act). The statutory rate of compensation is increased if the worker also has a spouse and/or children dependent upon him or her for support.

Partial incapacity
If a worker is partially incapacitated for work it is necessary to quantify the worker’s reduced earning capacity in terms of lost income. In broad terms, this is done by calculating the difference between the worker’s probable weekly earnings, had the worker remained uninjured (including overtime, shift work, payments for special expenses and penalty rates) and the worker’s actual earnings. If the actual earnings are not a true reflection of the worker’s earning capacity, it is appropriate to determine the worker’s ability to earn in some suitable employment. For example, if a partially incapacitated worker decides to go on an overseas holiday instead of working, then the actual earnings will be nil even though the worker will have an ability to earn income.

The weekly amount of compensation payable for partial incapacity for work cannot exceed the weekly amount that would be payable to the worker if it were a period of total incapacity for work.

Partial incapacity, deemed total incapacity
Where a worker is partially incapacitated for work there is a general requirement on the worker’s employer to provide suitable employment to the injured worker. Where the employer has no suitable employment, there is a requirement on the worker to seek suitable employment from some other person. In cases where a worker is partially incapacitated for work as a result of an injury but the worker is not suitably employed during any period of partial incapacity, the worker is to be compensated as if totally incapacitated for work, provided the worker is seeking suitable employment (s 38 of the 1987 Act). To be seeking suitable employment, the worker must be ready, willing and able to work, have requested suitable employment from their employer and be taking reasonable steps to obtain suitable employment from another employer. The maximum total period for which a worker may be compensated as if totally incapacitated for work is 52 weeks. After that period the worker reverts to the amount payable for partial incapacity for work.

[3.530] Medical, hospital and rehabilitation expenses
A worker is entitled to the costs of medical, hospital, rehabilitation and related expenses incurred as a result of a work-related injury (s 60 of the 1987 Act). There is a strong focus in the legislation on rehabilitation to facilitate early return to work. The costs are in relation to treatment and services provided to the injured worker, which are reasonably necessary. Treatment includes the provision of medication, surgery or other services designed to arrest or abate the progress of the condition or to alleviate, cure or remedy the condition.

Whether treatments or services are reasonably necessary will depend on such factors as the appropriateness, possible alternatives, the cost, the effectiveness and acceptance by the medical profession of the treatment or service provided.

Medical, hospital and rehabilitation expenses include:
- ambulance services
- chiropractor
- dental prosthetist
- hospital treatment
- occupational rehabilitation services
- workplace rehabilitation services
- osteopath
- public hospital charges, and
- medical or related treatment including treatment by a medical practitioner, therapeutic treatment, crutches, artificial members and artificial aids, eyes, teeth, spectacles, nursing, medical supplies and domestic assistance.
The 2012 and 2015 amending Acts introduced changes to the entitlement to medical treatment expenses, as the above expenses are collectively called, which aim to limit an injured worker’s right to access such an entitlement. Section 59A, which was inserted into the 1987 Act, and commenced on 1 October 2012, provides that a worker’s entitlement to medical treatment expenses is limited to 12 months after a claim was first made or within 12 months after the payment for weekly benefits has been stopped. If the worker is still in receipt of weekly payments, then the 12-month limitation will not apply. If the worker, however, stopped receiving weekly payments on a certain date, the 12 months will run from that date and there will be no entitlement to the expenses after the expiration of that period.

The 2015 amending Act has now extended the limitation in s 59A of the 1987 Act, as follows:

- workers with a degree of permanent impairment of 10% WPI or less – the limit to the entitlement to reasonably necessary medical treatment expenses is up to two years from the date the claim was first made or from the last date of weekly payments made
- workers with a degree of permanent impairment of between 11% WPI and 20% WPI – the limit to the entitlement to reasonably necessary medical treatment expenses is up to five years from the date the claim was first made or from the last date of weekly payments made
- workers assessed with a degree of permanent impairment of more than 20% WPI – there is no limit and the entitlement to reasonably necessary medical treatment expenses is for life.

For claims made before 1 October 2012, a worker will continue to have access to the following medical and related treatment for life, regardless of the degree of permanent impairment as assessed:

- crutches, artificial members, eyes or teeth and other artificial aids or spectacles (including hearing aids and hearing aid batteries)
- modifications to vehicle and home
- secondary surgery.

Despite the extended or extinguished limitations above, a worker may still be required to seek prior approval from the insurer for certain types of medical treatment expenses (such as secondary surgery).

Transitional provisions have also been introduced (Pt 19H, cl 17(2) of Sch 6 of the 1987 Act) to address claims for compensation made before 1 October 2012. In this instance, the claim for medical treatment expenses is now deemed to have been made immediately before the commencement of s 59A and previous weekly payments made before 1 October 2012 are not taken into account. If the worker was not receiving weekly payments for claims made before 1 October 2012, the 12-month period after the weekly payments ceased will be deemed to have commenced on 1 January 2013 and expired on 31 December 2013. A worker who is or was not in receipt of weekly payments and has incurred medical treatment expenses on or before 31 December 2013 may still claim for the s 60 expenses as long as the claim for it was, or the expenses were incurred within the 12-month period.

What this all means is that a worker now has to take into consideration the circumstances under which a workers’ compensation claim was first made or whether or not weekly payments had been paid or had stopped before making a claim for medical treatment expenses.

If a worker is deemed to be a “worker with highest needs” (which, in the context of the 1987 Act, is taken to mean a worker suffering more than 30% whole person impairment or if the degree of permanent impairment cannot as yet be ascertained), then that worker will be exempted from the operation of s 59A.

A further exemption from the operation of s 59A also came into effect on 1 September 2014, where for a worker who had an “existing claim” (either a claim for weekly payments or medical treatment made before 1 October 2012), the 12-month limitation does not apply until the worker reaches retiring age, if that worker’s injury resulted in more than 20% whole person impairment or if the permanent impairment cannot as
yet be ascertained. In addition, from 1 September 2014, a worker with an existing claim may be entitled to the cost of “secondary surgery” without being subject to s 59A if the second surgery is directly consequential to the earlier surgery to the same body part and if the insurer has approved that second surgery within two years of approving the earlier surgery.

A worker is also entitled to the costs of fares, travelling expenses and maintenance necessarily and reasonably incurred by the worker in obtaining medical treatment or services (s 60(2)(a) of the 1998 Act). If a worker travels by private motor vehicle to attend medical treatment or service, the worker is entitled to the associated costs. The rate recoverable for private motor vehicles, since 1 October 2005, is $0.55 per kilometre.

There is also a provision in s 60(2A) introduced in 2012 where a worker is now required to obtain the approval from the insurer prior to incurring the medical treatment expenses. Subject to other considerations, treatments obtained within 48 hours of sustaining the injury or those that are exempted from the WorkCover Guidelines that regulate treatment expenses do not require the insurer’s prior approval.

[3.540] Permanent impairment compensation

The 2012 amending Act has had a profound impact on entitlements to permanent impairment and pain and suffering compensation, which has attracted the most public and judicial scrutiny since its operation. For lump sum compensation claims for permanent impairment made on or after 19 June 2012, s 66(1) now applies where an injured worker who has received an injury after that date must satisfy a new threshold of greater than 10% whole person impairment (WPI) in order to be compensated, in lieu of the previous 1% WPI introduced in the relevant legislative amendments in 2001. The new threshold of 11% WPI must be satisfied for a physical injury, including as a result of hearing loss (which was previously 6% binaural hearing loss (BHL), equivalent to 3% WPI). The threshold for a psychiatric or psychological injury remains at 15% WPI.

The High Court of Australia has since laid down the accepted position that if a worker’s claim for permanent impairment compensation was made on or after 19 June 2012, regardless of that worker having made a general workers’ compensation claim prior to that date, the relevant compensable threshold that must be satisfied is 11% WPI (ADCO Constructions Pty Ltd v Goudappel [2014] HCA 18). Despite this position, however, the judgment may be interpreted differently by various decision-making bodies such as the Workers Compensation Commission, where the circumstances of a particular claim or dispute may render the judgment not applicable and where the previous threshold may instead be applied (see Caulfield v Whelan Kartaway Pty Ltd [2014] NSWCCPD 34). This means that a worker used to continue to argue against the accepted position if there was sufficient evidence to support such an argument and depending on the facts of a claim or dispute.

Since 19 June 2012, a worker is also prevented from making more than one claim for permanent impairment compensation (s 66(1A) of the 1987 Act), which is a departure from the position prior to the amendments where a worker may continue to make a claim for further permanent impairment compensation if there is a deterioration in that worker’s condition since the last award or payment of s 66 compensation. The prohibition is supported by the decision of the NSW Court of Appeal in Cram Fluid Power Pty Ltd v Green [2015] NSWCA 250 in that a worker will only be entitled to one claim for lump sum compensation for permanent impairment. Despite this limitation, however, the Workers Compensation Amendment (Lump Sum Compensation Claims) Regulation 2015 (NSW) has now allowed one further claim for lump sum compensation for permanent impairment for a worker who has made a previous claim under s 66 of the 1987 Act before 19 June
2012. See also [3.360] Entitlement to workers’ compensation benefits above.

For an existing claim or dispute where the amendments to permanent impairment compensation do not apply, the determination of such a claim or dispute would be made in accordance with the previous position as set out in the following paragraphs.

A worker who has received an injury is entitled to receive lump sum compensation for permanent impairment resulting from the work-related injury or disease (s 66 of the 1987 Act). Lump sum compensation for permanent impairment is payable in addition to any other workers’ compensation benefits. To be entitled to lump sum compensation, the impairment must be permanent and must be to a recognised body system, structure or disorder. Compensation is payable for permanent impairment resulting from primary psychological and psychiatric injuries, however, there is a requirement that the level of permanent impairment is at least 15% (s 65A of the 1987 Act). In relation to hearing loss, the threshold for entitlement to permanent impairment lump sum compensation is 6% BHL (equivalent to 3% WPI) (s 69A of the 1987 Act). For lump sum compensation claims due to hearing loss made after 19 June 2012, the amending Act increased this threshold to at least 11% (s 66(1) of the 1987 Act, with s 69A being repealed).

Assessing permanent impairment involves clinical assessment by a WorkCover-trained medical specialist of the following:

- whether the worker’s condition has resulted in impairment
- whether the impairment has reached maximum medical improvement
- whether the impairment is permanent
- the degree of permanent impairment, expressed as a percentage.

For injuries received on or after 1 January 2007 the maximum amount payable for permanent impairment is $220,000. The maximum amount is payable for impairments of 75% or more. For permanent impairment to the back resulting from injuries received on or after 1 January 2006, the amount payable for permanent impairment compensation is increased by 5%.

### [3.550] Pain and suffering compensation

If a worker suffers an injury resulting in at least 10% permanent impairment (except for psychological or psychiatric injuries, which require at least 15% permanent impairment), a further entitlement to lump sum compensation for pain and suffering exists (s 67 of the 1987 Act). For claims lodged on or after 12 January 1997 where the date of injury is on or after 1 February 1992, the maximum amount payable for pain and suffering is $50,000.

“Pain and suffering” is defined in s 67(7) of the 1987 Act to mean actual pain or distress or anxiety suffered or likely to be suffered by an injured worker, whether resulting from the permanent impairment concerned or from any necessary treatment. The more severe a worker’s permanent impairment, the more the worker is likely to suffer and the greater the interference with the worker’s daily living, distress and frustration.

Factors relevant when assessing the amount of compensation for pain and suffering include:

- the actual individual experience by the injured worker including the intensity and duration of the pain and suffering
- the age of the worker
- interference with social activities and the effects on worker’s relationships including marriage
- the type of surgical procedures undergone, the nature of the convalescent process and any complications flowing therefrom
- the need for ongoing medication, and
- difficulty sleeping.

For new and existing claims made or determined on or after 19 June 2012 and where the High Court decision in ADCO Constructions Pty Ltd v Goudappel [2014] HCA 18 applies, there is no longer an entitlement to pain and suffering compensation because s 67 has been repealed by the 2012 amending Act.
[3.560] Property damage
Compensation is payable for damage to artificial limbs, crutches, artificial eyes and teeth, spectacles and clothing (ss 74–78 of the 1987 Act). A wristwatch has been held to be an item of clothing.
In each case it is not enough that the artificial limb, clothing etc is damaged – it is also necessary that the worker personally had an accident arising out of or in the course of employment. Therefore, if a worker falls over at work and breaks his or her glasses, compensation will be payable for repair or replacement of the glasses. If the glasses merely fall off the worker’s head, without an accident, compensation will not be payable for damage to the glasses.
The compensation for property damage is relatively modest. Since 1 February 1992 the maximum amount payable for damage to artificial limbs etc is $2000 and the maximum amount payable for damage to clothing is $600.

[3.570] Compensation in respect of death of a worker
If a worker dies as a result of a work-related injury, dependants of the worker may claim workers’ compensation benefits (s 25 of the 1987 Act). In the event that the worker does not leave dependants (often the case when the worker is a young person), the compensation is paid to the estate of the deceased worker.
Death does not have to be immediate and may occur many years after the injury.
The compensation payable to dependants of the estate of the deceased worker comprises:
- lump sum compensation apportioned between dependants. In the event that there are no dependants, the lump sum is paid to the estate of the deceased worker and distributed to beneficiaries
- additional weekly amounts for the maintenance of children of the deceased worker, payable until the child reaches 16 years of age, extended to 21 years of age for students
- funeral and associated expenses.
The lump sum compensation amount is adjusted periodically, usually on 1 April and 1 October each year. The relevant lump sum amount is the amount payable as at the date of death, not the amount as at the date of claim or date of payment. As at 1 October 2016, the lump sum payable for the death of a worker is $765,650 and the weekly amount payable in respect of each dependent child is $137.10. The maximum amount for reasonable funeral expenses from 5 August 2015 is $15,000. Reasonable funeral expenses include:
  - funeral director’s professional fees
  - the cost of the funeral service (including cremation and burial)
  - coffin
  - mourning car
  - cemetery site
  - flowers
  - newspaper notice, and
  - death certificate.
In addition, the reasonable costs of transporting the deceased worker’s body are payable.
"Dependants" are those members of the worker’s family who were wholly or partially dependent for support upon the worker at the time of death. Members of a family include the worker’s wife or husband, daughter, son, mother, father, grandmother, grandfather, granddaughter, grandson, sister, brother, stepdaughter, stepson, stepmother, stepfather, half-sister and half-brother. An unborn child of a deceased worker is a dependant. Persons who the worker stands in the place of a parent, persons who stand in place of the parent of the deceased worker, de facto partners and divorced spouses may also claim as dependants of a deceased worker. It is not enough that the person is a family member; the person must also establish that they were dependent for support upon the deceased at the time of death.
There is a single lump sum apportioned between all dependants. The same amount applies regardless of how many persons are dependent. The amount apportioned to each dependant is determined having regard to
Making a claim for compensation

[3.580] The Guidelines for Claiming Workers Compensation set out the procedures for:

- the initial notification of an injury
- making and handling of claims for compensation, and
- disputing liability for claims for compensation.

The guidelines aim to:

- ensure the prompt management of a worker’s injury
- ensure a worker’s timely, safe and durable return to work as early as possible after the injury
- give a worker certainty and proper income support while incapacitated as a result of an injury
- facilitate sound decisions regarding claims and reduce disputes.

Further information and assistance regarding making a claim for workers compensation benefits are also available through the Workers Compensation Independent Review Office (see [3.625] Costs of making a claim or pursuing a dispute).

[3.590] Notice of injury

Except in special circumstances, a worker may not make a claim for workers’ compensation benefits unless notice of the injury has been given to the employer as soon as possible after the injury. Special circumstances may be found to exist if the worker was unaware of the requirement to give notice of the injury or where the employer will not be prejudiced by the failure. Notice of the injury is not required where the employer is already aware that the injury occurred.

Notice of injury may be given orally or in writing. A notice of injury must include the following information:

- the name and address of the injured person
- the cause of the injury, and
- the date on which the injury happened.

Employers have responsibility to keep and maintain a register of injuries, which should be readily accessible so that injuries may be recorded.

A person must not make a statement in a notice of injury that they know is false or misleading. Monetary penalties and/or imprisonment may be applied for false or misleading statements.

All employers must notify their insurer or SIRA within 48 hours of becoming aware of a workplace injury where workers’ compensation is payable or may become payable. An employer who fails to notify their insurer or SIRA within 48 hours may be fined.

[3.600] Provisional payments of compensation

If a worker is incapacitated for work as a result of a work injury, the employer’s workers’ compensation insurer must commence provisional payments of weekly compensation to the worker within seven calendar days from the date of notification for an initial period of up to 12 weeks, while the insurer investigates the claim for compensation (s 267 of the 1998 Act). The insurer is
not however required to commence provisional payments if it has a reasonable excuse. A reasonable excuse exists where:
• there is insufficient medical information
• the injured person is unlikely to be a worker
• the insurer is unable to contact the worker
• the injury is not work related
• the injury is not a significant injury
• the injury is notified after two months. During the 12-week period of provisional payments, or up to a further three weeks after the provisional liability period expires, the insurer must make a decision regarding liability for the claim for weekly compensation. The insurer will either accept liability and continue to make weekly payments or it will dispute liability for the claim, notify the worker and cease payments.
If liability is accepted, weekly payments of compensation will continue until such time that the worker returns to work, or reaches retirement age (plus one year), or the insurer is no longer satisfied that the worker is incapacitated for work. During the period of incapacity for work the worker is required to provide ongoing medical certificates. The worker is also required to provide the insurer with authority to allow the insurer to obtain information from the worker’s treating doctors.

An insurer can also provisionally accept liability for the payment of medical and related treatment up to $8,808.80 while it investigates and determines liability for the claim (ss 280 and 297 of the 1998 Act). The intention of provisional payments of medical expenses while liability is still being determined is to ensure an injured worker receives prompt medical attention, so as to lessen the long-term effects of an injury. The payment of medical expenses on a provisional basis is not an admission of liability and the insurer otherwise must make a decision either accepting or denying liability within 21 days after the claim for medical expenses compensation has been made.

[3.610] When to make a claim
Claims for compensation are generally required to be made within six months of the injury (s 261(1) of the 1998 Act). The time for making a claim can be extended, especially if the delay was occasioned by the worker’s ignorance, mistake or absence from New South Wales or for any other reasonable excuse. A claim form may be obtained from the employer or the employer’s workers’ compensation insurer.

If a claim does not exceed the provisional liability period for weekly compensation (12 weeks) or the provisional liability amount for medical expenses compensation ($8,808.80), a claim form will usually not be required. If, however, the insurer has disputed liability to make provisional payments or the compensation claimed exceeds the provisional liability maximums, a claim form must be completed.

A worker who is incapacitated for work as a result of a work injury must provide his or her employer or the employer’s workers’ compensation insurer with a medical certificate that provides sufficient medical information regarding the nature of the injury, the period of incapacity, whether the incapacity for work is total or partial and, if partial, the work restrictions of the worker.

The claim form may be lodged with either the employer or the insurer. If a worker lodges the form with the employer, the employer has seven days to complete their relevant sections and forward it on to the insurer. The insurer has 21 days to gather sufficient information and make a decision on liability for weekly compensation and medical expenses compensation, noting the extended time to determine a claim if provisional payments are being made.

In relation to lump sum compensation entitlements, the insurer will generally require a claim form. The claim form must include relevant particulars about the claim and a medical report from a WorkCover-trained medical specialist that supports the percentage impairment claimed. An insurer must determine a claim for permanent impairment lump sum compensation within two months after the worker has provided the insurer with all relevant particulars about the claim. The insurer may get an independent medical assessment by a WorkCover-trained medical specialist of
their choosing to assist them to determine a claim for permanent impairment.

[3.620] Disputing liability

The reasons an insurer may dispute liability to pay workers’ compensation include:

• the claimant was not a worker as defined by the workers’ compensation legislation
• the worker did not suffer an injury or was not injured as alleged
• the worker’s employment was not a substantial contributing factor to the injury
• the worker is not incapacitated for work as a result of the injury
• the medical treatment was not reasonably necessary
• the worker does not suffer from permanent impairment as a result of the injury or the impairment is not to the extent claimed by the worker.

An insurer must consider all relevant information before disputing liability for a claim and must carry out an internal review of the decision to dispute liability before notifying the worker of the decision (s 74(5) of the 1998 Act).

If an insurer disputes liability, the insurer must provide the worker with a dispute notice that includes, in plain language, the following information:

• a statement of the reason the insurer disputes liability and of the issues relevant to the decision
• a statement to the effect that the worker can request a review of the claim by the insurer
• a statement to the effect that the worker can refer the dispute to the Workers Compensation Commission, being the authority that reviews decisions to dispute liability
• a statement to the effect that the worker can also seek advice or assistance from the worker’s trade union organisation or from a lawyer.

If a dispute is based on the opinion of a medical practitioner, the insurer must attach a copy of the relevant medical report to the dispute notice.

[3.625] Costs of making a claim or pursuing a dispute

Costs in the workers’ compensation scheme prior to the 2012 amending Act used to be determined by the Workers Compensation Commission under the provisions in s 341 of the 1998 Act, where one party to a matter or proceeding was ordered to pay the costs of the other party (“party/party costs”) and the extent of those costs payable. This followed the principle at common law that “costs follow the event”. Hence, the unsuccessful party would usually be ordered to pay the successful party’s costs, subject to other relevant considerations.

The amending Act has since abolished the power of the tribunal to make an order for costs such that s 341 of the 1998 Act now reads that each party is to bear its own costs in relation to a claim, dispute or proceeding, regardless of the outcome of that matter. This costs prohibition applies to any claim or dispute made on or after 1 October 2012 and for which proceedings have been commenced in the Workers Compensation Commission after 2 April 2013. If a claim or dispute was made prior to 1 October 2012 and proceedings had been commenced prior to 2 April 2013, the old costs provisions where “costs follow the event” still apply.

For new claims, however, the costs prohibition appears to contribute to the apprehension of an injured worker in making a claim or pursuing a dispute, in addition to the anticipated complexities of the workers’ compensation legislation. It also seemingly limits a worker’s ability to pursue a claim or dispute, despite its merits, due to this financial hurdle and risk. As part of addressing this concern, the amending Act in establishing the Workers Compensation Independent Review Office (WIRO) has vested it with a specific function of providing funding for legal aid to a lawyer in order to make a claim or pursue a dispute on behalf of a worker.

Among its powers and functions under the amended 1987 Act, the WIRO provides accreditation to legal practitioners who possess sufficient skills and expertise in the
workers’ compensation scheme. The office maintains a roll of approved lawyers that can lodge a legal aid application to fund a worker’s claim or dispute. The WIRO makes an independent and informed decision on whether or not to approve legal funding on the basis of information that the approved lawyer submits as to the merits of the claim or dispute and the reasonable prospects of success of such a case. Funding of a claim or dispute is sourced from a public fund and, if approved, is paid to the approved lawyer, regardless of the outcome of the proceeding. Legal aid is available at all stages of a claim, dispute or proceeding, but WIRO will not fund any action or evidence that had been done or obtained prior to an approval of legal funding.

A worker intending to lodge a claim or pursue a dispute must first inquire with WIRO as to the list of approved lawyers that could deal with the claim or dispute and for further information necessary to seek legal aid funding (www.wiro.nsw.gov.au).

Dispute resolution

[3.630] If a worker does not agree with an insurer’s decision to dispute liability for a claim, the worker may seek either an informal or formal review of the decision.

[3.640] Informal review

A worker may request an insurer to review a claim after the insurer has disputed liability (s 287A of the 1998 Act). The worker may raise further issues and/or provide further information when making a request for review, although this is not essential.

If a worker makes a request for review, the insurer must review the claim within 14 days of receipt of the request. Following review, the insurer may reverse the decision to dispute the claim or confirm the decision to dispute the claim. If the insurer maintains its dispute of the claim, a fresh dispute notice must be issued to the worker.

[3.645] Merit review

If the decision of an insurer is a work capacity decision, made under the provisions for the new weekly payments regime according to the amending Act, and a worker is not satisfied with that decision, the worker may submit an initial informal review with the insurer (s 44(1)(a) of the 1987 Act).

If there is still a dispute after the insurer’s informal review or the insurer has not provided a decision on the internal review within 30 days, the worker may lodge an application to SIRA’s Merit Review Service for a further review (s 44(1)(b) of the 1987 Act).

Within 30 days of receiving the application, the Merit Review Service must make a decision on the merits of the insurer’s decision and how the insurer has come to that decision. The merit reviewer may make a binding recommendation as to what the insurer should do or pay in relation to the worker’s weekly payments or the worker’s capacity for work.

[3.650] Work capacity decision review

If the worker is not satisfied with the decision of the Merit Review Service, a worker may within 30 days lodge an application for a review of that decision with the newly formed Workers Compensation Independent Review Office (WIRO), which under the amending Act has the power and function to perform a further review of the decision.

The WIRO may conduct a review but only on a procedural basis, which means that the review will look into the procedures undertaken by the insurer in making the initial work capacity decision, including the time in which the insurer gave the worker formal notice of the work capacity decision. At the conclusion of the procedural review, the
WIRO may make recommendations that are binding on the insurer in relation to the work capacity decision that was initially made.

If a decision is not a work capacity decision and is instead classified as a decision by the insurer to dispute liability for the claim, then the dispute goes instead to the Workers Compensation Commission after the insurer’s informal review. (Merit reviews and procedural reviews of the WIRO only apply if the issue in dispute is an insurer’s work capacity decision.)

If a work capacity decision has been made and the matter goes to the Workers Compensation Commission on other grounds or issues concerning the weekly payments, the tribunal cannot make a determination of any entitlement or issue that is inconsistent with the work capacity decision (s 43(3) of the 1987 Act). The Workers Compensation Commission cannot make a decision on a dispute concerning a worker’s entitlement to weekly payments while there is a merit review or procedural review of a work capacity decision on foot (s 44(5) of the 1987 Act).

[3.655] Formal review

The Workers Compensation Commission of New South Wales ("the Commission") commenced operation on 1 January 2002 as the forum for resolution of disputed workers’ compensation claims. While not a court, the Commission is nevertheless a statutory body with jurisdiction to deal with all matters arising under the New South Wales workers’ compensation legislation.

If a worker wishes to formally challenge an insurer’s decision to dispute a claim, the worker may lodge an application to resolve the dispute with the Commission. An insurer or employer may also lodge dispute applications for resolution by the Commission.

At the outset, the Commission requires full and frank disclosure of documents between the parties. Therefore, a worker must attach to the dispute resolution application all relevant documents on which the worker proposes to rely. The employer is required to lodge a reply to the application and attach to the reply all relevant documents on which it proposes to rely.

The early exchange of information is intended to fully inform each party of the relevant issues and documents in existence and provides the parties with an opportunity to attempt early resolution of the dispute.

It is usual for each party to be legally represented in proceedings before the Commission and only in a small number of matters do workers proceed without a legal representative. Legal costs are regulated in workers’ compensation matters and workers have a general protection against the payment of legal costs, including their own legal costs, unless the proceedings before the Commission are held to be frivolous, vexatious, fraudulent or made without proper justification (s 341(4) of the 1998 Act, as it then was, before the 2012 amending Act).

Most disputes lodged with the Commission proceed at first instance before an arbitrator. There is a strong focus on resolution of disputes by agreement of the parties. Arbitrators have a legislative requirement to use their best endeavours to bring the parties to a dispute to a resolution acceptable to them (s 355 of the 1998 Act). Failing agreement, an arbitrator will determine a dispute and issue a written decision with reasons for the decision.

Given the focus on resolution by agreement of the parties, it is unsurprising that the first two listings before an arbitrator are a telephone conference (occurring 35 days from the date of lodgment of the dispute resolution application) followed, if necessary, by a face-to-face conciliation conference. The telephone conference is attended by all parties and their legal representatives. It is often the case, although not necessary, for a worker to attend the offices of his or her legal representative for the purposes of participating in the telephone conference. If the parties do not reach a settlement, the arbitrator will set the matter down for a conciliation conference which the parties and their legal representatives are required to attend in person. The same arbitrator will conciliate at the face-to-face conciliation
conference. The face-to-face conciliation conference will be set down at a location suitable to the worker, unless the worker’s legal representative requests a different venue or the arbitrator deems that a different location is preferable.

If the parties remain in dispute at the conclusion of the face-to-face conciliation conference, the arbitrator will proceed to a formal arbitration hearing. The arbitration hearing is held on the same day as the face-to-face conciliation conference and usually follows a short break to allow the parties time to prepare for the arbitration hearing. The same arbitrator who facilitated the conciliation will conduct the arbitration hearing. The arbitration hearing is sound recorded and witnesses may be called to give evidence. At the conclusion of the arbitration hearing, an arbitrator may either give a decision orally or conclude the proceedings and issue a written decision at a later time.

On occasion, a dispute may be determined by an arbitrator on the strength of the documents lodged by the parties, without holding a conciliation conference or arbitration hearing.

The Commission also operates an expedited assessment resolution service for small claims (weekly compensation up to 12 weeks and/or medical expenses up to $8,808.80, as at 30 September 2016) and for work injury management disputes. Matters proceeding to expeditious assessment are listed for telephone conference before the registrar or a delegate of the registrar. The telephone conference is usually held 14 days from the date of lodgment of the dispute resolution application. Expedited assessment applications are usually resolved or determined at the telephone conference and disputes usually do not proceed past this stage.

A medical dispute, being a dispute between a worker and insurer about a medical question including the need for a proposed medical treatment or service (see s 319 of the 1998 Act), will be referred to a Commission-appointed approved medical specialist, who will examine the worker and provide the Commission and the parties with a medical opinion and report regarding the medical dispute. Failing resolution of the matter, the Commission will list the matter before an arbitrator who will conciliate the dispute and, if necessary, hold an arbitration hearing and determine the dispute if the parties fail to reach an agreement.

Common law damages

[3.660] The workers’ compensation scheme is established by legislation. Quite separate to workers’ compensation is a worker’s possible entitlement to damages at common law. It is well established that an employer has a duty of care to all employees to provide a safe place of work, adequate plant and equipment, safe systems of work and the engagement of competent people to carry out the work. In the event that a worker suffers an injury or death as a result of a breach of the employer’s duty of care, the employer may be liable in a claim for damages.

In New South Wales the recovery of damages by injured workers, or their dependants in the case of death of a worker, has been subject to numerous legislative modifications (refer to Berowra Holdings Pty Ltd v Gordon [2006] HCA 32; (2006) 225 CLR 364 per Kirby J for an historical review of the legislation modifying common law damages for work injuries). The current entitlement to common law damages for work injuries was introduced on 27 November 2001 by the Workers Compensation Legislation Further Amendment Act 2001 (NSW).

[3.670] Modified common law damages

Common law damages are an alternative to, and not in addition to, most workers’ compensation benefits. Damages take the
form of a single lump sum payment, calculated to compensate and indemnify a person in monetary terms for the loss they have suffered. In New South Wales, the calculation of damages for work injuries is modified by legislation (refer to Part 5 of the 1987 Act). Section 151G of the 1987 Act provides that the only damages that may be awarded for work injuries are to be calculated having regard to a worker’s past and future economic loss due to the injury. Other heads of damage, including the cost of future medical and related expenses, are not taken into account. Calculating damages for future loss of earnings is restricted to future loss of earning capacity up to pension age (s 151IA of the 1987 Act). The calculation of the present value of future economic loss is also subject to a discount (s 151J of the 1987 Act).

Upon payment of damages an employer ceases to be liable for any further workers’ compensation benefits. In addition, any weekly workers’ compensation benefits already paid are to be deducted from the damages (s 151A of the 1987 Act).

[3.680] Threshold for common law damages

To be eligible to claim work injury damages a worker must have suffered at least 15% permanent impairment as a result of the injury (s 151H of the 1987 Act).

A medical dispute as to whether a worker’s injury satisfies the 15% permanent impairment threshold is resolved by referral of the matter to the Commission. The Commission will refer the medical dispute to an approved medical specialist who will examine the worker and assess the degree of impairment resulting from the injury. The assessment of the degree of permanent impairment by an approved medical specialist is conclusively presumed to be correct (s 326 of the 1998 Act).

The 2012 amending Act has now limited a worker’s ability to obtain a separate medical assessment for the purposes of a threshold matter or dispute (whether or not the degree of permanent impairment is at least 15% WPI). Section 322A of the 1998 Act, inserted by the amending Act, provides that only one medical assessment may be made of an injured worker’s degree of permanent impairment.

Prior to the 2012 amending Act, a worker could obtain a medical assessment for the purpose of a lump sum compensation claim within the statutory scheme and a separate medical assessment for the purpose of a common law damages claim. Section 322A now limits that process, such that a worker’s medical assessment made in relation to a statutory claim for permanent impairment lump sum compensation is also the medical assessment made in relation to a claim for damages at common law.

[3.690] Other restrictions on entitlement to damages

Mitigation

In assessing work injury damages, regard must be had to the reasonable steps taken by an injured worker to reduce the effects of the injury. Relevant factors to be considered include whether the worker sought appropriate medical treatment and rehabilitation, and whether the worker promptly sought suitable employment when fit to return to work (s 151L of the 1987 Act).

Voluntary assumption of risk

While the defence of *volenti non fit injuria* (that to which a man consents cannot be considered an injury – M Woodley (ed), *Osborn’s Concise Law Dictionary* (11th ed, Sweet & Maxwell, London, 2009)) is not available to an employer, the amount of any work injury damages is to be reduced to such extent as is “just and equitable” on the presumption that the injured or deceased worker was negligent in failing to take sufficient care for their own safety (s 151O of the 1987 Act).

Contributory negligence

While not a complete defence, an award of work injury damages may be reduced by such percentage as is “just and equitable” having regard to the worker’s responsibility for the injury (s 151N of the 1987 Act).
Making a claim

A claim for work injury damages cannot be made unless a claim for lump sum workers’ compensation for permanent impairment has been made (s 280A of the 1998 Act).

A work injury damages claim must include details of the alleged economic losses and details of the alleged negligence or other tort of the employer.

A worker making a claim for damages must prove that:

- the injury was reasonably foreseeable. It is not necessary that the employer should have foreseen the precise risk of injury or how it occurred. It is sufficient if the risk was within a class of risk that the employer should have foreseen. It may be reasonably foreseeable even though the injury was unlikely to occur but not if the likelihood of injury was far-fetched or fanciful

- the employer’s failure to take steps to avoid the risk showed a lack of reasonable care for the worker’s safety. What the employer could have reasonably practicably have done to avoid the risk will be relevant

- the employer’s failure to take reasonable care caused the injury or damage that occurred.

A worker may also claim damages for an injury received as a result of the negligent act of a fellow worker. Generally, employers are legally responsible for the acts of their employees.

An employer who can show that no reasonable person could have anticipated what occurred, or that reasonable steps were taken to avoid injury, may not be liable for damages.

Proceedings for work injury damages (excluding dust diseases)

Court proceedings for work injury damages cannot be commenced until a claim for the damages has been made (s 262 of the 1998 Act).

The workers’ compensation legislation also sets out procedures for pre-trial negotiation and mediation in an attempt to facilitate resolution without the need to commence court proceedings.

Pre-filing statement and pre-filing defence

If, after a claim is made, the employer disputes entitlement to damages or the extent of the entitlement, the parties are required to serve on each other their proposed court pleadings (statement of claim and defence). The Workers Compensation Commission Rules 2011 (NSW) (2011 Rules) require that the worker and employer serve with their respective proposed pleadings a copy of all information and documents on which they propose to rely (rr 17.4 and 17.6).

Mediation

A claimant must refer a disputed claim for work injury damages to the Commission for mediation before they can commence court proceedings for the recovery of work injury damages (s 318A of the 1998 Act). An employer may decline to participate in mediation of the claim if the employer wholly disputes liability in respect of the claim, however, in all other cases the employer must participate in the mediation process (s 318A(3) of the 1998 Act). Upon receipt of a mediation application, the Commission will refer the matter to a Commission-appointed mediator who has a legislative mandate to use his or her best endeavours to bring the parties to agreement on the claim (s 318B of the 1998 Act). If a matter fails to resolve at mediation, the mediator will issue a certificate certifying the final offers by the parties. Offers at mediation cannot be disclosed in court proceedings, however, the certificate may be used in relation to arguments over entitlement to legal costs at the conclusion of court proceedings.

Court proceedings

At the conclusion of mediation, if the parties remain in dispute, the claimant may commence court proceedings in a court of competent jurisdiction, usually the District Court of New South Wales. The parties are restricted to the pleadings and supporting documents and information that they served
on each other in the pre-trial dispute resolution process. However, the court may give leave to amend the pleadings or to introduce new evidence.

Court proceedings must be commenced within three years of the injury (s 151D of the 1987 Act), subject to some exceptions.

In proceedings for damages, workers are not afforded the same protection against costs as is afforded in proceedings for workers’ compensation. A worker who does not succeed in common law proceedings to a greater extent than their last offer in the mediation stage may be liable for their own costs and the costs of the other party or parties (refer to Smith v Sydney West Area Health Service (No 2) [2009] NSWCA 62, Chubs Constructions Pty Ltd v Chamma [2009] NSWCA 98 and Pacific Steel Constructions Pty Ltd v Barahona (No 2) [2010] NSWCA 9).

Given the restrictions on entitlement to and calculation of common law damages, and the costs associated with court proceedings, it is often preferable for a worker to remain on workers’ compensation benefits rather than to pursue damages, even though they may have a strong case. This is especially the case where a worker has the need for extensive ongoing medical treatments and services, which have to be personally funded by a worker once a damages settlement or award is received, even though the costs of future medical treatments and services are not taken into account to calculate the amount of damages to which a worker is entitled.

### [3.720] Dust diseases

A worker who suffers from a dust-related condition that results from exposure in his or her employment has an entitlement to pursue damages under a specialist jurisdiction established by the Dust Diseases Tribunal Act 1989 (NSW) (1989 Act). “Dust-related condition” is defined in the 1989 Act to be:

- aluminosis
- asbestosis
- asbestos induced carcinoma
- asbestos related pleural diseases
- bagassosis
- berylliosis
- byssinosis
- coal dust pneumoconiosis
- farmers’ lung
- hard metal pneumoconiosis
- mesothelioma
- silicosis
- silico-tuberculosis
- talcosis, or
- any other pathological condition of the lungs, pleura or peritoneum that is attributable to dust (s 3 and Sch 1 of the 1989 Act).

Claims for dust-related conditions are brought in accordance with the 1989 Act. The 1989 Act establishes a specialist tribunal (Dust Diseases Tribunal of New South Wales) to hear and determine damages claims.
Contact points

[3.730] If you have a hearing or speech impairment and/or you use a TTY, you can ring any number through the National Relay Service by phoning 1300 677 (TTY users, chargeable calls) or 1800 555 677 (TTY users, to call an 1800 number) or 1300 555 727 (Speak and Listen, chargeable calls) or 1800 555 727 (Speak and Listen, to call an 1800 number). For more information, see www.relayservice.gov.au.

Non-English speakers can contact the Translating and Interpreting Service (TIS National) on 131 450 to use an interpreter over the telephone to ring any number. For more information or to book an interpreter online see www.tisnational.gov.au.

Aboriginal Medical Service
ph: 9319 5823

Animal Welfare Branch
NSW Primary Industries
livestock/animal-welfare
ph: 6391 3149

Animal Welfare League (NSW)
www.animalwelfareleague.com.au
ph: 8899 3333

Ingleside Shelter
ph: 8899 333

Kemps Creek Shelter
ph: 8777 4424

Attorney General & Justice,
Victims Services
gov.au/vs/vs_index.html

Australasian Legal Information Institute (AustLII)
www.austlii.edu.au

Australian Industrial Relations Commission
www.airc.gov.au
ph: 8374 6666
out of hours emergency: ph: 0419 318 011

Centrelink
www.centrelink.gov.au

Comcare Australia
www.comcare.gov.au
ph: 1300 366 979

CRS Australia
www.crsaustralia.gov.au
ph: 1800 277 277

Fair Trading, Office of
www.fairtrading.nsw.gov.au
ph: 133 220 or 9895 0111
For a list of regional offices see Chapter 10, Consumers, Contact points.

Health Care Complaints
Commission (HCCC)
www.hccc.nsw.gov.au
ph: 1800 043 159 or 9219 7444

Insurance & Care NSW (iCare)
www.icarensw.gov.au

LawAccess NSW
www.lawaccess.nsw.gov.au

Law and Justice Foundation of
NSW
www.lawfoundation.net.au

Legal Aid NSW
www.legalaid.nsw.gov.au

Metropolitan offices in Ashfield,
Bankstown, Blacktown, Campbelltown, Chatswood,
Darlinghurst, Dee Why, Epping,
Fairfield, Hurstville, Liverpool,
Manorba, Marrickville, Mt Druitt,
Parramatta, Penrith, Rockdale,
Sutherland, Windsor.

NSW regional offices in Albury,
Armidale, Ballina, Batemans Bay,
Bathurst, Bega, Broken Hill,
Bunswick Heads, Charlestown,
Coffs Harbour, Deniliquin, Dubbo,
Gosford, Goulburn, Grafton,
Griffith, Katoomba, Kempsey,
Lismore, Macksville, Maitland,
Merimbula, Mittagong, Moree,
Mudgee, Nambucca Heads,
Newcastle, Nowra, Orange, Port
Macquarie, Queanbeyan,
Shellharbour, Tamworth, Taree,
Tuncurry, Wagga Wagga,
Wallsend, Wollongong, Woy Woy,
Wyong.

Medicare enquiries
(Medicare Australia)
www.medicareaustralia.gov.au
ph: 132 011

Motor Vehicle Repair Industry
Authority
www.fairtrading.nsw.gov.au
ph: 9895 0696

NRMA
www.nrma.com.au
Member Legal Service
www.mynrma.com.au
ph: 131 122

Police, NSW
www.police.nsw.gov.au
ph: 9281 0000
Customer Assistance Unit
ph: 1800 622 571

Insurance Services Unit
ph: 8835 8377
Police Assistance Line
ph: 131 444

Private Health Insurance
Ombudsman
www.phio.org.au
ph: 1800 640 695 or 8235 8777

Roads & Maritime Services
www.rma.nsw.gov.au
ph: 132 213

For location and business hours of motor registries ring the number above.
Royal Society for the Prevention of Cruelty to Animals (RSPCA)
www.rspcansw.org.au
ph: 9770 7555 or 1300 278 3589

State Insurance Regulatory Authority
www.sira.nsw.gov.au
ph: 1300 137 131

Unions NSW
www.unions.nsw.gov.au
ph: 9881 5999

Workers Compensation Commission
www.wcc.nsw.gov.au
ph: 1300 368 040

Interpreter service
ph: 131 450

Workers Compensation Independent Review Office (WIRO)
www.wiro.nsw.gov.au
ph: 13 94 76