

SUBMISSION TO THE
INQUIRY INTO CLAIMS
MADE TO THE TRANSPORT
ACCIDENT COMMISSION

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Dr Jai Cooper is a long-standing client of the TAC, [REDACTED]. Injured in a no-fault motor vehicle accident (MVA) in 1987, Jai is amongst the earliest clients of TAC and has remained an ongoing low-needs client over several decades. Jai is a social scientist working as a consultant researcher for the University of Newcastle. This submission is presented as an individual and not as a representative of the University of Newcastle. Dr Cooper specialises in environmental sociology. Jai has experience teaching the sociology of health and working collaboratively with health researchers. Further details of Jai’s personal experience of injury in a MVA are provided as an appendix.

Summary

The purpose of this submission is to improve outcomes for clients of the TAC, improve our capacity to contribute productively to society, and to support the purposes of the Transport Accident Commission Act 1986.

This submission is primarily based on decades of personal interaction with the TAC during which a change of organisational culture has been observed. Further observations include discussions with other TAC clients, media analysis, a review of literature, discussions with senior TAC staff, and formal and informal discussions with professional practitioners including medical and health practitioners, disability advocates, National Disability Insurance Scheme (NDIS) staff, legal advisors, and policy makers.

It is my concern that activities of the TAC have not always been of sufficient standard to meet the intentions of the Act. Consequently, some outcomes have not been achieved efficiently. These include impacts upon client health and productivity, and bureaucratic inefficiencies.

A series of examples are provided as vignettes demonstrating experiences with the TAC. These are reflected upon with consideration of the inquiry's terms of reference and the aims of this submission. Suggestions are offered in the areas of recovery and support planning, bureaucratic processes, values-orientation, and research.

Experience of the TAC since 1987

As a long-term and relatively low-needs client of the TAC over almost four decades, the majority of my experience has been positive. The TAC was established with good intentions. In the early period following my MVA my solicitor showed me through a Melbourne CBD building with a hallway of empty consulting rooms. He explained that, prior to the TAC Act, these were filled with small claims. The TAC Act clearly reduced a burden on the legal system and clients. The attention of TAC staff, particularly during 1987 and 1988, was excellent. They personally attended to me in hospital to assist in lodging my claim. I had the benefits of a two-month program at TAC's Glen Waverley rehabilitation centre. This experience, recovering alongside fellow TAC clients, each of us with our own individual challenges and supported by professional staff, was extremely beneficial in setting me up for life. I also understood that the purpose of the TAC Act was to remove medical and rehabilitation expenses from common law claims and, rather, to provide them on an ongoing basis. In the mid-90s, I concluded a common law claim for expenses

relating to pain and suffering and for loss of earnings. It has been my understanding that coverage for medical and rehabilitation expenses is life-long.

I was advised on a few occasions by both medical and legal professionals that I would need ongoing and future medical and rehabilitation support and that it was sensible to keep making a small claim for something periodically. Their reasoning was that they had experienced insurers attempting to decline claimants who did not have a continuing relationship. As an example of an ongoing expense, I have required elasticised ankle braces. These braces wear out every few months. There has never been a period of more than a few months during which I have engaged with the TAC.

However, since those early experiences, I have never been actively contacted by the TAC. I have found this to be alienating and somewhat surprising that the TAC does not actively consult nor assist with injury management planning for their long-term, low-needs clients. This is despite the reimbursement for medical and rehabilitation expenses from TAC to be life-long. Occasionally, I have even experienced a rejection for the ankle braces which I have claimed over decades. I have provided medical support confirming this expense on several occasions. It has been surprising that there is no ongoing assessment of my needs as a life-long client. On one occasion, during a discussion with a TAC claims officer, they referred to the terminology of 'recovery'. It occurred to me that they viewed the intention of the TAC to get clients back to a capacity to return to employment and, at that point, the TAC's responsibility had been completed. It suggested that the TAC had begun to replicate the principles of workplace rehabilitation, not its intention to provide ongoing life-long support.

I have raised this principle with TAC claims staff and with senior executives. In one discussion with [REDACTED] she confirmed that 'you have a right to reasonable medical and rehabilitation costs for the length of your life'. In 2025, [REDACTED] a team-leader, confirmed ongoing support for five years for ankle and knee braces. However, when I mentioned that my medical practitioner had previously confirmed need for a walking stick, she replied that I would need another letter in future. The absence of long-term assessment and planning again demonstrated a culture of resistance, rather than support. I have received no long-term needs assessment and approval of ongoing costs. This creates a burden of making another visit to a doctor for approval as well as bureaucratic burden.

Following some frustrating experiences, I became concerned that a cultural change had occurred at the TAC and that there was scope to improve some of TAC's processes. In 2023, I requested contact with senior executives. In May of 2023, [REDACTED], Executive Assistant to [REDACTED], Chief Risk Officer, facilitated a meeting for me with

██████████ – Head of Strategy, Sectors and Research, and ██████████ - Head, Complex Recovery and Serious Injury Division.

In discussions with ██████████ and ██████████ in May 2023, they agreed that, although support is given to high-needs clients, that supporting low-needs clients is a shortcoming of TAC's operations. Further, they expressed that many low-needs clients have increasing needs with age. They also expressed that there would be value by increasing research into the outcomes for long term clients.

They also praised me as an example which defied a common outcome for young males injured in motor vehicle accidents. They advised me that there was a common problem for people of my demographic to encounter opioid addiction, obesity and other health problems. They advised that I stood out as an exemplar of how clients of my background could recover and contribute to society. There was discussion of a client advisory body or some scope for engaging me with research with the TAC. Following our meeting, ██████████ emailed me with further information and that he would be in touch soon. ██████████ suggested that, in the meantime, I explore TAC's 'Client Voice' initiative. I did not hear further from ██████████ and ██████████ and understand that they left TAC during 2023. My experience with 'Client Voice' was disturbing and prompted me to seek further support with other clients through social media. Further details of the 'Client Voice' experience are provided in a vignette below. I have since met online with other clients who have shared traumatic experiences with TAC describing the culture as 'toxic' and that the TAC 'will gaslight you'. Some of us formed a discussion group to initiate an inquiry and met with David Limbrick MLC who subsequently initiated this parliamentary inquiry.

My experiences are incomparable to some of those experienced by other clients. I am a highly-qualified individual with relatively low needs. There are other clients with extremely debilitating conditions whose lives are far more challenging than mine. If I experience difficulties dealing with TAC, I can only imagine the level of challenge facing some others. I suspect that my experiences are relatively trivial in comparison, yet they may help to demonstrate some of the dynamics involved.

Examples of experiences with TAC

Long term planning

Long term planning is absent. I have looked for ways to have a long-term formal plan developed. This would avoid having to justify each expense independently. The 'MyPlan' scheme appeared to be one possible option. However, my experience was disappointing.

Example: 'MyPlan'

While reviewing TAC's website, I found information about 'MyPlan'. The website claims:

"MyPlan is a new way for the TAC to work with some of our clients. We will contact eligible clients to start the planning process and develop a MyPlan." The eligibility criteria are not stated.

The 2023-24 Annual Report states that in that year, 3,655 clients received their own MyPlan.

The website also states:

"From Monday, 12 September 2022, TAC clients with complex recovery needs or serious injuries will work collaboratively with the TAC and their treating providers to develop a MyPlan. This planning tool supports the client, their providers and the TAC to work together more effectively to identify a client's goals and the services and supports they need in place to reach them."

As someone found to have a 'serious injury', I felt encouraged that this may apply to me.

On 21 Feb, 2025, I rang the 1300 number and spoke with a customer service officer who had no knowledge of 'MyPlan'. I asked to be referred to a manager. [REDACTED] a team leader, replied and, when asked what they knew about 'MyPlan', stated 'to be honest, not a lot'. [REDACTED] offered to find out more and stated that they would get back to me. Days later, [REDACTED] did reply and explained that 'MyPlan' only applies to new cases.

My experience of recovery planning with the TAC was initially excellent in 1987 and 1988. The support given at that time has been of great benefit throughout my life. However, despite more complex needs arising due to compensatory behaviours, TAC has provided no further support for ongoing injury management planning. I have been left to initiate all planning individually. For there to be no engagement for over three decades as an ongoing client of TAC has been alienating.

Bureaucratic inefficiencies

It is not unusual for there to be inefficiencies in a large bureaucracy. For example, long waiting times from a call centre. However, there can be absurd experiences of bureaucratic duplication. It should be noted that clients already experience mobility and, sometimes cognitive, disadvantages due to their impairments. The time-penalty endured is an additional impost upon daily activities. In the absence of active contact from TAC, this places the burden of contact upon the client. Delegating the effort to the client potentially frees TAC from some effort but is inconsistent with the intention of maximising the productive potential of clients. There are also internal review processes when there is a dispute over an expense. These include long waiting times which add further burden to clients who may spend weeks or months wondering if they will be reimbursed for an expense. In some cases, this results in clients avoiding the expense and suffering health impacts. In some cases, bureaucratic absurdity occurs.

Example: The ‘treating doctor’ trap - a Kafkaesque loop

In mid-late 2024, I contacted the TAC about ongoing costs for physiotherapy, pool and gym membership. I was advised to visit my GP to get written support. On that advice, I booked an appointment at my GP.

On 16 Sep 2024, I attended Dr [REDACTED] practice. Dr [REDACTED] wrote a letter of support that day commencing with “Mr Cooper was injured in an accident 24/9/1987. He suffered serious injuries ...” . Dr [REDACTED] identified some of the injuries I suffered in the transport accident and his “support for the medical need of a gym membership, pool and exercise physiologist for rehabilitation”. The receptionist advised that payment could be sought from TAC so I gave them my claim number.

I subsequently submitted the letter to TAC to support my request for services.

On 1 Oct 2024, I received a letter from TAC advising that they had ‘received an invoice from Dr [REDACTED] [REDACTED] and requiring a ‘detailed letter’ from my ‘treating doctor/specialist ... to assist us in reviewing the request and determining how the need for a GP consultation is related to your transport accident injuries’.

Effectively, the TAC wanted a letter from Dr [REDACTED] to approve me seeing him upon the TAC’s own direction. This was despite that I had already provided a letter in which Dr [REDACTED] had clearly stated the relevance of the transport accident. This drama all occurred even before the clinical services that I was seeking were even considered by the TAC.

I have also experienced surprising bureaucratic discretion. On some occasions, TAC appears to act rigidly. However, other experiences have demonstrated that staff are able to use discretion regarding expenses.

Example: 'good will'

On 3 Dec, 2024, despite a lengthy process of providing clinical evidence from both a GP and physiotherapist, the TAC declined to pay for further physiotherapy treatment. I subsequently requested an 'informal review' which was received by the Dispute Resolutions Team.

On 26 Feb, 2025, [REDACTED] – Dispute Resolution Officer replied:

"I acknowledge your goals of prevention however this is not supported by the Clinical Framework. As a good will, to assist you with your goals, the TAC will pay for one further 3 month gym/swim membership to have begun by the 1 June 2025."*

I rang and spoke directly with [REDACTED] I was confused that, despite the review finding against the clinical evidence, that I was still being offered a payment. When I asked if this was 'appeasement', [REDACTED] agreed. I was quite surprised but willing to accept the 'good will'.

That afternoon, I attended New Lambton pool (Bluefit) and purchased a 10 visit pass for \$54. Bluefit does not issue 3 month memberships. I claimed for reimbursement via the TAC app. I included a note about the pass and referred that, if there were questions, to review correspondence from [REDACTED]

On 3 Mar 2025, I received a payment of \$10 with the service code 'GM0010 Individual Pool Fee' and the reason 'paid at the TAC max'. Rather than reimbursed for the 10 visits, I was reimbursed for merely one visit.

Later that day, I sent a message via the TAC app with the written approval from [REDACTED] attached including informing the TAC that the \$10 payment had caused distress and a request to avoid causing further distress.

On the 4 Mar 2025, I received an inbox message from [REDACTED] Claims Advisor', that 'The TAC will require a copy of your receipt from Bluefit to process your reimbursement. We are unable to process the reimbursement from the EFTPOS receipt your [sic] submitted."

Despite it being possible to reimburse me the \$10 based on the eftpos receipt, this new reason had now appeared inhibiting further payment. After several emails each way, multiple direct messages through the app, and a \$10 payment for a promised uncapped service which only cost \$54, I decided to avoid further distress. On 6 Mar, [REDACTED] messaged me including an apology and that the amount would be fully refunded.

This is my experience of the TAC's 'good will', a Kafkaesque comedy of bureaucratic absurdities and inefficiencies (and possibly hostility): resist reasonable costs, create new barriers, cause distress and (when it was indicated that distress had been caused and a warning provided about possible further distress) then cause further distress. Further, despite specifically flagging 'distress' and that it continued and grew, I was not referred for psychological support. This example could simply be one of TAC engaging in inconsistent practices. However, at its potential worst, wholly or in part, it may involve an act (or acts) of hostility towards me as an outspoken client. Regardless, it was a significant use of resources by both myself and the TAC far exceeding in kind the value of \$54.

*no previous payment had been made

This experience of discretionary ‘goodwill’ was somewhat comic. It was a small amount of money for an expense which had originally declined, and for which a token amount had been provided.

Unethical conduct

Example: ‘Client Voice’

On Sep 13, 2023, after learning that both [REDACTED] (Head, Complex Recovery and Serious Injury Division) and [REDACTED] (Head of Strategy, Sectors and Research) had left the organization in the previous months, I was disappointed that ongoing communication with senior management had ceased (despite [REDACTED] intention).

Here is email text from [REDACTED] received on May 19, 2023:

Hi Jai,

Thanks for meeting with [REDACTED] and me a couple of weeks ago. Thanks for sharing part of your journey and experiences with us. As we discussed I’m keen to stay in touch and ask for your assistance down the track as we embark on some of the service design changes that we talked about. Your input would be invaluable. I’ve attached a link from our website that articulates (briefly) our approach to engaging with clients and incorporating their voice. You don’t need to do anything with this – I have your details and will be in touch – it’s more for your interest.

Thanks again for the discussion – much appreciated.

Cheers,

<https://www.tac.vic.gov.au/about-the-tac/our-clients/client-voice>

Later that day, I registered for ‘Client Voice’.

Here is a section from the TAC website about Client Voice:

Benefits of our Client Voice work include:

- Our clients feel valued.*
- Our clients have an opportunity to develop new skills and build social networks with others affected by road trauma.*
- Our clients take part in social and economic activities.*
- We better balance client and business objectives.*

I received this automated reply:

Thanks for registering to be part of the TAC's Client Voice.

- We will keep your details handy and might contact you to take part in an activity. To unregister, please email us and let us know you don’t want to be in the Client Voice program.*
- If you are contacted about a Client Voice activity, it is your choice whether you want to take part or not. We will send you information about the activity so you can make your decision.*
- You can find out more about TAC client Voice at [tac.vic.gov.au/clientvoice](https://www.tac.vic.gov.au/clientvoice)*

My experience with TAC's 'Client Voice' program was more disturbing. 'Client Voice' invited clients to participate in 'research'. On several occasions spanning over a year and a half, I was referred to 'Client Voice' by TAC staff. This even included after making a complaint and having the Complaints Specialist claiming to have made a 'thorough review of the interactions with our clients'. 'Client Voice' featured profile stories of clients and how they had recovered. In the belief that I represented a successful story of client recovery, I was interested in the prospect of telling my story. However, it also promised contact with other clients and I viewed that opportunity as of great benefit. I hadn't seen another client since 1988 and it made me realise how valuable it was to work alongside peers. I registered for 'Client Voice' in May 2023 and again later that year but only ever received an automated response. I never told my story, participated in any research or met any other clients. There were no 'social or economic activities' and there only appeared to be a 'business objective' for TAC being served. I did not feel valued.

This experience concerned me that TAC was more focused upon self-promotion than the well-being of clients. Client Voice appeared to be an insincere exercise and could be potentially exploiting clients, not for their wellbeing, but for the purposes of improving TAC's public relations. Both [REDACTED] and [REDACTED] left the TAC in 2023 for reasons not known to me. The suggestion that Client Voice 'might contact' me was not effective at making me feel valued. Nor did it suggest that I would have opportunity to develop new skills and build social networks with others affected by road trauma. The experience left me feeling further alienated. It stood in stark contrast to [REDACTED] and [REDACTED] communications. Further, I could see no evidence that any other TAC clients were building social networks with others affected by road trauma through 'Client Voice'. My earlier experience of rehabilitation at Glen Waverley in the late 1980s was inspiring largely because of the benefits of being alongside other clients and sharing our challenges. I realised that I had not been in contact with any other clients in decades. The promise of meeting with other clients had enthused me. The failure to meet with other clients was demoralising. Further, 'Client Voice' was promoted as 'research'. As a researcher, I considered it to be unethical conduct to allude to meeting with other clients and then not delivering upon it.

In response to registering for Client Voice, I have received only automated emails that my response has been received. Eventually, when I requested evidence that 'Client Voice' exists, the Complaints Specialist apologised that it had been superseded. However, the 'Client Voice' page remained on the TAC website for a significant period and was only removed after I pointed out that it had caused me harm and that it may be causing harm to other clients.

The TAC allowed vulnerable clients to register for a service promising benefits and claiming to make us feel valued when that service did not provide those benefits and, for some time, did not even exist. In combination with other factors, for example the extensive promotions of TAC (such as AFL sponsorship), I became concerned that TAC was more focussed upon self-promotion than the well-being of clients. This experience prompted me to seek further support through social media where I have since met with many other clients.

Discussion

The experiences with TAC have led me to further explore its operations including its research agenda. Annual reports of research and studies completed are available through the TAC website. Links to the reports are not always included. There is a significant body of research into accident prevention for which the TAC should be lauded. There is also some valuable research into supporting high-needs clients. However, there is an absence of data, analysis or reporting available on the outcomes across the range of clients on a longitudinal basis.

The TAC Annual Report includes performance ratings in the Client Outcomes and Experiences Survey. A client experience score of 6.78 was reported in 2023-24. The report stated (p.42) that:

“... our clients also told us they would like for the TAC to be easier to contact and more responsive in returning calls. We have improved our call response rate over the financial year and will continue to focus on this so our clients can speak to us when they need to.”

Research such as the Client Outcomes and Feedback Survey conducted by the TAC will be subject to response bias. For example, clients who have been alienated by the TAC are unlikely to contribute to a survey presented by the TAC itself. A deeper understanding of complex support challenges and advanced feedback will not be received through this type of research. Internal research with TAC client-facing staff and research conducted with clients under human research ethical protocols (such as guaranteed anonymity) and conducted by an independent research body are more likely to produce robust and reliable insights.

Further, there is a significant scope for expanding data collection and analysis of client outcomes. For example, fundamental social science data on causes of attrition of clients, life expectancy, employment, suicide, and other outcomes would provide indicators for the effectiveness of TAC's client support and could provide useful opportunities for improving services.

As a result of the limitations of TAC's current research program, knowledge of key outcomes for TAC clients are limited and lacking in reliability.

There is a significant disconnect between the operations of TAC and its clients. There are some glaring absences such as a client advisory group. On one occasion, a claims officer revealed that they were also a client. However, the TAC board membership does not appear to include any clients. Board positions on large corporations are also subject to

being compromised by individuals seeking personal ambition rather than sincere intention. An alternative to which I have more recently been referred is 'Amber Community'. However, I have also observed cynicism from other TAC clients towards Amber Community that they are funded by TAC and, therefore, lacking in independence. There is a clear need for independent and frank advice from TAC clients if the gap between the TAC and its clientele is to be bridged. There is an apparent lack of accountability of TAC to its client base. Given the TAC has been in operation for four decades, there will now be many thousands of clients spread throughout Victoria and beyond.

State capture may be underway. As a resident of NSW, there is a different compulsory vehicle insurance scheme in place. TAC has not only monopolised insurance provision, but is also so large that legal practitioners are at risk of being conflicted regularly. Other clients have often cited that their legal practitioner is conflicted by defending TAC in other cases. The degree of state monopoly may be leading to compromised services due to conflicts of interest.

There are also significant questions about internal competing priorities within TAC. Although preventive road safety is a sound use of revenue, it could be detracting from client support. At its extreme, in the example of 'Client Voice', the promotion of TAC has been unethical and has undermined client well-being.

Jurisdictional cost-shifting may be occurring. The development of the NDIS has provided another option for clients of the TAC. Duplication of processing and a cost-shifting exercise are possibly underway between TAC (state) and NDIS (federal). These are being experienced by clients as poor and diminishing service in recent years. Several TAC clients have stated that they have given up on TAC and are now utilising the NDIS instead because the rates are better and there is better support. There is an economic incentive for the TAC to resist payments to clients and drive them into utilising the NDIS. However, there is no formal process by which clients are supported to transfer between schemes. This could be a means to save costs for the TAC yet, if it is being conducted in an ad hoc manner, it is likely to be causing harm to vulnerable clients.

Suggested improvements

Long-term support planning:

Clients should be periodically (for example, five-yearly) contacted by TAC staff to actively plan their ongoing needs and to determine which expenses are a result of their MVA. This should include clients of all levels of need. The burden of substantiating the cause of expenses is re-traumatising for clients and should be minimised.

Client Advisory Group

Currently, the TAC has no legislated requirement to seek the advice of clients. The 'Client Voice' program misleadingly purported to offer some benefits which it does not. Amber Community is not viewed as independent. This would be formalised through an amendment to the Act including establishing a shared contact point, clear lines of reporting, and regular meetings. Consideration should be given to eligibility and remuneration for participation on the CAG. The current TAC Board is not a sufficient body because they do not provide contact details. They do not represent, nor are they responsible to, clients.

Review terminology:

Clients need 'support'. 'Recovery' to a pre-accident condition is unlikely for many clients. Ongoing life-long support is a legislated intention of the TAC Act and should be ensured. Internal policies of TAC should reflect the intentions of the Act.

Research planning

The research program for TAC is disparate. Key data is unavailable. For example, it is unclear how many individuals are or have been clients of the TAC. Long-term outcomes for key cohorts are required. For example, reliable data sets for life expectancy and other key outcomes are unavailable. There does not appear to be reliable longitudinal research being conducted into the client cohort. The periodic consultation for feedback is received cynically by many clients as a promotional exercise. Independent research should be promoted. The experience of 'Client Voice' also suggests that TAC's research agenda was misappropriated by its communications and engagement division. Formal research should

adhere to human research ethics protocols and other TAC activities should not be allowed to compromise research integrity.

Review of TAC's client services

It is recommended that a suitable consultant is engaged for the purpose of reviewing TAC's Client Management functions. Consideration should be given to whether the TAC is adequately meeting its legislated responsibility for reasonable medical and rehabilitation costs for clients. The establishment of the NDIS has created an alternative mechanism through which to service clients. If rates of payment for services through the NDIS are higher, then clients would wish to use the NDIS. If there is duplication of client support by having legislated government systems at both state and federal levels, then there exists a potential to rationalise the two bureaucracies and thus save revenues. There is also scope to review internal processes to ensure that the road safety promotion and the general promotion of TAC is not unfairly impacting upon client services.

A review would ask:

- Is TAC adequately supporting clients or is the NDIS a better option?
- Could revenue from compulsory third party insurance payments be transferred from the Victorian to the Commonwealth Government to support transfer of client services from TAC to the NDIS?
- Could the TAC's assessment functions remain in place to determine impairment levels and liabilities under common law?
- Are the proportions of TAC budgets fairly distributed between different priorities such as road safety promotions and client services?

Appendix - My story

I consider myself to be the model client of TAC. Over more than 38 years, I have maximized my clinical recovery and progressed from being severely injured, with a major disruption to my life trajectory, to being a successful contributor to society. I give a lot of credit to TAC for supporting me with these outcomes. However, I have concerns about some of the practices of the TAC which could be improved. Further, I have deeper concerns about recent developments which may be indicative of a worsening culture within the TAC.

I never asked for any of this. None of us did. I paid my vehicle registration because it's what is required with the understanding that it included protections for myself and others. It makes sense to rationally manage risk.

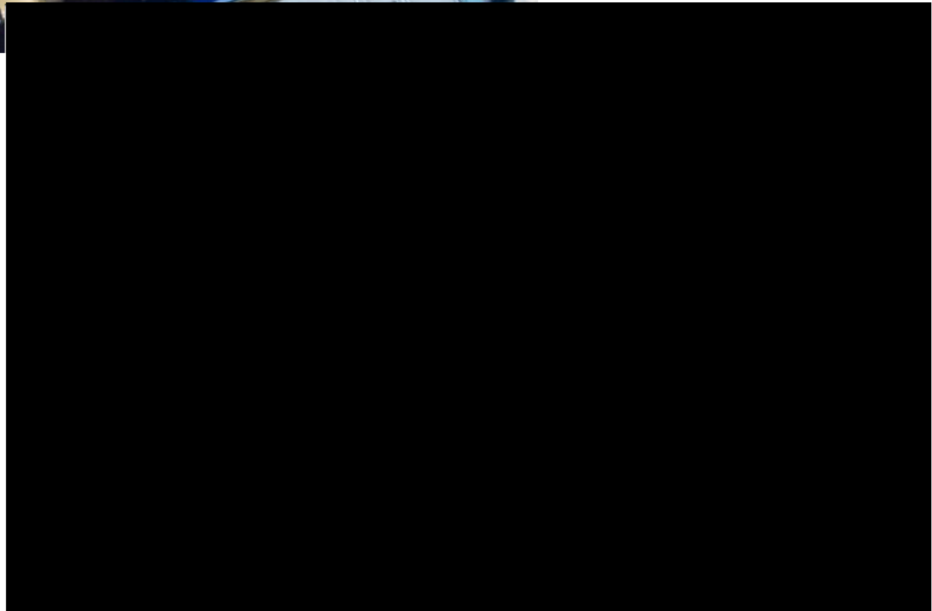
I am a low-needs client. This isn't about me. I've got skills, so I'll be okay. I worry about how others without my skills would cope. I expect that there would be a lot of attrition and depression from, not only the injuries and the ongoing pain, but from varying levels of support, and sometimes resistance, experienced socially, of which one part is the role of the TAC.

Pre-accident

In the latter part of 1987, I was 19 years old, working in the hospitality industry and had just spent the winter coaching the Under 16s of my former junior football club. We had just won the 'Best Conducted Club' award for the league. I was at an elite level of fitness. I finished HSC in 1986 and, after some discussion with my grandparents, I aimed to follow in my grandfather's distinguished military experience and subsequent career. By mid-1987, I had progressed through the first stage of testing for RMC Duntroon with a view to commencing there on January 1, 1988.

On the morning of September 24, 1987, I was driving to Point Leo to go surfing. A car crashed into mine sending mine through three end-over-end rolls and landing on the roof. My car was still running, I was hanging upside down, and I could see blood pooling on the inside of the roof below me. I could smell petrol. I could only see through one eye and thought I may have lost the other. My nose and right orbital had been fractured and my right eyeball lacerated. I screamed, 'get me the fuck out of here, help, help'. I tried to turn the ignition off but couldn't. My right index finger collapsed during the attempt. It was broken. Someone's hand reached in and turned the ignition off. A group of bystanders helped to turn the car over and, in time, emergency services arrived. Both of my legs were still pinned. My right leg was distorted at various angles. My right femur was smashed. My right ankle was crushed, with my foot swept across through the pedals. My right fibula was protruding through the skin. I could still feel my legs (the pain was a positive in that regard),

so I hoped that my spine was not fractured. In about twenty minutes, emergency services arrived. The jaws of life went to work. A police officer jumped on the bonnet trying to peel back the car's roof not realising that my legs were being crushed by his weight. I told him, in no polite terms, to get off the bonnet. I received a jab of morphine from a paramedic. I couldn't feel the needle. It was insignificant compared to the rest of the pain. Eventually, I was cut out of the vehicle and lifted onto a stretcher. A bystanding doctor performed a rapid traction of my right leg drawing my exposed fibula back within the skin and helping to align my leg. My leg was placed in an air splint. I was transported to Dandenong hospital. At no point throughout did I lose consciousness. From there began a long process of recovery over years.



Injuries and the first few years after

A list of my initial injuries included:

- R tibia comminuted # @ distal joint
- R Fibula compound # distal
- R Femur comminuted # midshaft
- # Nose
- R index spiral #
- R eyeball lacerated and traumatized
- Multiple lacerations and soft tissue damage: face, R arm, legs
- L medial knee ligament laceration and strain
- Right toe extensors tethered

On the first stay in hospital, I spent about five and a half weeks of which about ten days on morphine derivatives. I was in an orthopedic ward with other men of a range of injuries. In the bed beside me was a man who was severely injured. I was later told that he had killed two people while he was driving drunk. Another warned me about the morphine because he had become addicted and had never fully recovered.

My family told me that the surgeon had told them that, had I been a smoker or ten years older, that they would have probably amputated my lower leg due to the likelihood of necrosis. However, because I was extremely fit, they chose to retain it to see if it would function.

I was told that I would never run again and would, most likely, always walk with a limp.

I was told that it was inevitable that my ankle would need arthrodesis. It may be three years, ten, maybe thirty.

In early 1988, I attended the Glen Waverley TAC Rehabilitation Centre. I was the sixty-ninth client going through the centre.

At the rehabilitation centre, I worked closely with other clients and staff primarily undertaking physiotherapy, hydrotherapy, counselling, vocational guidance.

By February 1988, able to drive an automatic car.

The physiotherapist trialed me on an exercise bike using strapped pedals at which point I realised that they were beneficial.

I spent 1988 trying to get my health back. I had some work in the family business including travelling to Darwin. I was partially on a TAC benefit. I spent some of the winter in Queensland.

My ankle had no support. No plates. The lower part of my tibia had been pulverised. With weight bearing, the alignment of my lower right leg began to warp over time.

In June 1988, I removed the Stiman pin from my fibula with assistance from an orderly in Royal Canberra Hospital.

I had an osteotomy in October 1988 spending two weeks in Dandenong Private Hospital. In 1987, I had experienced withdrawal symptoms so, this time, I minimized and controlled the analgesia closely.

I redirected my career aspirations, commencing a BA in Recreation in 1989 and graduated with distinction in 1991. I started university on crutches. I was inspired by the disabled adaptive athletes that I met at uni. Examples included a paraplegic who was whitewater kayaking. In one example, I went abseiling and threw my crutches to the team below. I was upstaged by him coming down after me in his wheelchair.

I experienced kidney stones which I was advised were a likely side effect of my fractures and the time I had spent incapacitated.

Stabilisation

My injuries stabilised. I was assessed to have a 17% impairment but that it was a 'serious injury' and so I was approved to claim for pain and suffering and loss of earnings under common law. Medical and rehabilitation expenses were not included.

In 1994, my compensation claim was settled for loss of earnings and pain and suffering. Medical and rehabilitation expenses were to be met on an ongoing basis by TAC. In 1994, I changed my name from 'Michael Douglas Cooper' to 'Jai Michael Cooper' to formalise a long held nickname.

I tried working in outdoor and environmental education, but it was extremely difficult. It was complex trying to manage fieldwork with the pain. It was not sustainable, so I planned further education to move into managerial roles. In the mid-90s, I experimented with living in a warmer climate and found it beneficial. So, I relocated to Sydney and completed a Master of Environmental Education at Macquarie University 1995-96. I have two daughters born in 1997 and 2000. I was married in 1997 and divorced in June 2003.

Through the late 90s and early 2000s, I managed to have work arrangements which gave me some fieldwork while occasionally exceeding my pain tolerances.

At 16 years post-injury (2003), I attended an orthopedic surgeon who praised my efforts and advised me to continue with them. He advised that arthrodesis was still likely in the future.

By 2010, I had moved into environmental training. This was more within the limits of pain tolerance. I continued in this field until 2018 while also engaging in research/sessional academia.

In 2013-14, I completed an honours thesis in Sociology/Anthropology with the University of Newcastle (UoN).

In 2017, I specifically recall praising TAC to nursing students at UoN. I have regularly raised the example of the TAC when teaching the sociology of health.

From 2018-2022, I completed a PhD in Sociology/Anthropology with the University of Newcastle (part and full-time).

After 32 years post-injury, in 2020, I attended another orthopedic surgeon in Newcastle who stated, 'you have a very interesting ankle' and that arthrodesis would not be advisable in future given my age and the likelihood of surgery failing. The surgeon told me that I had achieved excellent results given the nature of my injuries and to 'keep doing what you're doing'.

I attribute much of the success to the support of my family and friends, amazing medical and health professionals, the support of the TAC, and to myself for my determination to contribute to my society and to repay the investment that has been made in me.

I have worked in outdoor and environmental education, often in great pain. Yet, this has given me a lot of rewarding experiences. On many occasions, people have been surprised to learn that I have an impairment. Unfortunately, there have been several occasions where people have attempted to deny its existence, have become angry at me for not being able to meet their expectations, or accuse me of seeking sympathy. Often, people do not understand that, despite being agile over short distances on foot and with a powerful upper body, my capacity to walk will decline quickly over longer distances. I am concerned that some purported 'friends' have sought to take advantage of the compensation I received in 1994.

I am now 57, and work as a consultant in a research institute. Amongst my work, I conduct social impact assessments for health infrastructure developments, support clean and renewable energy initiatives, assist in sustainable business development, and conduct research with Aboriginal and Torres Strait Islander communities.

Throughout, I have made minor requirements for assistance from the TAC.

Examples:

- Elasticised ankle braces. Later, I also needed knee braces.
- Periodically, I need a new walking stick.
- I originally required modified ski boots to go around the deformation of my ankle. I later abandoned this option with cross-country skiing being less painful.
- I have periodically visited physiotherapists for support with ankle, knee and back challenges.
- Visits to orthopedic surgeons.
- Physiotherapy for back pain and knee degradation.

Throughout, I have attempted to maximise my clinical outcomes. Bushwalking is undermined by the pain. I have been able to briefly sprint on sand, but any running quickly exacerbates pain and inflammation. Discovering cleated bike pedals was a revelation because they enable activity without downwards pressure on my ankle joint. I've become an 'adaptive cyclist' which has greatly improved my musculature and circulation without the associated impact of walking. Water sports, kayaking, wave-skiing (sit-down) replaced surfing. Rock-climbing has been great but is getting more difficult as my left knee degrades. I switched the arrangement of my drumkit to drum right-handed and left-footed and learned new co-ordinations. I continue to have an elite level of cardio-vascular fitness. My family has a history of cardio-vascular illnesses. My resting heart rate often reaches the low 40s and, during exercise, I recently reached 173bpm. I have shared the parenting of two wonderful daughters, and we are now expecting a grandchild in November of this year. I have wished to own a dog but have avoided it because of my limitations. I have trained my partner's dog to run with me while I cycle.

I continued to use bikes and other supports yet have not claimed these as medical or rehabilitation expenses. I developed a prosthesis for bike shoes to reduce backache from having different leg lengths. I purchased a Brompton bike which folds into a walker.

Ongoing symptoms

The ongoing symptoms I experience are...

Direct and associated effects from these injuries include:

- Arthritis – in particular, the surface of the major ankle joint has been disrupted, misaligned and is now prone to accelerated inflammation. Pain and inflammation

when walking increases with distance. I must start gently to manage pain and stiffness, after which I get some agility which degrades over distance. A few hundred metres is usually the maximum at which point I must stop to reduce inflammation.

- Significant loss of range of movement of the right ankle.
- Reduced sensitivity of the right foot due to nerve damage.
- Inability to lift right big toe, restrictions on other toes. My right toes do not effectively flex and present a trip hazard when walking without shoes. The inability to raise them from the shoe bed leads the sole of my foot to become hot, sticky and uncomfortable when wearing shoes.
- Poor circulation in the right ankle and foot due to extensive soft tissue damage.
- Joint swelling – particularly during heat.
- Asymmetric knee joint alignment.
- Shortening of the right leg (approx. 15mm).
- Compensatory spinal misalignment and associated backache.
- My left knee is increasingly arthritic, and the meniscus is deteriorating, which I have been advised by multiple medical practitioners that it has been accelerated by compensatory behaviours to protect my right ankle.
- Sensitivity to rapid variations in barometric pressure and high levels of humidity and cold.
- Some blockage of my right nostril due to misalignment.

Some things I'm not sure about:

In 1995, a chiropractor noticed one of my lumbar vertebrae was displaced slightly further forward. I have not claimed to associate this with the accident. However, it's the most significant trauma that my back has experienced.

I have an expectation that knee surgery will be required at a future point but that I have potential to delay it if I retain good muscular and general health condition.

It appears that I've saved myself (and the TAC) from further ankle surgery for the rest of my life. I do not expect arthrodesis to be a future option.