The Law Handbook

YOUR PRACTICAL GUIDE TO THE LAW IN NEW SOUTH WALES

15th EDITION

THOMSON REUTERS

REDFERN LEGAL CENTRE PUBLISHING

Published in Sydney
by Thomson Reuters (Professional) Australia Limited
ABN 64 058 914 668

19 Harris Street, Pyrmont NSW 2009
First edition published by Redfern Legal Centre as *The Legal Resources Book (NSW)* in 1978.
First published as *The Law Handbook* in 1983
Second edition 1986
Third edition 1988
Fourth edition 1991
Fifth edition 1995
Sixth edition 1997
Seventh edition 1999
Eighth edition 2002
Ninth edition 2004
Tenth edition 2007
Eleventh edition 2009
Twelfth edition 2012
Thirteenth edition 2014
Fourteenth edition 2016
Fifteenth edition 2019

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ISBN: 9780455243689

This edition is up to date as of 1 October 2019.

The Law Handbook is part of a family of legal resource books published in other states:
Vic: *The Law Handbook* by Fitzroy Legal Service, ph: (03) 9419 3744
SA: *Law Handbook* by the Legal Services Commission of South Australia, ph: (08) 8111 5555
Qld: *The Queensland Law Handbook* by Caxton Legal Centre, ph: (07) 3214 6333
Tas: *Tasmanian Law Handbook* by Hobart Community Legal Service, ph: (03) 6223 2500
NT: *The Northern Territory Law Handbook* by Northern Territory Legal Aid Commission, Australasian Legal Information Institute and Darwin Community Legal Services, ph: (08) 8982 1111

Editor: Newgen Digitalworks
Product Developer: Karen Knowles

Printed by: Ligare Pty Ltd, Riverwood, NSW

This book has been printed on paper certified by the Programme for the Endorsement of Forest Certification (PEFC). PEFC is committed to sustainable forest management through third party forest certification of responsibly managed forests.

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Accidents and Compensation*

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* Dedicated to the memory of Ramon Loyola who was a valued contributor to this chapter of The Law Handbook for many years.

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; *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" (ie, 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.

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).

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.

[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.

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.

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

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.

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.

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* 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.

Injuries to animals

[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 (eg, shooting the dog);
- *an action on the case* (a very old common law action) applies, where the damage occurs indirectly (eg, 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 ss 126, 132, 503 and 505 of the *Crimes Act 1900* (NSW).

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

The *Prevention of Cruelty to Animals Act 1979* (NSW) contains many provisions relating to ill-treatment of 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* (see [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, that is:

- 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*, a conviction for alcohol-related driving offences, and the tests related to them, is 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 [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 [3.160]);
- pay the cost of repair themselves;
- demand payment from the other party and sue them if necessary (see [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.

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
- after processing the claim, the insurer was able to recover damages from the other driver.

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.

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.

[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 [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.

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.

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 [3.190]).

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 at [3.170]).

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 (eg, 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 substantial (say, over $1,000) 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 from 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) 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) at [3.300].

If the insurance company:

- does not reply; or
- refuses to accept liability (because, eg, 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) 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) 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).

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) 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.

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) 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 at [3.190]).

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 can arrange for it to be served on the other party.

Fees

For claims up to $10,000, the fees are:

- $103 for lodging the statement of claim, plus;
- $44.00 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.

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 (eg, 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 (ie, 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 Authority. Ph 02 9712 2200 (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) and *Motor Accident Injuries Act 2017* (NSW) (for injuries occurring on or after 1 December 2017).

The Acts apply 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.

[3.225] Motor Accidents Compensation Act 1999

Please note paragraphs [3.230]–[3.280] relate to injuries after 5 October 1999 and before 1 December 2017 which are covered under the *Motor Accidents Compensation Act 1999*.

[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 [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 [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.

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 [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.

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.

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.

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 or 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 [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 at [3.250]).

[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? at [3.250]).

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 at [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 (ie, pain and suffering) are restricted to a maximum of $565,000 (as at 1 October 2019 – 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 settling the claim.

[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* (eg, 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.

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.

[3.285] Motor Accident Injuries Act 2017

This section is applicable to the accidents that occur on or after 1 December 2017.

New regime

The most significant difference from previous motor accidents compensation and insurance schemes is the Act introduces two types of claims: claims for statutory benefits and claim for common law benefits. Each claim has separate forms, processes and procedures.

Legislative framework

- *Motor Accident Injuries Act 2017*;
- *Motor Accident Injuries Regulation 2017* (NSW);
- *Motor Accident Guidelines*.

Statutory entitlements

Statutory entitlements include income support payments, medical expenses (including dental, pharmaceutical and rehabilitation), cost of travel, personal care and help around home.

Income support payments (also called weekly payments) will be a percentage of an injured person's pre-accident earnings.

For the first 13 weeks, the maximum is 95% of an injured person's pre-accident earnings, then 85% (depending on whether the injured person has total or partial loss of earning capacity).

Statutory entitlements are accessible by every injured person, regardless of the fault of the driver/owner/injured person, up to six months (26 weeks) post accident. Anyone injured in a motor vehicle accident in NSW can apply (including pedestrians, riders, pillion passengers and cyclists).

Only seriously injured claimants (claimant with injuries that are "non-minor" – see below for more information about non-minor injuries) and who are not wholly or mostly at fault are entitled to statutory benefits after first 26 weeks.

"Mostly at fault" is defined as greater than 61% contributory negligence (*Act*, s 3.36). Note that if the owner/driver of an uninsured car wholly or mostly at fault – no statutory benefits are payable (s 3.36).

By alleging contributory negligence in access of 61%, the insurer will avoid liability for weekly benefits and treatment expenses after 26 weeks. Therefore, careful consideration must be given to circumstances in which contributory negligence will be found (*Act*, s 3.38).

No statutory benefits are payable if the injured person has a workers compensation claim, if the claimant has been charged with or convicted of

a serious driving offence, or if the claimant is the owner or driver of an uninsured vehicle.

Common law benefits

This is a lump sum compensation with two types of damages that may be awarded: damages for economic loss and/or damages for non-economic loss. No award for past or future treatment and care is allowed (even when claim for statutory benefits was not made or denied). The Common law benefits claim is available only to claimants who have more than minor injuries and who were not at fault in the accident.

A Claim Form should be lodged with the CTP insurer of the vehicle at fault. If there is no at-fault driver or they cannot be identified, the claim should be lodged with SIRA to be forwarded to the "Nominal Defendant" – an insurer assigned responsibility for the claim by SIRA.

If a person is killed in the car accident, then "reasonable" funeral expenses can be claimed as a statutory benefit. The costs of the head stone and the dependents' claim for financial support are common law claims.

Time limits

Claim for statutory benefits

A specially prescribed Application for Personal Injury Benefits form and Certificate of Fitness must be lodged with the insurer of the vehicle that is believed to be most at fault. Or call SIRA CTP assist for help (1300 656 919).

To receive back-pay from the date of the accident – the above forms must be lodged with the insurer within 28 days of the accident.

Otherwise, these forms must be lodged with the insurer within three months. Late service will require "full and satisfactory" explanation for the delay (s 6.14).

Claim for common law benefits

A claim for damages must be made within three years of the date of the motor accident.

If injuries are assessed at 10% of "whole person impairment" or less – no claim for damages can be made until 20 months have passed since the accident.

If injuries are assessed at 11% of "whole person impairment" and more – claim for damages can be made any time within three years.

The first claims lodged, since the introduction of the scheme, will reach the 20-month period in around October 2019. To date, practitioners would have primarily dealt with the statutory benefits scheme under the Act.

Minor injuries

If an injured person suffered only has "minor injuries", his entitlements to statutory benefits will cease after first 26 weeks after the date of the accident (but note clause 5.16 of the *Motor Accident Guidelines* for circumstances, where payments for treatment expenses can be made to claimants with minor injuries and beyond 26 weeks).

Also, "minor injuries" means no damages may be awarded in a common law claim.

Given the significance of the distinction, it is essential to understand the difference between a minor injury and non-minor injury. For definition, see:

- *Motor Accident Injuries Act 2017* (s 1.6);
- *Motor Accident Injuries Regulation 2017* (cl 4);
- *Motor Accident Guidelines* (Chapter 5).

Section 1.6 of the *Act* defines minor injury as a sort tissue injury or a minor psychological injury or psychiatric injury.

Section 1.6(2) states that a minor injury is an injury "to tissue that connects, supports or surrounds other structures or organs of the body, but not an injury to nerves or a complete or partial rupture of the tendons, ligaments, menisci or cartilage".

A minor psychological or psychiatric injury is an injury that is not a recognized psychiatric illness (s 1.6(3)).

SIRA website contains summaries of minor injuries decisions made by medical assessors (https://www.sira.nsw.gov.au/disputes-and-complaints/decisions/record/).

Termination of statutory benefits

Statutory benefits stop after six months for injured person at fault (responsible for the accident) or those "mostly at fault" (with contributory negligence of more than 61%) and for injured person of minor injuries.

For injured people not at fault, weekly income support payments can last for up two years. The payments are extended if an injured person has a

pending common law claim: with injuries under 10% whole person impairment – payments can be extended to three years; and with injuries at 10% and more – to five years.

The insurer can make decisions about the injured person's pre-accident earning capacity or post-accident earning capacity at any time during the course of the statutory claim. Chapter 4 of the *Motor Accident Guidelines* states that the insurer may follow its own procedure but must align with the following principles:

- 4.47.1 Insurers comply with statutory duties;
- 4.47.2 Claimants are given procedural fairness;
- 4.47.3 Communication is in plain language;
- 4.47.4 Insurers fix errors promptly.

Dispute resolution

If an injured person disagrees with the insurer's decision, they may seek an internal review of that decision. Request for review must be made within 28 days of receiving the insurer's decision. Late applications may be declined by the insurer. The reviewer will consider the initial decision and any further information that an injured person will provide with the review application.

If the review application is accepted, the insurer will provide the outcome (issue certificate of assessment and "reasons" for the decision) within 14–21 days. If further information needs to be requested, the time for provision of the outcome can be extended to maximum 28 days.

If an injured person is still not satisfied with the outcome, they can refer that dispute to SIRA for determination.

The Act creates a new unit within the SIRA – Dispute Resolution Service (DRS).

See Sch 2 of the *Act* for the list of disputes that may arise during the course of a statutory benefits claim or a common law claim and that are subject to DRS jurisdiction.

An injured person must complete a short application form in order to refer a dispute to DRS.

There are four broad categories which DRS uses to categorise and assess a dispute:

- merit review (about weekly benefits, treatment, care and other related disputes);
- medical assessments (about medical issues such as permanent impairment, earning capacity, minor injury and other related disputes);
- disputes about damages;
- miscellaneous claims assessments.

Contributory negligence

Clauses 4.41 and 4.42 of the *Motor Accident Guidelines* require the insurer, when considering liability, to provide:

> Reasons for the determination, the nature and source of evidence, a copies of all relevant documents and information considered in the making of the determination, regardless of whether the information or document supports the reasons for the determination.

A mere denial of liability without the provision of all relevant documents will be in breach of the Guidelines. Lawyers for the injured person must ensure that adequate reasons and copies of all relevant documents were provided.

Because statutory benefits are not payable after six months (26 weeks) for injured person who are mostly at fault (ie, people whose contributory negligence is assessed at 62% and higher), there is an incentive for the insurer to make findings of contributory negligence of 62% and higher. Section 3.38 of the *Act* provides circumstances, where contributory negligence will be found:

- conviction of drug or alcohol-related offences;
- being a voluntary passenger with a driver affected by alcohol or drugs;
- not wearing a protective helmet;
- voluntary assumption of risk; and
- other conduct defined by the *Motor Accident Injuries Regulation 2017*.

Relevant case law needs to be considered when determining contributory negligence.

Statutory income support benefits can be reduced on account of the claimant's contributory negligence if it is assessed at 61% or less.

Blameless accidents and statutory benefits

Blameless accidents are now referred to as "no fault motor accidents" (*Act*, Pt 5).

Single vehicle accidents are not excluded from the scheme. Drivers of single-vehicle accidents who are partially at fault and not mostly at fault (contributory negligence at less than 62%) are

entitled to statutory benefits providing their injuries are non-minor.

There are matters currently before the Supreme Court, where the no-fault and liability provisions are being tested.

Going to court and limitation period

Same as in the previous scheme – most motor accident cases do not go to court. Instead, they are assessed by DRS Assessors, who are experienced solicitors and barristers appointed by SIRA (called CARS Assessor in the previous scheme).

The claims must be exempt from assessment before proceedings can be commenced in court. There are limited cases that can be exempt from assessment (*Motor Accident Injuries Regulation 2017*, s 14): claims involving children or people who lack legal capacity, claims made against a person other than the insurer; when the insurer makes an allegation of fraudulent conduct on behalf of the claimant; when insurer declines indemnity.

Restriction on health practitioners who can give evidence in DRS proceedings and court

Section 7.52 of the *Act* states that only treating health practitioners and practitioners authorized by the *Motor Accident Guidelines* can give evidence (in court or DRS proceedings) in relation to a medical matter. "Medical matter" means degree of impairment of an injured person and medical assessment matter of a kind prescribed by the regulations.

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.

SAMPLE LETTERS

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

..... [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 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]

..... [name of insurance co]

..... [address of insurance co]

Dear sir/madam

Accident on ..... [date] at ..... [place of accident]

I am the owner of motor vehicle number ..... [registration number] which was involved in an accident with motor vehicle number ..... [registration number] owned by your insured Ms/Mr ..... [name of insured].

I enclose a copy of a letter of demand sent to [her or him] together with a quotation for the damage. I will be happy to arrange for 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 ..... 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]

[3.330] (5) Letter of demand – insurance excess

..... [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

The New South Wales workers compensation scheme

[3.340] Background

A worker who suffers an injury that results in an incapacity for work and/or the need for medical treatment and/or permanent impairment and/or damage to property, 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 deceased at the time of their death, or the deceased worker's estate (if there are no dependants), may also be entitled to workers compensation benefits.

[3.350] Legislation

New South Wales has a statutory scheme of workers compensation benefits. There are three Acts that are relevant to the scheme:

1. *Workers Compensation Act 1926* (NSW) (the *1926 Act*), which is relevant to injuries that occurred prior to 1 July 1987 and claims made by Coal Miners;
2. *Workers Compensation Act 1987* (NSW) (the *1987 Act*), which is relevant to injuries that occurred on or after 4 pm on 30 June 1987, and governs the benefits that are payable with respect to workplace injuries and compulsory insurance requirements for employers; and
3. *Workplace Injury Management and Workers Compensation Act 1998* (NSW) (the *1998 Act*), which provides for scheme administration, injury management and dispute management procedures.

The *1987 Act* and the *1998 Act* are supported by the *Workers Compensation Regulation 2016* (NSW) (the *2016 Regulation*), several Guidelines (published by the State Insurance Regulatory Authority (SIRA)) and several Practice Directions (published by the Workers Compensation Commission (WCC)). Links to the legislation, regulation, guidelines and practice directions are available on the websites of both the WCC (www.wcc.nsw.gov.au) and SIRA (www.sira.nsw.gov.au).

[3.360] Entitlement to workers compensation benefits

Section 9 of the *1987 Act* provides that a worker who has received an injury (and, in the case of their death, their dependants) shall receive compensation from the worker's employer, and the compensation is payable whether the injury was received at or away from their place of employment.

The fundamental concepts of "worker", "injury" and "compensation" have been the subject of legislative amendments and judicial determinations since the introduction of the first statutory scheme in 1926.

There are currently three schemes of statutory benefits in operation in NSW. These are:

1. the *1926 Act*, which remains in force for injuries that occurred before 1 July 1987;
2. the *1987 Act* as it existed before the *Workers Compensation Legislation Amendment Act 2012* (NSW) (the *2012 amendments*), which applies to Exempt Workers (Police Officers, Paramedics and Firefighters, Coal Miners, Emergency Services Volunteers and claims made under the *Workers Compensation (Dust Diseases) Act 1942* (NSW)); and
3. the *1987 Act* following the *2012 amendments*, which applies to claims for injury suffered on or after 1 July 1987 by non-exempt workers.

The 2012 amendments

The *2012 amendments* significantly altered the benefits payable to non-exempt workers under the statutory scheme and took effect on 1 October 2012. As a result:

- the insurer was required to "transition" all open claims with respect to injuries suffered before 1 October 2012 from the previous statutory scheme to the current statutory scheme by conducting a work capacity assessment and making a work capacity decision;
- a bifurcated system of dispute resolution was introduced under which:
  - an administrative law pathway applied to the review of work capacity decisions, which removed the WCC's power to make a determination in relation to weekly payments that was contrary to the insurer's work capacity decision and to award weekly payments after the worker had received payments for an aggregate of 130 weeks;
  - the WCC retained its jurisdiction to determine liability, the entitlements to lump sum compensation for permanent impairment, medical and related treatment expenses and property damage;
  - the WCC lost its jurisdiction to make a determination regarding weekly payments that was contrary to an insurer's work capacity decision and to award weekly payments once the worker had received payments for a cumulative total of 130 weeks; and
  - the WCC lost its jurisdiction to award costs under Sch 6 of the *Workers Compensation Regulation*, in respect of claims made by non-exempt workers;
- s 59A of the *1987 Act* was introduced. This reduced the period in which a worker could recover medical and related treatment expenses under s 60 of the *1987 Act* to a period of 52 weeks from the last date on which weekly payments were paid in respect of an injury.

The 2015 amendments

The statutory scheme was further amended by the *Workers Compensation Amendment Act 2015* (NSW) (the *2015 amendments*) by significantly increasing the amount of compensation payable in respect of the death of a worker and extending a worker's entitlement to compensation for medical and related treatment expenses by reference to the degree of permanent impairment that resulted from an injury.

The *State Insurance and Governance Act 2015* (NSW), which commenced on 1 September 2015, abolished the WorkCover Authority of New South Wales and created three independent agencies with distinct functions:

- the State Insurance Regulatory Authority (SIRA), which assumed the regulatory functions of WorkCover (with respect to workers compensation insurance), the Motor Accidents Authority (with respect to Compulsory Third Party (CTP) insurance) and management of the Home Building Compensation scheme;
- Insurance & Care (NSW) (iCare), which is an insurance and care service provider for injured workers (including the Workers Compensation Nominal Insurer) and a service provider for claimants under the Lifetime Care and Support Authority, the Dust Diseases Authority, SICorp and the Sporting Injuries Compensation Authority; and
- Safework NSW, which regulates workplace health and safety.

On 27 August 2015, in *Cram Fluid Power Pty Ltd v Green* [2015] NSWCA 250 (*Cram Fluid*), the New South Wales Court of Appeal considered the interpretation of s 66(1A) of the *1987 Act* and determined that a worker who had made a claim for compensation for permanent impairment under s 66 of the *1987 Act* before 19 June 2012 (when s 66(1A) commenced), was not entitled to make a further claim for compensation for permanent impairment.

However, the effect of the decision in *Cram Fluid* was overcome by the *Workers Compensation Amendment (Lump Sum Compensation Claims) Regulation 2015* (NSW) (the *2015 amending Regulation*), which is now found in cl 11 of Sch 6 of the *2016 Regulation*. This permits a worker who made a specific claim for lump sum compensation for permanent impairment before 19 June 2012 to make one (and only one) further claim under s 66 of the *1987 Act* after 19 June 2012.

For the purposes of the one further claim, the threshold imposed by s 66(1) of the *1987 Act* ("greater than 10%") does not apply and the worker need only prove that there has been an increase in the degree of permanent impairment resulting from the injury since their previous claim was resolved.

Worker

[3.370] Who is a worker?

The entitlement to compensation under the statutory scheme depends upon the claimant proving that they are a worker.

"Worker" is defined in s 4 of the *1998 Act*, which provides:

> ***worker*** means a person who has entered into or works under a contract of service or a training contract with an employer (whether by way of manual labour, clerical work or otherwise, and whether the contract is expressed or implied, and whether the contract is oral or in writing). ***However, it does not include***:
>
> (a) a member of the NSW Police Force who is a contributor to the Police Superannuation Fund under the *Police Regulation (Superannuation) Act 1906*, or
>
> (b) a person whose employment is casual (that is for 1 period only of not more than 5 working days) and who is employed otherwise than for the purposes of the employer's trade or business, or
>
> (c) an officer of a religious or other voluntary association who is employed upon duties for the association outside the officer's ordinary working hours, so far as the employment on those duties is concerned, if the officer's remuneration from the association does not exceed $700 per year, or
>
> (d) except as provided by Schedule 1, a registered participant of a sporting organisation (within the meaning of the *Sporting Injuries Insurance Act 1978*) while:
>
> (i) participating in an authorised activity (within the meaning of that Act) of that organisation, or
>
> (ii) engaged in training or preparing himself or herself with a view to so participating, or
>
> (iii) engaged on any daily or periodic journey or other journey in connection with the registered participant so participating or the registered participant being so engaged,
>
> if, under the contract pursuant to which the registered participant does any of the things referred to above in this paragraph, the registered participant is not entitled to remuneration other than for the doing of those things.

A contract of service is distinct from a contract for services. A contract for services typically involves an independent contractor, who is often a tradesperson, being contracted to perform a specific task. A person working under a contract for services is not "a worker" and is not entitled to compensation under the scheme.

A contract of service does not need to be in writing, but the absence of a written contract may result in a dispute regarding the precise nature of the relationship between the parties and the terms that the parties agreed to.

The claimant bears the onus of proving the essential features of a contract, namely: (1) an offer of employment; (2) the acceptance of that offer; (3) consideration (being the value of the contract); and (4) an intention to create legal relations.

In most cases, consideration will be in the form of money paid (ie, wages or salary) in exchange for a person's labour, although it can include anything with a value such as the provision of food and accommodation.

If it is unclear whether a contract of service exists, it is necessary to apply the indicia of employment test and the Courts and the WCC have determined that the indicia that are to be weighed include:

- ***Control***

  This is considered the most important feature of an employment relationship and includes the rights: to direct what work is to be performed and how it is to be performed; to approve or not to approve whether a person may take leave; and to dismiss the person or terminate the relationship.

- ***Hours of work and method of payment***

  The right to determine the hours of work and days of attendance is a classic feature of an employment relationship, as is the method of payment. Workers will usually be paid at an hourly rate and have tax deducted from that payment before they receive it. However, an independent contractor will usually perform a specific job for a fixed fee that includes GST and will be responsible for payment of their own tax.

- ***Provision of tools, material and plant***
  Where an employment relationship exists, the employer generally provides and maintains all tools, equipment and business premises. However, independent contractors generally supply and maintain their own tools, equipment and plant.
- ***Entitlements other than remuneration***
  Workers are usually engaged under an award, an Enterprise Bargaining Agreement or a Workplace Determination, which governs their entitlement to paid leave (including annual leave, sick leave, long service leave etc).
- ***Exclusivity of services***
  An employer is usually entitled to the person's labour or services exclusively. However, the person may be permitted to provide labour or services to another person with the employer's express consent.
- ***No right to employ other workers or to delegate the work***
  A worker cannot employ other persons to do the work or otherwise enter into a sub-contract arrangement with respect to their work.
- ***Intention to enter into a legal relationship***
  It is essential that the parties intended to enter into a legal relationship at the time that they entered into the contract.

These indicia are not exhaustive and none are alone determinative of the existence of an employment relationship. Therefore, a merits-based assessment is required in each matter.

[3.380] Volunteers

Under the terms of the *Workers Compensation (Bush Fire, Emergency and Rescue Services) Act 1987* (NSW), volunteer bushfire fighters, volunteer surf lifesavers and SES volunteers are entitled to compensation under the statutory scheme if they suffer an injury in the course of undertaking "volunteer activities".

However, a volunteer who is otherwise injured at work premises is not entitled to benefits under the statutory scheme, as they are unable to establish the essential elements of a contract of service.

[3.390] Deemed workers

Schedule 1 of the *1998 Act* deems certain persons to be workers for the purposes of the statutory scheme even though they do not satisfy the definition of "worker" under s 4 of the *1998 Act*. The categories of deemed workers include taxi drivers, jockeys and harness racing drivers, ministers of religion, entertainers and performers such as professional boxers, wrestlers and referees.

[3.400] Excluded workers

In addition to the categories of excluded workers found in s 4 of the *1998 Act*, miners who suffer a dust disease and persons employed by the Commonwealth or by a Commonwealth authority or licensed corporation are also specifically excluded from the statutory scheme.

[3.410] Illegal employment

If the claimant suffers an injury while engaged under an illegal contract of service or a training contract, that claim may be dealt with as if they were a worker engaged under a valid contract (s 24 of the *1987 Act*).

This issue frequently arises where there is evidence that the claimant did not hold a valid work visa when the injury occurred and they were prohibited from legally undertaking work in Australia.

The Courts and the WCC have consistently held that despite the illegal nature of the employment, the claimant is entitled to benefits under the statutory scheme provided that the injury arises out of or in the course of employment (see, eg, *Nonferral (NSW) Pty Ltd v Taufia* (1998) 43 NSWLR 312; *Singh v TAJ (Sydney) Pty Ltd* [2006] NSWCA 330).

Injury

[3.420] What is an injury?

Once it is established that the claimant is a worker or deemed worker, it is necessary to consider whether they suffered an injury as defined in s 4 of the *1987 Act* and s 4 of the *1998 Act*.

Section 4(a) of the *1998 Act* provides that injury "means a personal injury arising out of or in the course of employment".

Section 4(b) of the *1998 Act* provides that "injury" includes:

(i) a disease contracted by a worker in the course of employment, where the employment was a contributing factor to the disease, or

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

However, s 4(c) of the *1998 Act* excludes – except in the case of a worker employed in or about a mine:

(i) a dust disease, or

(ii) the aggravation, acceleration, exacerbation or deterioration of a dust disease.

Proving that a worker has suffered a work injury is relatively simple, where there is an identifiable incident or traumatic event, for example, a fall at work that results in a broken arm or other internal damage to the body (such as a hernia or disc lesion) or external damage to the body (such as cuts or abrasions). However, that task becomes more difficult when there is no identifiable incident or traumatic event or when a worker suffers from a disease that could also be attributed to non-work factors.

Claims for compensation are frequently made in respect of an injury is alleged to have resulted from repeated trauma that has the cumulative effect of producing a pathological change. This mechanism of injury is commonly referred to as "the nature and conditions of employment".

The worker bears the onus of proving the existence of a sudden, identifiable pathological change (*Castro v State Transit Authority (NSW)* [2002] NSWCC 12; (2002) 19 NSWCCR 496).

The *2012 amendments* amended the definition of injury in s 4(b) of the *1987 Act* to include "disease injury", which means:

(i) 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

(ii) 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 … (emphasis added)

The worker bears the onus of proving that employment was the *main contributing factor* to the contracting of, or to the aggravation, acceleration, exacerbation or deterioration of a disease injury.

Section 2A(2) of the *1987 Act* provides that the *1987 Act* is to be construed with, and as if it formed part of the *1998 Act*. Therefore, a reference in the *1987 Act*, to the *1987 Act*, includes a reference to the *1998 Act*. In the event of an inconsistency between the *1987 Act* and the *1998 Act*, the *1998 Act* prevails to the extent of the inconsistency (s 2A(3) of the *1987 Act*).

Section 4 of the *1998 Act* does not require work to be the *main contributing factor* in disease cases, whereas s 4 of the *1987 Act* does. This is clearly an inconsistency between the *1987 Act* and the *1998 Act* and if s 2A(2) of the *1987 Act* was strictly construed, there would be no requirement for *main contributing factor* to be established under either Act.

[3.430] Arising out of or in the course of employment

The worker must also prove that the injury arose out of or in the course of their employment.

"Arising out of employment" suggests a causal connection between the employment and the injury, whereas "in the course of employment" suggests a temporal connection between the injury and employment.

"Arising out of employment" has a fairly wide import and a worker can suffer an injury arising out their employment even though they were not doing their job when the injury occurred. For example, an injury that resulted from a verbal exchange between a worker and his supervisor about the work to be performed may be said to arise out of employment.

An injury that occurred away from the workplace and/or outside normal working hours may, in certain circumstances, also be found to have arisen in the course of employment. For example, where an employer induces or encourages the worker to participate in an activity outside of work, such as attending a work social function.

However, the employer's mere authorisation to engage in such an activity will not generally be sufficient and actual inducement or encouragement by the employer must be established.

[3.440] Disease injury

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 Ermington Hotel* [1998] NSWCC 14; (1998) 16 NSWCCR 253).

The wide interpretation of what constitutes a disease at law can be applied to many injuries, where the mechanism of injury is the nature and conditions of the worker's employment.

Clause 4 of Sch 1 of the *2016 Regulation* prescribes a number of occupations in which it is accepted that a worker has an increased risk of contracting specific diseases. For example, Brucellosis, Leptospirosis and Q fever are deemed to be work-related if the worker was employed in an abattoir.

While not prescribed in Sch 1 of the *2016 Regulation*, it is not uncommon for shearers to contract Q fever and while the test of "main contributing factor" in s 4(b) of the *1987 Act* would apply to such a claim, it is unlikely that an employer would successfully dispute the issue of causation.

Where the injury is the "aggravation, acceleration, exacerbation or deterioration of a disease", it is not necessary that the disease was originally contracted in the course of the employment. It is sufficient that the employment is the main contributing factor to the aggravation etc.

[3.450] Employment as a substantial contributing factor

Where the worker suffers a personal injury (as defined in the *1987 Act*, s 4(a)), they are not entitled to compensation for that injury unless the employment concerned was a substantial contributing factor to the injury (the *1987 Act*, s 9A(a)).

Section 9A(2) of the *1987 Act* provides examples of matters to be considered when determining whether employment was a substantial contributing factor to an injury, namely: (1) the time and place of the injury; (2) the nature of the work performed and the particular tasks of that work; (3) 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. However, this list is not exhaustive.

Section 9A(3) of the *1987 Act* provides that a worker's employment is not to be regarded as a substantial contributing factor to a worker's injury merely because of either or both of the following:

(a) the injury arose out of or in the course of, or arose both out of and in the course of, the worker's employment,

(b) the worker's incapacity for work, loss as referred to in Division 4 of Part 3, need for medical or related treatment, hospital treatment, ambulance service or workplace rehabilitation service as referred to in Division 3 of Part 3, or the worker's death, resulted from the injury.

Whether the employment is a substantial contributing factor to an injury is a question of fact that requires an analysis of the causal factors in each matter.

Section 9A does not apply to claims made under s 10 of the *1987 Act* (journey claims), s 11 of the *1987 Act* (recess claims), s 12 of the *1987 Act* (claims by trade union representatives) and claims, where the injury is a heart attack and/or stroke (s 9A(4)).

Heart attack and stroke injuries

Section 9B(1) of the *1987 Act* provides that no compensation is payable in respect of an injury that consists of, is caused by, results in or is associated with a heart attack injury or stroke injury unless the nature of the employment concerned gave rise to a significantly greater risk of the worker suffering the injury than had the worker not been employed in employment of that nature.

Section 9B(2) of the *1987 Act* defines "heart attack injury" and "stroke injury" as follows:

> **Heart attack injury** means "an injury to the heart, or any blood vessel supplying or associated with the heart, that consists of, is caused by, results in or is associated with: (a) any heart attack, or (b) any myocardial infarction, or (c) any myocardial ischaemia,

or (d) any angina, whether unstable or otherwise, or (e) any fibrillation, whether atrial or ventricular or otherwise, or (f) any arrhythmia of the heart, or (g) any tachycardia, whether ventricular, supra ventricular or otherwise, or (h) any harm or damage to such a blood vessel or to any associated plaque, or (i) any impairment, disturbance or alteration of blood, or blood circulation, within such a blood vessel, or (j) any occlusion of such a blood vessel, whether the occlusion is total or partial, or (k) any rupture of such a blood vessel, including any rupture of an aneurism of such a blood vessel, or (l) any haemorrhage from such a blood vessel, or (m) any aortic dissection, or (n) any consequential physical harm or damage, including harm or damage to the brain, or (o) any consequential mental harm or damage".

stroke injury means "an injury to the brain, or any of the blood vessels supplying or associated with the brain, that consists of, is caused by, results in or is associated with: (a) any stroke, or (b) any cerebral infarction, or (c) any cerebral ischaemia, or (d) any rupture of such a blood vessel, including any rupture of an aneurism of such a blood vessel, or (e) any subarachnoid haemorrhage, or (f) any haemorrhage from such a blood vessel, or (g) any harm or damage to such a blood vessel or to any associated plaque, or (h) any impairment, disturbance or alteration of blood, or blood circulation, within such a blood vessel, or (i) any occlusion of such a blood vessel, whether the occlusion is total or partial, or (j) any consequential physical harm or damage, including neurological harm or damage, or (k) any consequential mental harm or damage".

[3.460] Psychological and psychiatric injury

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, the worker will be entitled to claim compensation under the statutory scheme.

Mere emotional impulses are strong feelings that do not cause the claimant to become dysfunctional (*Yates v South Kirkby Collieries Limited* [1910] 2 KB 538). What is required is a medical diagnosis of a recognisable psychological or psychiatric condition.

The injury 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; *Yeo v Western Sydney Area Health Service* (1999) 17 NSWCCR 573).

However, in *Attorney-General v K* [2010] NSWWCCPD 76, Acting President Roche reviewed a number of authorities, including *State Transit Authority of New South Wales v Chemler* [2007] NSWCA 249 (*Chemler*), and stated the following principles:

(a) employers take their employees as they find them. There is an "egg-shell psyche" principle which is the equivalent of the "egg-shell skull" principle (Spigelman CJ in Chemler at [40]);

(b) a perception of real events, which are not external events, can satisfy the test of injury arising out of or in the course of employment (Spigelman CJ in Chemler at [54]);

(c) if events which actually occurred in the workplace were perceived as creating an offensive or hostile working environment, and a psychological injury followed, it is open to the Commission to conclude that causation is established (Basten JA in Chemler at [69]);

(d) so long as the events within the workplace were real, rather than imaginary, it does not matter that they affected the worker's psyche because of a flawed perception of events because of a disordered mind (President Hall in Sheridan);

(e) there is no requirement at law that the worker's perception of the events must have been one that passed some qualitative test based on an "objective measure of reasonableness" (Von Doussa J in Wiegand at [31]), and

(f) it is not necessary that the worker's reaction to the events must have been "rational, reasonable and proportionate" before compensation can be recovered.

Roche AP also stated:

> The critical question is whether the event or events complained of occurred in the workplace. If they did occur in the workplace and the worker perceived them as creating an

> "offensive or hostile working environment", and a psychological injury has resulted, it is open to find that causation is established. A worker's reaction to the events will always be subjective and will depend upon his or her personality and circumstances. It is not necessary to establish that the worker's response was "rational, reasonable and proportional" ...

Section 11A(1) of the *1987 Act* provides the following defence to a claim for a psychological or psychiatric injury if it was "… wholly or predominantly caused by reasonable action taken or proposed to be taken by or on behalf of the employer with respect to transfer, demotion, promotion, performance appraisal, discipline, retrenchment or dismissal of workers or provision of employment benefits to workers".

The employer bears the onus of proving all elements of a defence under s 11A and in determining whether the injury is compensable, the decision-maker must consider of all the factors that resulted in the psychological or psychiatric injury (*Manly Pacific International Hotel Pty Ltd v Doyle* [1999] NSWCA 465; (1999) 19 NSWCCR 181).

[3.470] Hearing loss

A worker may suffer hearing loss as a result of a traumatic event that occurred at work (eg, exposure to a loud explosion) or by gradual onset (exposure to loud noise over a period of time).

Gradual onset hearing loss claims are frequently referred to as "industrial deafness" claims. Section 17(2) of the *1987 Act* deems the condition known as "Boilermakers Deafness or any deafness of similar origin" to be caused by a gradual process.

Section 17(1)(a) of the *1987 Act* deems the date of the hearing loss injury depending on whether or not the worker was employed in "employment to the nature of which the injury was due" (ie, noisy employment) when they gave notice of the injury.

Where the worker was employed in noisy employment when notice was given, the deemed date of injury is the date that notice was given (s 17(1)(a)(i)). However, if the worker was not employed in noisy employment at that time, the deemed date of injury is the last day on which they were employed in noisy employment (s 17(1)(a)(ii)).

Section 17(1)(c) of the *1987 Act* provides that the liability to pay compensation to the worker also depends upon whether or not the worker was employed in noisy employment when notice was given. Where they were employed in noisy employment at that time, liability rests with that employer (s 17(1)(c)(i)). However, where they were not employed in noisy employment at that time, the last noisy employer is liable (s 17(1)(c)(ii)).

[3.480] Journey claims

Section 10(1) of the *1987 Act* provides that a personal injury received by a worker on any journey to which the section applies is, for the purposes of the *1987 Act*, an injury arising out of or in the course of employment, and compensation is payable accordingly.

Journey claims are restricted to personal injuries (to which *1987 Act*, s 4(a) applies). Section 10(3) prescribes a number of specific daily or periodic journeys that includes journeys:

- between the worker's place of residence and workplace;
- between the worker's place of residence or place of employment and any educational institution that the worker is required by the terms of their employment (or expected by their employer) to attend; and
- between the worker's place of residence or employment and any other place, where the journey is made for the purpose of obtaining a medical certificate or receiving medical, surgical or hospital advice, attention or treatment or of receiving payment of compensation in connection with any injury for which the worker is entitled to receive compensation.

The worker bears the onus of proving that such an injury is compensable.

A worker may be entitled to compensation for a personal injury suffered during an interruption or deviation from a journey provided that the deviation or interruption does not materially increase the risk of injury (s 10(2)).

A journey under s 10 of the *1987 Act* commences from, and ends at, the boundary of a worker's place of residence – that is, at the front gate and not the front door (s 10(4)).

For personal injuries suffered on or after 19 June 2012 during a journey to or from the worker's place of abode, the worker must also prove that there is a real and substantial connection between their employment and the accident or incident out of which the personal injury arose (s 10(3A)).

The meaning of "real and substantial connection" has been considered in the following decisions:

- In *Badawi v Nexon Asia Pacific Pty Limited trading as Commander Australia Pty Ltd* [2009] NSWCA 324, the New South Wales Court of Appeal held that "substantial" means "real and of substance".
- In *Mitchell v Newcastle Permanent Building Society Ltd* [2013] NSWWCCPD 55, Deputy President O'Grady held that "real" means "actual" and "connection" should take the meaning of "association" or "relationship" or "link".
- In *Bina v ISS Property Services Pty Limited* [2013] NSWWCCPD 72, President Keating held that in applying the test under s 10(3A) of the *1987 Act* there must be a determination in a common-sense and practical manner.

No compensation is payable if the personal injury is attributable to the serious and wilful misconduct of the worker (s 10(1A)).

A personal injury is deemed to be attributable to the serious and wilful misconduct of the worker if they were at the time under the influence of alcohol or other drug (within the meaning of the *Road Transport Act 2013*), unless the alcohol or other drug did not contribute in any way to the injury or it was not consumed or taken voluntarily.

[3.490] Recess claims

Section 11 of the *1987 Act* provides that if a worker has:

(a) attended at their place of employment under their contract of service or training contract and is temporarily absent from that place during any ordinary recess or authorised absence;

(b) does not during that absence voluntarily subject themselves to any abnormal risk of injury; and

(c) receives a personal injury during that absence, the injury is deemed to be an injury arising out of or in the course of employment, and compensation is payable accordingly.

An "ordinary recess" describes a break in the actual performance of work duties during a period of employment. For example, a lunch break or a morning or afternoon tea break.

However, where a worker is rostered to work a split shift, where they are free to do whatever they wish during between shifts, it is unlikely that the period between those periods of work will be held to be an "ordinary recess". It is far more likely that each "shift" will be found to be a separate period of employment and that an injury suffered during the intervening period will not be compensable.

The employer bears the onus of proving that the risk of injury was abnormal. For example, where a worker suffers an injury as a result of being struck by a vehicle while crossing a busy road, where a safer means of doing so was available (ie, an overhead pedestrian bridge or crossing at traffic lights), may be found to have voluntarily submitted themselves to an abnormal risk of injury.

[3.500] Serious and wilful misconduct of a worker

Section 14(1) of the *1987 Act* provides that compensation is payable in respect of any injury resulting in the death or serious and permanent disablement of a worker, notwithstanding that the worker was, at the time when the injury was received:

(a) acting in contravention of any statutory or other regulation applicable to the worker's employment, or of any orders given by or on behalf of the employer, or

(b) acting without instructions from the worker's employer, if the worker did the act for the purposes of and in connection with the employer's trade or business.

The employer bears the onus of proving this defence.

Where an injury is solely attributable to the worker's serious and wilful misconduct, no compensation is payable in respect of that injury unless it results in death or serious and permanent disablement (s 14(2)).

No compensation is payable in respect of any injury to or death of a worker caused by an intentional self-inflicted injury (s 14(3)).

[3.510] Categories of compensation

The statutory scheme provides for three categories of compensation, namely:

1. economic loss – comprising loss of wages, medical and related treatment expenses and loss due to property damage;

2. non-economic loss – comprising compensation for permanent impairment; and
3. compensation payable in respect of the death of a worker.

[3.515] Weekly payments of compensation

The *2012 amendments* significantly altered the manner of assessment and payment of weekly compensation to non-exempt workers. The current statutory scheme for these workers is based upon three separate entitlement periods and the entitlement is calculated based upon the worker's pre-injury average weekly earnings ("PIAWE").

The "First entitlement period" is defined in s 32A of the *1987 Act* as "an aggregate period not exceeding 13 weeks (whether or not consecutive) in respect of which a weekly payment has been paid or is payable to the worker".

During this period, s 36 of the *1987 Act* provides for weekly payments of up to 95% of PIAWE.

The "Second entitlement period" is defined in s 32A of the *1987 Act* as "an aggregate period of 117 weeks (whether or not consecutive) after the expiry of the first entitlement period in respect of which a weekly payment has been paid or is payable to the worker".

During this period, s 37 of the *1987 Act* provides for weekly payments as follows:

- for a worker who is assessed as having no current work capacity, or who has current work capacity and has returned to work for less than 15 hours per week – up to 80% of PIAWE; and
- for a worker who has returned to work for at least 15 hours per week – up to 95% of PIAWE.

Section 38 of the *1987 Act* governs the entitlement to weekly payments after the end of the second entitlement period (130 weeks), as follows.

If the insurer assessed the worker as having no current work capacity and likely to continue indefinitely to have no current work capacity, they are entitled to ongoing weekly payments after 130 weeks (s 38(2)).

However, a worker (other than "a worker with high needs") who is assessed by the insurer as having current work capacity is only entitled to ongoing weekly payments if:

1. they applied to the insurer in writing no earlier than 52 weeks before the end of the second entitlement period for continuation of weekly payments after that period; and
2. they have returned to work (whether in self-employment or other employment) for at least 15 hours per week and are in receipt of current weekly earnings (or current weekly earnings together with a deductible amount) of at least $190 per week (note that this amount is indexed); and
3. they are assessed by the insurer as being, and as likely to continue indefinitely to be, incapable of undertaking further additional employment or work that would increase their current weekly earnings (s 38(3)).

Section 32A of the *1987 Act* defines "worker with high needs" as "a worker whose injury has resulted a permanent impairment of *more than 20%* and includes a 'worker with highest needs'". It also defines a "worker with highest needs" is defined as "a worker whose injury has resulted in a permanent impairment of *more than 30%*". (emphasis added)

Note that when the Act refers to more than 20% or 30%, the worker is required to show a percentage of 21% or 31% as a minimum. Neither 20% for "high needs" nor 30% for "highest needs" will suffice.

Section 39 of the *1987 Act* provides that a worker has no entitlement to weekly payments after an aggregate period of 260 weeks unless the injury results in a permanent impairment of *more than 20%*.

Where the worker satisfies the s 39 threshold, they will be eligible to receive weekly payments until the Commonwealth retiring age, subject to ongoing work capacity assessments by the insurer.

Further, under s 38A of the *1987 Act*, a worker with highest needs is entitled to receive a minimum weekly payment (currently $831 per week) regardless of their actual earnings or ability to earn.

This payment is indexed on 1 April and 1 October of each year.

Work capacity assessments and work capacity decisions

The *2012 amendments* introduced the concepts of "a work capacity assessment" and "a work capacity decision" by the insurer as the basis for determining a worker's entitlement to weekly payments.

A *work capacity assessment* requires the insurer to consider an injured worker's medical condition, their functional capacity and their vocational skills

to help inform a decision regarding their capacity to return to work in suitable employment.

A *work capacity assessment* can occur at any time during the life of a claim, but the insurer must make a *work capacity decision* before week 130 and, if the entitlement to weekly payments continues, at least every two years thereafter, unless the worker is *a worker with highest needs*. In that event, the insurer is not to conduct *a work capacity assessment* unless it thinks it appropriate to do so and the worker requests it (the *1987 Act*, s 38(5)).

Where a worker (except a *seriously injured worker)* was receiving weekly payments as at 1 October 2012, as a result of an injury suffered before that date, the *2012 amendments* required the insurer to transition the claim from the previous statutory scheme to the current statutory scheme by conducting a *work capacity assessment* and making a *work capacity decision* (the *1987 Act*, Sch 6, Pt 19H, cl 8).

However, Sch 6 of Pt 19H of cl 8(3) provides that if the worker was a *seriously injured* worker, the insurer "is not to conduct a work capacity assessment of the worker under this clause". Under the *2012 amendments*, "seriously injured worker" was defined *as a worker whose injury has resulted in permanent impairment of more than 30%* (the *1987 Act*, s 32A). However, this definition is no longer found in the *1987 Act* and it was replaced by the definitions of "Worker with high needs" and "Worker with highest needs".

The insurer was required to provide an injured worker with a notice period of three months before its work capacity decision took effect (the *1987 Act*, Sch 6, cl 9(1)), in cases, where a reduction or cessation of payments followed. There was no such requirement when the *Workers Compensation Act 1987* payments were to be increased (former reg 21 (now repealed)).

Work capacity decisions were reviewable by a three-step process:

1. internal review by the insurer;
2. if the worker was not satisfied with the outcome of the internal review, or the insurer failed to complete the review within 30 days, they could request a merit review of the insurer's decision by SIRA; and
3. if the worker was not satisfied with the outcome of the Merit Review by SIRA, they could apply for a procedural review by WIRO within 30 days of receiving the Merit Review decision from SIRA.

The *Workers Compensation Amendment (Existing Claims) Regulation 2014* (*the Existing Claims Regulation*) further changed the entitlement to weekly payments for workers who were injured and claimed compensation for that injury before 1 October 2012.

These workers could continue to receive weekly payments while a work capacity decision was being reviewed, provided that the worker requested a review of the decision within 30 days of receiving notification of it and they were also entitled to receive weekly payments for up to one year after reaching retirement age.

The *Workers Compensation Legislation Amendment Act 2018* (NSW) (the *2018 amendments*), *which commenced on 1 January 2019*, further amended s 32A of the *1987 Act*. The existing definitions of "base rate of pay", "base rate of pay exclusion", "current weekly earnings", "current work capacity", "no current work capacity", "non-pecuniary benefit", "ordinary earnings", "ordinary hours of work", "pre-injury average weekly earnings" and "relevant period" were deleted.

New definitions were introduced in Sch 3, including "current work capacity", "current weekly earnings" and "relevant period".

In addition, ss 34, 36, 37 and 38 of the *1987 Act* were amended; s 35 of the *1987 Act* was omitted; and s 44BAA was introduced, which provided that the regulations may provide for the procedures to be followed by insurers in connection with the making of work capacity decisions, including the adjustment of any amount of weekly payments as a result of a work capacity decision.

[3.520] Weekly payments under the pre-2012 statutory scheme

This statutory scheme remains in place for all exempt workers.

If an exempt worker is incapacitated for work as a result of a work injury, they are entitled to weekly payments in respect of that incapacity.

"Incapacity" is measured in terms of their reduced earning capacity in the open labour market that is reasonably accessible to them. If they have no earning capacity as a result of the work injury, they are deemed to be totally incapacitated for work. However, where they have a reduced earning capacity, they are deemed to be partially incapacitated for work.

Total incapacity

An exempt worker who is totally incapacitated for work is entitled to receive compensation equivalent to their "current weekly wage rate" for the first 26 weeks, subject to an overall cap on the amount of compensation payable set by the previous s 35 of the *1987 Act*. The current maximum weekly payment is currently $2,145.30 per week and the amount is indexed on 1 April and 1 October of each year.

The "current weekly wage rate" is calculated as follows:

- where they are paid under an award, industrial or enterprise agreement – 100% of the rate payable for one week – excluding overtime, shift work, special expenses and penalty rates (former s 42); or
- where they are not paid under an award, industrial or enterprise agreement – 80% of their average weekly earnings (including regular overtime and allowances) (former s 43).

Where an exempt worker remains totally incapacitated after the first 26 weeks, the maximum weekly payment is the lesser of either 90% of their average weekly earnings or the statutory rate (former s 37). The statutory rate is indexed on 1 April and 1 October of each year and includes allowances for a dependent spouse and dependent children.

Partial incapacity

Where an exempt worker suffers a partial incapacity, it is necessary to assess their reduced earning capacity by reference to lost income. In broad terms, this is achieved by calculating the difference between their "probable weekly earnings" and their "average weekly earnings".

"Probable weekly earnings" means "the weekly amount which the worker would probably have been earning as a worker but for the injury and had the worker continued to be employed in the same or some comparable employment" (former s 40(1)(a)). This is determined by reference to their current weekly wage rate for the pre-injury employment (former s 40(2)(b)).

"Average weekly earnings" means "the average weekly amount which the worker is earning, or is able to earn in some suitable employment, from time to time after the injury" (former s 40(1)(b)). This is determined by reference to the current weekly wage rate for some suitable employment (former s 40(2)(a)).

However, the amount of weekly payments to a partially incapacitated exempt worker cannot exceed the amount payable if they were totally incapacitated.

Partially incapacitated workers treated as if totally incapacitated

Where an exempt worker is certified fit for suitable duties and the pre-injury employer fails to provide suitable duties for them, they may be entitled to receive weekly payments under the former s 38 of the *1987 Act*. To be eligible for these payments, they must be undertaking rehabilitation, or retraining approved by the insurer or be job seeking.

Weekly payments under the previous s 38 of the *1987 Act* are available for a maximum period of 52 weeks.

During the first 26 weeks of incapacity (including any period of total incapacity), an exempt worker may receive their current weekly wage rate. For the remainder of the 52 weeks, they may receive the greater of 80% of their current weekly wage rate or the statutory rate. If they remain fit for suitable duties thereafter, they may be entitled to make-up pay based on an assessment of their capacity for work – provided that this does not exceed the statutory rate under the previous s 37 of the *1987 Act*.

[3.530] Medical and related treatment expenses and domestic assistance – ss 59, 59A, 60 and 60AA of the 1987 Act

Non-exempt workers

The statutory scheme is strongly focused on achieving an early return to work. Treatment includes the provision of medication, surgery or other services designed to arrest or abate the progress of the injury (or disease) or to alleviate, cure or remedy its effects.

A worker is entitled to recover the costs of reasonably necessary medical, hospital, rehabilitation and related expenses incurred as a result of a work injury (s 60(1)).

If it is necessary for the worker to travel to receive such treatment or service, the insurer is liable for the cost of any fares, travelling expenses

and maintenance necessarily and reasonably incurred by the worker in obtaining the treatment or being provided with the service (s 60(1)(a)). If they are not reasonably able to travel unescorted, the insurer is also liable for the amount of the fares, travelling expenses and maintenance necessarily and reasonably incurred by an escort provided to enable the worker to be given the treatment or provided with the service (s 60(1)(b)).

"Medical or related treatment" is defined in s 59 of the *1987 Act* and includes: treatment by a medical practitioner, a registered dentist, a dental prosthetist, a registered physiotherapist, a chiropractor, an osteopath, a masseur, a remedial medical gymnast or a speech therapist; therapeutic treatment given by direction of a medical practitioner; the provision of crutches, artificial members, eyes or teeth and other artificial aids or spectacles; any nursing, medicines, medical or surgical supplies or curative apparatus, supplied or provided for the worker otherwise than as hospital treatment; care (other than nursing care) of a worker in the worker's home directed by a medical practitioner having regard to the nature of the worker's incapacity; domestic assistance services; the modification of a worker's home or vehicle directed by a medical practitioner having regard to the nature of the worker's incapacity; and treatment or other thing prescribed by the regulations as medical or related treatment. However, it does not include "ambulance services", "hospital treatment" or "workplace rehabilitation services", which are separately defined in s 59.

Whether a particular treatment or service is reasonably necessary requires a consideration of factors including: its appropriateness; whether possible alternatives are available; cost; and whether the treatment or service is accepted by the medical profession as being effective for the injury or disease.

The *2012 amendments* introduced s 59A of the *1987 Act*, which changed an injured worker's entitlement to compensation for medical and related treatment expenses from 1 October 2012 (for new claims) and from 1 January 2013 (for existing claims).

The entitlement ceased either 12 months after the last date on which weekly payments were made to the worker or, if no weekly payments of compensation are payable, 12 months after the claim for compensation was made. However, this restriction did not apply to workers who suffered a permanent impairment of *more than 30%* and they were entitled to payment of medical and related treatment expenses for life.

Section 60(2A) of the *1987 Act* was introduced and this provided that the employer was not liable for the cost of any treatment or service (or related travel expenses) if:

- it is given or provided without the insurer's prior approval unless the treatment was provided within 48 hours of the injury happening and or the treatment or service is exempt under the *Workers Compensation Guidelines* from this requirement (s 60(2A)(a)); or
- it is given or provided by a person who is not appropriately qualified to give or provide it (s 60(2A)(b)); or
- it is not given or provided in accordance with any conditions imposed by the *Workers Compensation Guidelines* on the giving or providing of the treatment or service (s 60(2A)(c)); or
- it is given or provided by a health practitioner whose registration as a health practitioner under any relevant law is limited or subject to any condition imposed as a result of a disciplinary process, or who is suspended or disqualified from practice (s 60(2A)(d)).

The *2014 amendments* further changed the entitlement to compensation for medical and related treatment expenses for workers who were injured and claimed compensation before 1 October 2012.

If this category of workers suffered a permanent impairment of between 21% and 30%, they were entitled to compensation until retiring age. All other workers in this category were entitled to compensation until retirement age for home and vehicle modifications, crutches, artificial members, eyes or teeth, spectacles or other artificial aids (including hearing aids and hearing aid batteries), regardless of the degree of their permanent impairment.

The *2014 amendments* also provided for the insurer to meet the costs of any secondary surgery, provided that: it is directly consequential to an earlier surgery; affects a part of the body affected by the earlier surgery; and is approved by the insurer within two years of approval of the earlier surgery (the *Regulation*, Sch 6, cl 28).

The *2015 amendments* defined a worker's entitlement to compensation under s 60 of the *1987 Act* by reference to the degree of permanent

impairment that resulted from a work injury and whether or not weekly payments are or have been paid or payable, as follows:

(a) If it resulted in 10% or less, or the degree of permanent impairment has not been assessed as provided by s 65 of *the 1987 Act* – 2 years commencing on: (i) the date when compensation was first claimed (if weekly payments are not or have not been paid or payable to the worker), or (ii) the day on which weekly payments of compensation cease to be payable (if weekly payments of compensation are or have been paid or payable); or

(b) If it resulted in more than 10% but not more than 20% – 5 years commencing on: (i) the date when compensation was first claimed (if weekly payments are not or have not been paid or payable to the worker), or (ii) the day on which weekly payments of compensation cease to be payable (if weekly payments of compensation are or have been paid or payable).

If weekly payments became payable to a worker after compensation under Div 3 of Pt 3 of the *1987 Act* ceases to be payable, they were entitled to further compensation of that type but only for any treatment, service or assistance given or provided during a period in which weekly payments are payable.

Domestic assistance

Section 60AA(1) of the *1987 Act* provides for compensation for reasonably necessary domestic assistance to an injured worker if:

(a) a medical practitioner has certified, on the basis of a functional assessment of the worker, that it is reasonably necessary that the assistance be provided and that the necessity for the assistance to be provided arises as a direct result of the injury, and

(b) the assistance would not be provided for the worker but for the injury (because the worker provided the domestic assistance before the injury), and

(c) the injury to the worker has resulted in a degree of permanent impairment of the worker of at least 15% or the assistance is to be provided on a temporary basis as provided by subsection (2), and

(d) the assistance is provided in accordance with a care plan established by the insurer in accordance with the Workers Compensation Guidelines.

Domestic assistance can be provided on a temporary basis for up to six hours per week, for a total period not exceeding three months, where it is provided under the requirements of an injury management plan (s 60AA(2)).

However, no compensation is payable for gratuitous domestic assistance unless the person who provides it has lost income or foregone employment as a result of providing it (s 60AA(3)). Compensation for gratuitous assistance is payable at the same rate as that payable under s 60AA(2) (s 60AA(4)).

Payments are to be made as the costs are incurred or, in for gratuitous assistance, as the services are provided (s 60AA(5)(a)). The costs and provision of assistance must be properly verified (s 60AA(5)(b)) and payments for gratuitous assistance must be made to the provider of the assistance (s 60AA(5)(c)).

[3.540] Compensation for non-economic loss (permanent impairment)

The *2012 amendments* significantly changed a worker's entitlement to compensation for non-economic loss, as follows:

- it repealed s 67 of the *1987 Act*, which provided for the payment of compensation for pain and suffering resulting from a permanent impairment;
- s 66(1) of the *1987 Act* imposed a threshold of "greater than 10%" upon the entitlement to recover compensation for permanent impairment in respect of physical injuries and hearing loss. The separate threshold of 15% continued to apply to claims for compensation for permanent impairment in respect of a psychological or psychiatric injury (s 65A);
- s 66(1A) of the *1987 Act* provided that only one claim can be made for permanent impairment compensation in respect of the permanent impairment that results from an injury; and
- s 66(3) significantly altered the manner of calculating the entitlement to compensation depending upon the degree of the permanent impairment.

Under the *2012 amendments*, the degree of permanent impairment was to be assessed using *The WorkCover Guides for the Evaluation of Permanent Impairment* (*the Guides*) and the evaluation could only be conducted by a suitably qualified medical specialist who was trained in the use of the Guides and listed on SIRA's website. The maximum amount of compensation payable under s 66 of the *1987 Act* was $220,000.00, but an increase of 5% applied to permanent impairment of the back.

The interpretation of ss 66(1) and 66(1A) of the *1987 Act* was considered by the New South Wales Court of Appeal and High Court of Australia.

In *ADCO Constructions Pty Ltd v Goudappel* [2014] HCA 18 (*Goudappel*), the High Court determined that the threshold under s 66(1) applies, where the claim for compensation for permanent impairment was made or after 19 June 2012, regardless of whether other types of compensation were claimed before that date.

In *Cram Fluid Power Pty Ltd v Green* [2015] NSWCA 250 (*Cram Fluid*), the New South Wales Court of Appeal determined that the worker was only entitled to make one claim for lump sum compensation for permanent impairment that results from an injury.

The *2015 amendments* overcame the effect of the decisions in *Goudappel* and *Cram Fluid* by introducing cll 10 and 11 of Sch 8 of the *Regulation*.

Clause 10 provides that the *2012 amendments* do not apply, where a claim under s 66 was made on or before 19 June 2012. In other words, the threshold of "more than 10%" imposed by s 66(1) of the *1987 Act* does not apply to these claims (Sch 8, cl 11(3)).

Clause 11(1) provides that a worker may make a further claim for lump sum compensation in respect of an existing impairment. "Existing impairment" is defined as "permanent impairment resulting from an injury in respect of which a lump sum compensation claim was made before 19 June 2012".

However, cl 11(2) provides that only one further lump sum compensation claim can be made in respect of the existing impairment.

For injuries suffered on and after 5 August 2015, the maximum amount of compensation payable under s 66 of the *1987 Act* increased to $577.505 (where permanent impairment is 75% or more) and the amounts payable for each percentage of impairment above 10% were also increased. Since 1 July 2016, these amounts have been indexed annually.

Section 65 of the *1987 Act* provides that the degree of permanent impairment that results from an injury is to be assessed "as provided by this section and *Part 7 (Medical assessment) of Chapter 7*" of the *1998 Act*.

Section 322(4) of the *1998 Act* provides that an approved medical specialist may decline to make an assessment of the degree of permanent impairment until they are satisfied that the impairment is permanent and the degree of permanent impairment is fully ascertainable.

Section 322A(1) of the *1998 Act* provides that only one assessment may be made of the degree of permanent impairment of an injured worker.

The medical assessment certificate (MAC) that is given in connection with that assessment is the only MAC that can be used in connection with any further or subsequent medical dispute about the degree of permanent impairment of the worker as a result of the injury concerned (whether the subsequent or further dispute is in connection with a claim for permanent impairment compensation, the commutation of a liability for compensation or a claim for work injury damages) (s 322A(2)).

Therefore, a medical dispute about the degree of permanent impairment of a worker as a result of an injury cannot be referred for, or be the subject of, assessment if a medical dispute about that matter has already been the subject of: (a) assessment and a MAC under Pt 7 of Ch 7 of the *1998 Act*, or (b) a determination by the WCC under Pt 4 of the *1998 Act*.

However, s 322A of the *1998 Act* does not affect the operation of s 327 (Appeal against a medical assessment) or s 352 (Appeal against a decision of the WCC constituted by Arbitrator).

Disputes regarding the degree of permanent impairment are determined by the WCC.

From 1 January 2019, the WCC may refer the dispute to an approved medical specialist for the assessment of the degree of permanent impairment, but referral is no longer mandatory, and an Arbitrator is empowered to determine a dispute under s 66 of the *1987 Act* without a MAC.

Where the parties resolve the dispute regarding the degree of permanent impairment they can lodge Consent Orders or enter into a Complying Agreement under s 66A of the *1987 Act* with the proceedings being discontinued.

A determination by an arbitrator is an assessment of permanent impairment for the purposes of s 322A of the *1998 Act*.

A party may appeal a decision of an Arbitrator in respect of permanent impairment to a Presidential Member.

On appeal, the decision may be confirmed or revoked and either a new decision made in its place or the matter is remitted to the Arbitrator (or a different Arbitrator) for determination in accordance with the decision of the Presidential Member. This may include a direction that the matter is to be referred to an approved medical specialist for assessment under s 352(7) of the *1998 Act*.

[3.550] Nervous shock and compensation to relatives

The *2012 amendments* prevented claims for damages for nervous shock, where the nervous shock was not a work injury and claims for damages by relatives of an injured or deceased worker, because the relatives' injuries are not work injuries.

These amendments applied where court proceedings were not commenced before 19 June 2012.

[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.

To be entitled to recover compensation for property damage, the worker must have suffered an accident arising out of or in the course of their employment. For example, if a worker falls over at work and breaks their glasses, compensation will be payable for the repair or replacement of the glasses.

However, if the damage occurs because the glasses merely fell off the worker's head, without an accident, no compensation is recoverable.

The amount of compensation for damage to artificial aids under s 76(1) of the *1987 Act* is $2,000 and the amount for damage to clothing (the *1987 Act*, s 77(1)) is $300.

However, these amounts can be increased on a case-by-case basis by application to SIRA or a direction from the WCC.

[3.570] Compensation in respect of death of a worker

Where a worker dies as a result of an injury leaving dependants, s 25 of the *1987 Act* provides for the payment of compensation by the employer. This includes a lump sum death benefit, which is to be apportioned among any persons who are wholly or partially dependent for support on the worker, or if there are no dependants, the amount is to be paid to the worker's legal personal representative (s 25(1)(a)).

A weekly payment is also payable in respect of each dependent child under the age of 16 years or between the ages of 16 and 21 years if the child is a student (s 25(1)(b)). "Child of the worker", "dependent child of the worker" and "student" are defined in s 25(5) of the *1987 Act*.

The worker's death does not have to occur immediately following the injury and a claim may be made, where it occurs a significant time after the injury occurred.

Where a worker died in a workplace accident or because of a workplace injury that occurred on or after 5 August 2015, the maximum lump sum benefit payable to their dependants is $750,000 and the maximum amount payable for funeral expenses is $15,000.

From 1 April 2016, the lump sum death benefit has been indexed annually and from 1 October 2018 to 31 March 2019, the maximum is $798,100.

The amount payable is determined based on the date of the worker's death.

Compensation is also payable for funeral expenses (s 26). 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.

Compensation is also payable for the expenses of transporting the deceased worker's body (s 27).

"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 for whom the worker stood 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. However, it not enough that a claimant is a family member of the deceased worker – they must prove

that they were dependent for support upon the deceased at the time of death.

The increased death benefits also apply to police officers; fire fighters; paramedics; volunteer bush fire, emergency and rescue services workers; and coal miners (*Workers Compensation Amendment (Death Benefits) Regulation 2016*).

Where there are multiple dependants, an Arbitrator will apportion the lump sum death benefit between each dependant based upon the consideration of criteria that include: the extent of their past dependence; the anticipated duration of any future dependence; the ages of the dependants; and any special needs, such as health requirements.

Where any part of the lump sum benefit is apportioned to a child, the payment is required to be made to the NSW Trustee and Guardian and must be applied for the child's maintenance, education, advancement and benefit.

However, any weekly payments in respect of a dependent child are payable to the child's guardian.

Any lump sum benefit that is apportioned to an adult dependant may be paid directly to that person.

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; to give a worker certainty and proper income support while incapacitated as a result of an injury; and to facilitate sound decisions regarding claims and to reduce disputes.

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

[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. However, notice of the injury is not required, where the employer is already aware of its occurrence.

Notice of injury may be given orally or in writing. It 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 a 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 them for an initial period of up to 12 weeks while the insurer investigates the claim (the *1998 Act*, s 267). These payments must commence within seven calendar days from the date of notification of the injury.

However, 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 and/or the injured person is unlikely to be a worker and/or the insurer is unable to contact the worker and/or the injury is not work related and/or the

injury is not a significant injury and/or the injury is notified after two months.

Table 2.1 of the *SIRA Guidelines* sets out each reasonable excuse and reasons for invoking them.

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 to the insurer and to provide the insurer with authority to allow it to obtain information from their treating doctors.

An insurer can also provisionally accept liability for the payment of medical and related treatment up to $9,389 (this amount is indexed on 1 April and 1 October of each year) while it investigates and determines liability for the claim (the *1998 Act*, ss 280, 297).

The intention of provisional payments of medical expenses, while liability is being determined, is to ensure that the worker receives prompt medical attention in order to lessen the long-term effects of the 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 (the *1998 Act*, s 261(1)).

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 ($9,389), 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 their employer or its 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 applicable work restrictions.

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 permanent impairment claim form must include relevant particulars about the claim and a medical report from a SIRA 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. It may obtain an independent medical assessment by a SIRA-trained medical specialist of its choosing to assist it to determine the claim.

[3.620] Disputing liability

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

- the claimant was not a worker as defined by the *1987 Act* and the *1998 Act*;
- 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 degree of impairment is less than alleged.

An insurer must give the worker a written notice of a decision to dispute liability in respect of a claim or any aspect of a claim (the *1998 Act*, s 78(1)(a)) or to discontinue or reduce the amount of weekly payments (the *1998 Act*, s 78(1)(b)).

Where the insurer decides to dispute liability and to discontinue or reduce the amount of weekly payments, a single notice may be issued (s 78(2)), but the requirement to give written notice to discontinue weekly payments does not affect any limitation on weekly payments under Div 2 of Pt 3 of the *1987 Act*.

The written notice must contain a concise and readily understandable statement of the reason for the insurer's decision and the issues relevant to it (s 79(2)) and, where the decision is to dispute liability, the provision(s) of the legislation that the insurer relies upon must be identified.

The *Regulation* sets out the information that must be served with the dispute notice.

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

Exempt workers

The pre-2012 statutory scheme continues to apply to exempt workers. Under this scheme, the WCC has power to determine a claim for costs under s 341 of the *1998 Act*.

The general rule is that costs follow the event and the successful party would usually be entitled to have their party/party costs (as regulated under the *Regulation*, Sch 6) paid by the unsuccessful party, subject to relevant considerations in each matter.

Non-exempt workers

The *2012 amendments* abolished the WCC's power to order costs order under s 341. As a result, each party is required to bear its own costs in relation to a claim, dispute or proceeding, regardless of the outcome of that matter.

The Workers Compensation Independent Review Office (WIRO) was created and vested with a specific function of providing funding for legal assistance to a lawyer to enable them to investigate a claim, make a claim and/or respond to a dispute on behalf of a worker.

WIRO's powers include the accreditation of legal practitioners who possess sufficient skills and expertise in the field of workers compensation and it maintains a roll of approved lawyers who are able to lodge an application for legal assistance on behalf of a worker.

WIRO makes an independent and informed decision regarding the approval of funding based upon a merits-based assessment of the proposed claim and/or the reasonable prospects of successfully resolving a dispute.

Legal assistance is sourced from a public fund and, if approved, is paid to the approved lawyer regardless of the outcome that is achieved.

Legal assistance is available at all stages of a claim, dispute or proceedings, but WIRO does not have power to approve funding for any action taken or any costs or disbursements incurred before the approval of legal assistance.

A worker who wishes to make a claim or to seek to resolve a dispute must first contact WIRO to enquire about the approved lawyers who are available to assist them and/or to seek further information regarding the dispute resolution process.

Dispute resolution

[3.630] Following the commencement of the 2018 amendments on 1 January 2019, if the worker does not agree with an insurer's decision to either dispute liability for a claim or any aspect of a claim or a work capacity decision, they may request the insurer to conduct an internal review of that decision (the *1998 Act*, s 287(1)).

[3.640] Internal review by insurer

The worker may request an internal review by the insurer at any time before the dispute is referred for determination by the WCC (the *1998 Act*,

s 287A(2)). If a worker makes a request for review, the insurer must review the claim within 14 days of receipt of the request (s 287A(3)).

Following review, the insurer may reverse its decision to dispute the claim or confirm the decision to dispute the claim. If the insurer maintains its dispute, a fresh dispute notice must be issued.

From 1 January 2019, the same procedure applies to work capacity decisions made by an insurer and disputed by a worker.

[3.655] Formal review

From and after 1 January 2019, any party to a dispute may refer it to the Registrar of the WCC for determination. However, if the dispute relates to lump sum compensation, only the claimant may refer it (s 288).

Restrictions on the commencement of proceedings in the WCC

A dispute about a claim for weekly payments (other than a dispute based upon a work capacity decision) cannot be referred for determination unless the person upon whom the claim is made either disputes liability for it (wholly or in part) or fails to determine it as and when required by the *1998 Act* (s 289(1)).

The note in s 289(1) provides:

> The determination of a claim requires the commencement of weekly payments of compensation. The failure to commence weekly payments pursuant to a work capacity decision (without having disputed liability) constitutes a failure to determine the claim.

A dispute about a claim for compensation for medical and related treatment expenses cannot be referred for determination unless the person upon whom the claim is made either disputes liability for it (wholly or in part) or fails to determine it as and when required by the *1998 Act* (s 289(2)).

However, this does not prevent the referral of a dispute about whether any proposed treatment or service is reasonably necessary as a result of an injury (s 298(2A)).

A dispute about a claim for lump sum compensation cannot be referred for determination by the WCC unless the person on whom the claim is made either wholly disputes liability for the claim (s 289(3)(a)) or made an offer of settlement to the claimant as and when required by the Act and one month has elapsed since the offer was made (s 298(3)(b)) or fails to determine the claim as and when required by the Act (s 289(3)(c)).

The note in s 289(3) provides:

> The determination of a claim requires the making of a reasonable offer of settlement (if liability is wholly or partly accepted). Failure to make a reasonable offer of settlement constitutes a failure to determine the claim.

A dispute about a claim for property damage cannot be referred for determination by the WCC until 28 days after the claim is made (s 289(4)(a)) or the person on whom the claim is made disputes liability for it (wholly or in part), whichever happens first.

It should be noted that the WCC may not hear or otherwise deal with any dispute if s 289 of the *1998 Act* provides that it cannot be referred for determination by the WCC (s 289(5)).

Where the worker refers a dispute for determination by the WCC in relation to a work capacity decision to discontinue or reduce the amount of weekly payments before the expiry of the period of notice required by s 80 of the *1998 Act*, the referral operates to stay the decision and prevents the insurer from taking action based upon it for the duration of the stay (s 289B(1)).

The stay operates from the time that the Registrar accepts the dispute for referral until the proceedings are determined, dismissed or discontinued (s 289B(2)).

However, if the WCC considers that a party to the dispute is unreasonably delaying the proceedings, it may order that the stay ceases to have effect (s 289B(3)).

Exchange of information between the parties

When a dispute is referred for determination by the WCC, each party to it must provide to the other party and the Registrar, as an when required by the WCC Rules, the information and documents required by the Rules (s 290(1)).

A party who fails without reasonable excuse to comply with s 290(1) is guilty of an offence that carries a maximum penalty of 50 penalty units (s 290(2)).

Any document or information that a party fails to provide in breach of s 290(1) cannot be admitted into evidence in the proceedings (s 290(3)).

However, ss 290(2) and 290(3) do not apply to a worker unless they are represented by a legal

representative or agent (as defined in the *1998 Act*, s 131) at the relevant time (s 290(4)).

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.

Resolution of disputes

Most disputes in the WCC are referred to either an Arbitrator or a delegate of the Registrar for determination at first instance. There is a strong focus on achieving resolution by consent and s 355 of the *1998 Act* requires Arbitrators to use their best endeavours to bring the parties to an acceptable resolution.

Where the dispute is referred to the WCC constituted by an Arbitrator, it will first be listed for a telephone conference, which all parties and their legal representatives are required to attend. If the dispute cannot be resolved, the Arbitrator will set the matter down for a face-to-face conciliation conference, which requires the personal attendance of all parties and their legal representatives.

If the dispute fails to resolve during conciliation, the Arbitrator will then conduct 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 arbitration hearing is sound recorded and witnesses may be called to give evidence. At the conclusion of the arbitration hearing, the Arbitrator may either give an oral decision or reserve their decision and publish written reasons at a later time.

Alternatively, the parties may request the Arbitrator to determine the dispute "on the papers" without conducting a face-to-face conciliation conference or arbitration hearing. In that event, the Arbitrator will usually require the parties to file and serve written submissions regarding the matters in dispute.

Expedited assessment

The Registrar, or a delegate of the Registrar, may deal with a dispute under Pt 5 (expedited assessment) if the dispute is one to which that Part applies (the *1998 Act*, s 292).

Part 5 applies to a dispute that concerns weekly payments of compensation or medical expenses compensation (s 295(1)(a)); or failure by an insurer, employer or worker to comply with a requirement imposed by or under Ch 3 (workplace injury management) (s 295(1)(b)). It also applies to a dispute concerning the failure to commence provisional payments of compensation as required by Div 1 of Pt 3 (s 295(2)).

The Registrar may exercise functions under Pt 5 with respect to a dispute based upon the documents an information provided to him when the dispute is referred for determination by the WCC (s 296(1)).

Except as provided by Pt 5, the exercise of any function of the Registrar under Div 2 or 3 of Pt 5 is not subject to appeal or review (s 296(2)).

Division 2 of Pt 3 – Disputes concerning weekly payments or medical expenses

Section 304B(1) of the *1998 Act* provides that the Registrar may determine this type of dispute instead of the WCC constituted by an Arbitrator.

For the purposes of determining the dispute, the Registrar has all the functions of the WCC constituted by an Arbitrator and any determination of the Registrar is taken to be a determination of the WCC (so constituted) (s 304B(2)). Under s 371, he may delegate a function conferred upon him under ss 304B(1) or 304B(2) (s 304B(3)).

When the dispute concerns weekly payments of compensation or medical expenses, the Registrar can direct the person upon whom the claim is made to pay the compensation concerned. This is referred to as an *interim payment direction* (s 297(1)).

However, an interim payment direction cannot be for an amount of more than $9,389 (the maximum amount is indexed on 1 April and 1 October each year) (s 297(2)).

Section 297(3) of the *1998 Act* provides that the Registrar is to presume that an interim payment direction for weekly payments is warranted unless it appears to the Registrar that:

1. the claim concerned has minimal prospects of success; or
2. the worker has returned to work; or
3. the injury was not reported by the worker as required by s 44; or
4. insufficient medical evidence is available concerning the period of incapacity of the worker; or

5. circumstances exist that are prescribed by the regulations as circumstances in which it is not to be presumed that such a direction is warranted.

Section 297(4) of the *1998 Act* provides that if an injury management plan for the worker is in place, or the insurer has accepted that the worker has received an injury (as defined in the *1998 Act*), the Registrar is to presume that an interim payment direction for medical expenses compensation is warranted if satisfied that the treatment or service to which the compensation relates is reasonably necessary:

1. to prevent deterioration of the worker's condition; or
2. to promote an early return to work; or
3. to relieve significant pain or discomfort; or
4. for such other reason as may be prescribed by the regulations.

An interim payment direction may be given subject to conditions (s 297(6)) and a further interim payment direction or directions can be given after the expiry of any earlier direction (s 297(7)).

A limitation of 12 weeks applies to an interim payment direction (or further interim payment direction) regarding the payment of weekly compensation (s 298(1)), but a maximum of 10 weeks of arrears may be included in that period (s 298(2)).

Section 298 does not apply to a dispute concerning an insurer's decision to discontinue or reduce weekly payments based on a work capacity decision under Div 2 of Pt 3 of the *1987 Act* (s 197(1A)).

The Registrar may revoke an interim payment direction at any time (s 299(1)) and when revoked, the obligation to make payments under it ceases (s 299(2)). However, revocation does not affect the obligation to make payments before the revocation (s 299(3)).

Section 301 of the *1998 Act* provides that the payment of compensation under an interim payment direction is not an admission of liability by the insurer or employer.

A decision made under s 304B is a final decision and if a party is dissatisfied with it, they may appeal under s 352 of the *1998 Act* (*Hobden v Illawarra Area Health Service* [2010] NSWWCCPD 13; *Kohlrusch v Macquarie Education Group Australia Pty Ltd* [2012] NSWWCCPD 15).

Note that the WCC uses the expedited assessment procedure to determine work capacity disputes.

Workplace injury management disputes

A workplace injury management dispute is a dispute concerning a failure by a party to comply with an obligation imposed by or under Ch 3 of the *1998 Act* (s 305).

Section 306 of the *1998 Act* provides that the Registrar may deal with a workplace injury management dispute: (1) by conciliating, or (2) by directing that an injury management consultant or other suitably qualified person (paid for by the employer) conduct a workplace assessment in connection with the dispute, or (3) by referring the dispute to SIRA, or (4) by making a recommendation.

The note to s 306 provides that the Registrar can refer the dispute to the WCC (constituted by an Arbitrator) for determination if action under this Division is not successful.

The Registrar can recommend that a party to the dispute take specified action, being action that he feels desirable to remedy the failure that is the subject of the dispute (s 307(1)). If the dispute concerns a failure to comply with an injury management plan, he can recommend compliance subject to any modifications that he considers appropriate (s 307(2)). If the dispute concerns the provision of suitable employment for the worker, he must have regard to the requirements of s 49 in making a recommendation regarding the provision of suitable employment (s 307(3)).

Where the Registrar makes a recommendation, the party to whom it is made must, within 14 days, comply with it (s 308(1)(a)) or request that he refer the dispute to the WCC (constituted by an Arbitrator) for determination (s 308(1)(b)).

If a worker's failure to comply with the Registrar's recommendation constitutes a failure to comply with s 308, they have no entitlement to weekly payments during the period in which the failure continues (s 308(2)).

If the employer's failure to comply with the Registrar's recommendation constitutes a failure to comply with s 308, the employer's insurer is entitled to recover from the employer the amount of weekly payments paid by it in respect of any period that the failure to comply with the recommendation continues (s 308(3)).

[3.660] Court proceedings for work injury damages

It is well-established law 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 to engage competent people to carry out 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 to the worker in a claim for damages at common law.

In New South Wales, the right to recover damages by injured workers or their dependants (in the case of a worker's death) has been significantly modified by statute and the current scheme of work injury damages was introduced on 27 November 2001 by the *Workers Compensation Legislation Further Amendment Act 2001* (NSW).

[3.670] Modified common law damages

As award of work injury damages takes the form of a single lump sum payment and is aimed at compensating and indemnifying the claimant for the loss that they have suffered. In New South Wales, the calculation of work injury damages is governed by Pt 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, considered.

The calculation of damages for future loss of earnings is restricted to future loss of earning capacity up to pension age (s 151IA). The calculation of the present value of future economic loss is also subject to a discount (s 151J).

Upon payment of an award of damages, an employer ceases to be liable for any further workers compensation benefits in respect of the subject injury. In addition, any weekly payments already paid must be deducted from those damages (s 151A).

[3.680] Threshold for work injury damages

A threshold of *at least 15%* permanent impairment applies to a claim for work injury damages (s 151H).

Note that "at least 15%" does not mean 16% or more, unlike the thresholds at 10%, 20% and 30%, which actually require a minimum of 11%, 21% and 31%, respectively.

If there is a dispute about whether that threshold is satisfied, the claimant cannot commence court proceedings for the recovery of work injury damages, and cannot serve a pre-filing statement under Division 3 unless the degree of permanent impairment has been assessed by an approved medical specialist under Pt 7 (the *1998 Act*, s 313).

A threshold dispute is resolved by referring the dispute to the WCC. Unless there is a dispute regarding liability, the Registrar will refer the dispute directly to an approved medical specialist for assessment.

Section 322A of the *1998 Act*, which was introduced by the *2012 amending Act*, provides that a worker may obtain only one assessment of the degree of permanent impairment with respect to an injury.

[3.690] Other restrictions on the 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 include whether the worker sought appropriate medical treatment and rehabilitation and whether they promptly sought suitable employment when certified as being fit to return to work (the *1987 Act*, s 151L).

Voluntary assumption of risk

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. However, 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 (the *1987 Act*, s 151O).

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 (the *1987 Act*, s 151N).

[3.700] Making a claim

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

A work injury damages claim must include details of the negligence or other tort alleged against the employer and details of any economic loss that allegedly resulted from the injury.

The worker bears the onus of proving 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 and it is sufficient that the risk was within a class of risk that the employer should have foreseen. The risk may be considered "reasonably foreseeable" even though the injury was unlikely to occur, provided that the likelihood of injury was not far-fetched or fanciful.

The worker must also prove that the employer's failure to take steps to avoid the risk showed a lack of reasonable care for their safety and that the employer's failure to take reasonable care caused their injury, loss and damage.

A worker may also claim work injury damages, where their injury resulted from the negligence of a fellow worker, as employers are generally considered vicariously liable for its employees' actions.

However, an employer who can prove that no reasonable person could have anticipated what occurred and/or that they took reasonable steps to avoid injury may not be liable for damages.

[3.710] Proceedings for work injury damages (excluding dust diseases)

Court proceedings for work injury damages may be commenced in any court of competent jurisdiction. However, proceedings cannot be commenced until a claim has been made (the *1998 Act*, s 262).

The legislation also sets out procedures for pre-trial negotiation and mediation aimed at informal resolution without recourse to formal court proceedings.

Pre-filing statement and pre-filing defence

If the employer disputes that the claimant is entitlement to damages or the extent of their entitlement, the parties are required to serve on each other their proposed court pleadings (statement of claim and defence). The WCC Rules also requires them to serve a copy of all information and documents on which they propose to rely (rr 17.4, 17.6).

Mediation

The claimant must refer a disputed claim for work injury damages to the WCC for mediation before they can commence court proceedings (the *1998 Act*, s 318A).

An employer may decline to participate in mediation of the claim if it wholly disputes liability in respect of the claim, but in all other cases, it must participate in the mediation process (s 318A(3)).

Upon receipt of a mediation application, the WCC will refer the matter to a WCC-appointed mediator, who has a legislative mandate to use their best endeavours to bring the parties to agreement (s 318B).

If a matter fails to resolve at mediation, the mediator will issue a certificate certifying the final offers made by the parties.

While offers at mediation cannot be disclosed in court proceedings, mediator's certificate may be used in relation to arguments over any entitlement to costs when court proceedings conclude.

Court proceedings

The parties are generally restricted to the pleadings and evidence that they served during the pre-trial dispute resolution process. However, the court may grant leave to amend the pleadings or to introduce new evidence in exceptional circumstances.

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

Claimants in proceedings for work injury damages are not afforded the same protection against costs as under the statutory scheme and a claimant who fails to recover damages exceeding the last offer of settlement made during mediation may be liable to pay their own legal costs and those of the other party or parties.

In view of the restrictions imposed on the recovery of work injury damages and the costs associated with court proceedings, it may be preferable for a worker to remain on statutory benefits rather than to pursue a work injury damages claim – even where they appear to have a strong case in negligence etc. For example, a worker who requires extensive ongoing medical treatment and services will be required to personally fund their future treatment costs once an award of work injury damages is received.

[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 (the *1989 Act*, s 3; Sch 1).

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 **133 677** (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.communications.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.

Changes are expected to the websites for many NSW government departments that were not available at the time of printing. See www.service.nsw.gov.au for further details.

Aboriginal Medical Service Co-operative
amsredfern.org.au/
ph: 9319 5823

Animal Welfare Branch
NSW Primary Industries
www.dpi.nsw.gov.au/animals-and-livestock/animal-welfare
ph: 6360 5344

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

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

Centrelink
www.humanservices.gov.au/individuals/centrelink

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

Fair Trading, Office of
www.fairtrading.nsw.gov.au
ph: 13 32 20

Fair Work Commission
www.fwc.gov.au/

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

Insurance & Care NSW (iCare)
www.icare.nsw.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

Medicare
www.humanservices.gov.au/individuals/medicare
ph: 132 011

NRMA Insurance
www.nrma.com.au
ph: 13 21 32
Member Legal Service
www.mynrma.com.au
ph: 13 11 22

Police, NSW
www.police.nsw.gov.au
ph: 9281 0000
Police Assistance Line
ph: 131 444
PrivateHealth.gov.au
www.privatehealth.gov.au/
ph: 1300 737 299

Private Health Insurance – Commonwealth Ombudsman
www.ombudsman.gov.au/How-we-can-help/private-health-insurance
ph: 1300 362 072

Roads & Maritime Services
www.rms.nsw.gov.au/
ph: 13 22 13
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 278 358

State Insurance Regulatory Authority
www.sira.nsw.gov.au

Unions NSW
www.unionsnsw.org.au/
ph: 9881 5999

Victims Services, Department of Justice
www.victimsservices.justice.nsw.gov.au/

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

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