THE LAW SOCIETY
OF THE AUSTRALIAN CAPITAL TERRITORY

Personal Injury Claim Notification

pursuant to the Civil Law (Wrongs) Amendment Regulation 2004

Complete the form in BLOCK LETTERS
Provide details on separate sheets if required

To Respondent MARIST COLLEGE
Address MARR STREET
PEARCE ACT Postcode 2607

1. Your personal details

Mr ☒ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Given name(s)
REDACTED

Surname
REDACTED

Date of birth
REDACTED

Home address
REDACTED

Postal address or 'as above'
AS ABOVE
Postcode

Home phone number (02) 6292 4414 Work phone number ( )

Have you even been known by another name?

No ☒
Yes ☐ Give details below

Surname

Given name(s)

Are you legally represented?

No ☐
Yes ☒ Give details

Name of firm
PORTERS LAWYERS

Name of solicitor
JASON PARKINSON

Date you first consulted a solicitor
13/5/2008

Date you first identified the respondent
13/5/2008

2. Accident/Incident Details

How were you injured?

☐ Motor Vehicle Accident
☐ Work Accident
☐ Health Providers Act or Omission
☐ Public Liability
☒ Other

Date of accident 1986 Time of accident ☐ am ☐ pm

Place of accident (include street and town if applicable)
MARIST COLLEGE
MARR STREET
PEARCE ACT Postcode 2607

Please provide a description of the accident

BROTHER KOSTKA CHUTE WAS A TEACHER AT THE SCHOOL. KOSTKA SEXUALLY ASSAULTED THE PLAINTIFF'S SON WHEN THE PLAINTIFF'S SON WAS A STUDENT AT THE SCHOOL. REDACTED TOLD BR TERRENCE HEINRICH, TH HEADMASTER, OF THE SEXUAL ASSAULT. HE TOLD THEM, THAT IF THEY LEFT IT WITH HIM, IT WOULD NEVER HAPPEN AGAIN. REDACTED NOT KNOW THAT A NUMBER OF OTHER BOYS WERE SUBSEQUENTLY SEXUALLY ASSAULTED BY BR KOSTKA. REDACTED IS NOW SUFFERING FROM DEPRESSION, KNOWING THAT SHE TRUSTED BR HEINRICH, BUT HIS NOT REPORTING BR KOSTKA TO POLICE LED TO A NUMBER OF OTHER BOYS BEING SEXUALLY ASSAULTED BY BR KOSTKA.

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Do you know if police, ambulance, fire brigade or any other emergency service attended the accident?

No ☒

Yes ☐ Give details below

Name of service

Name of person who attended

Contact details

Do you know if any witness statements were taken (for example by police)?

No ☒

Yes ☐ Give details below

Witness 1

Surname

Given name(s)

Home address

Postcode

Home phone number ( )

Work phone number ( )

Witness 2

Surname

Given name(s)

Home address

Postcode

Home phone number ( )

Work phone number ( )

Who in your opinion, other than the respondent, caused the accident?

Surname

Given name(s)

Home address

Postcode

Home phone number ( )

Work phone number ( )

Are you receiving, or entitled to, any other forms of compensation as a result of this accident?

(For example, workers compensation)

No ☒

Yes ☐ Give details below

Name of insurance company

Type of policy

Policy/Claim number

Have you lodged a claim?

No ☒

Yes ☐ Give details below

Date claim lodged / /

Claim number

3. Medical Details

What are your injuries from the accident? (list all injuries)

PSYCHOLOGICAL INJURIES.
DETAILS TO BE PROVIDED.

Did you go to hospital after the accident?

No ☒

Yes ☐ Name of hospital

Date

/ /

Who has treated you for your injuries since the accident?

List all doctors, surgeons, physiotherapists, specialitists etc. (Please include annexure if there is not enough room)

Name

Address (practice or surgery)

Postcode

Phone number ( )

What treatment or rehabilitation have you had?

4. Employment details

Have you lost income as a result of this accident/incident?

No ☒

Yes ☐

Please advise your employment status

- ☐ Full time employed
- ☐ Part time employed
- ☐ Self employed
- ☐ Casual
- ☐ Retired
- ☐ Student/Child
- ☐ Home duties
- ☐ Not working
- ☐ Pension (please describe)
- ☐ Other (please describe)

Please provide your employment details

Name of employer

Contact person's name

Contact phone number

( )

Workplace address

Postcode

Usual weekly working hours

Ordinary

Overtime

Usual weekly earnings
(include overtime, regular bonuses and commission)

Gross (before tax)

$

Net (after tax)

$

Description of duties

Is the work you do or your weekly earnings different because of the accident?

No ☒

Yes ☐ Give details below

If self employed:

Have you lost income from self employment in your own business because of the accident?

No ☒

Yes ☐ Give details below

Name and nature of business

Accountants name

Accountants contact details

Phone number ( )

Estimate of earning loss (if known, give details of how much you believe you have lost and how you calculated the amount. You must be able to give copies of your taxation returns, group certificates and assessment notices).

$

5. Claim against health service providers

Is the claim against a health service provider? (eg a doctor)

No ☒

Yes ☐ If yes, what is the medical condition for which you sought treatment?

Is the claim related to a new injury or the worsening of a pre-existing injury?

New ☐

Pre-Existing ☐

What did the health service provider do or not do which caused the injury or worsened a pre-existing injury?

Do you believe the health service provider failed to inform you of the risks involved in the treatment you undertook?

No ☒

Yes ☐ If yes, please provide details as to when you believe the information should have or could have been provided to you

Name of service provider

Date / /

Time am pm

Place

Did the health service provider provide any written or oral information or warning?

No ☒

Yes ☐ If yes, please provide details

Date / /

Time am pm

Place

Warning given:

Did you consent to the treatment given to you by the health service provider which has given rise to the injury?

Yes ☐

No ☐

Was it written or oral consent?

Written ☐

Oral ☐

When and where was the consent given?

Place

Date / /

Motor Vehicle Accidents

If the injury was caused by a motor vehicle accident, please complete the following questions otherwise turn to the next page

Do you have the registration number of the vehicle you consider at fault?

No ☐ There is an obligation on you as the claimant to provide evidence of steps taken to find out the registration number or the owner of the vehicle you consider at fault. Please list any action taken by you to find the registration number or the name of the person who drove the vehicle you consider at fault. (Please attach any proof such as newspaper advertisement or discussions with any witnesses etc)

Yes ☐ Give details below

Registration number

Type of vehicle (if known)

Vehicle you were travelling in

Registration number

Type of vehicle

If you were a driver/passenger, were you wearing a seat belt?

No ☐

Yes ☐

If you were a motorbike rider/cyclist, were you wearing a helmet?

No ☐

Yes ☐

Diagram of Accident

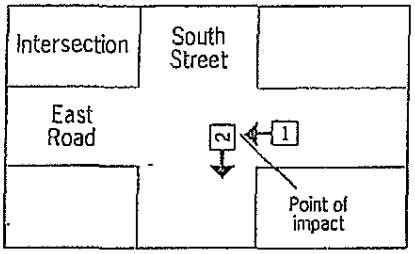
Draw a diagram of the accident. Include all intersections, streets, roads and their names. Show the point of impact and position of vehicles.

Use this box →

Symbols

- ←[1] vehicle that caused the accident
- ←[2] other vehicle(s)
- ←[3] etc
- ←○ pedestrian, cyclist, etc

Example diagram



Authorisation

Given name(s) [REDACTED] Surname [REDACTED]

address [REDACTED]

authorise the respondent and the respondent's insurer for the claim (if any) to have access to the following records and sources of information relevant to the claim which occurred on:

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1) Clinical notes in the possession of a health service provider who treated or assessed the injured person for the pre-existing injury or condition
2) Clinical notes in the possession of a hospital (including a private hospital) where the inured person received treatment relevant to the personal injury
3) Records in the possession of an ambulance or other emergency service that treated or assisted the injured person in relation to the personal injury
4) Clinical notes in the possession of a health service provider who treated or assessed the injured person in relation to the personal injury
5) Wage, leave and work history records in the possession of
   (i) the injured person's employer
   (ii) anyone else who employed the injured person at any time during the 3 years before the accident.

The respondent and the respondent's insurer (if any) must not use records and sources of information accessed under sub regulation (1) otherwise than for a purpose related to the claim. The person must provide the injured person within one month with copies of any documents obtained pursuant to this authorisation.

Documents to accompany notice of claim

The notice of claim must be accompanied by the following documents:

a) for a claim other than a claim against a health service provider – a copy of any certificate signed by a doctor relevant to the personal injury to which the claim relates that is in the claimant's possession.
b) for a claim against a health service provider – a copy of any advice or warnings given to the injured person by the health service provider about the treatment claimed to have given rise to the personal injury that is in the claimant's possession.
c) for a claim against a health service provider – a copy of any consent given to the health service provider by the injured person about the treatment claimed to have given rise to the personal injury that is in the claimant's possession.
d) a copy of any other document on which the claimant currently expects to rely for the claim that is in the claimant's possession.

Signature of injured person

*If another person signed on behalf of the injured person.

Details of the person who signed

Surname: PARKINSON Given name(s): JASON

Home phone number: ( ) Work phone number: 6246247 3477

Relationship to the injured person: SOLICITOR

Reason why the injured person could not sign: NOT PRESENT