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30th June 2018

Productivity Commission

Compensation and Rehabilitation for Veterans

Terms of reference

Inquiry into Veterans' Affairs' Legislative Framework and Supporting Architecture for Compensation and Rehabilitation for Veterans (Serving and Ex-serving Australian Defence Force Members)

I am providing a submission into this enquiry with the intention of simply highlighting the frustrations that I have experienced in my dealings with the Department of Veterans' Affairs since leaving the RAAF in 1996 after 16 years of service.

This will require a long read and I do not apologise for that, this topic is complex and has become protracted due to inherent bureaucracy, internal empires, opinions and a very draconian mindset enshrined within DVA. The end result after reading my submission is the hope that a very concise picture will be portrayed on how dealing with the framework for compensation & rehabilitation in its current form is unworkable and frustrating to veterans and their families.

This submission is not a deliberate attack on DVA, I do not wish to portray that in this submission. DVA have been very helpful and at times done some excellent work and actually listened to my side and have sought further clarification and explained some things which has been appreciated. On the main though, DVA is seen as a monster and has thrown significant frustration at me that defies logic and evidence. This is where I aim to centre my submission and contribution.

Maybe through the sharing of my experiences and how DVA have dealt with my health matters will give credence to the similar experiences of other veterans in dealing with the perpetual machine of bureaucracy. The frustration and labouring momentum of having to deal with and conform to such profound inconsistency does have lasting and telling impacts on individuals who have served and been injured or damaged as a result of volunteered and compulsory service.

My service was not conscripted, war was not apparent during my time and I like many, volunteered to serve my country at a time that was free of any conflict. Yet many of us were still injured and damaged in the service of our country and willingly gave our time and youth to such servitude. Most service personnel were prepared to take a bullet, however Defence and DVA are reluctant to apply basic first aid without first adopting a post-mortem.

My offerings to the Productivity Commission are in the following:

- Material Safety Data Sheets (MSDS)
- Allergic Reaction to Polyurethane
- F-111 Deseal/Reseal
- Allergic Rhinitis
- Prescriptions
- Hearing Loss
- Advocate
- Greater than 1,000 Days for a decision
- Claims for the following:
  - Post-oropharyngeal Candida infections
  - Laryngo-Pharyngeal Reflux
  - Occupational Asthma, and
  - Gastro-Oesophageal Reflux

Impact Statement

It has to be said that this process has been incredibly difficult to undertake. I am speaking about having to undertake this task to provide a submission. If any one thinks that I am simply sitting in my little home and easily knocking this stuff out and have great joy in demeaning the processes of DVA then they are misinformed.

It has taken me well over a month of immersion in this mess and it brings up all manner of anxiety and frustration to have to relive and reconstitute the detail provided. There is no joy whatsoever in sharing this. It has been hard and has generated many moments of difficulty and anger.

To have to share this information that has stretched from 1990 to now is a very hard and difficult task. There is almost 30 years of complete frustration that is being relived here and it is taking all my strength to be able to complete this. The only thing that is driving me is the fact that it may make some change so that no other veteran would have to be treated in this manner and endure the level of bureaucracy that exists in DVA.

The photo shows how many files I had to re-read and review for this submission. There have been many hours spent in ensuring everything I present in this submission is true and correct. The hours I have assigned to this submission have been very, very painful and unsettling. I have also done this with juggling a very busy working life but, I have a purpose for doing so.

I loved my career in the RAAF and it was the most significant experience that not only changed my life but also gave me a purpose. I cannot express what the experiences I had and the years of service have meant to me. It is simply indescribable. I enjoyed the camaraderie and the unity and the exhilaration of everything I did, saw and shared. The experiences I had are things that can never be experienced in a normal working environment.

When is discharged I was broken and injured. DVA didn't assist in my reconstruction and recovery. Specialist I saw were fabulous and I paid for my own treatment and medication but the minute Defence or DVA comes into play it is a different matter, the purse is closed, the doors are shut and the temperament changes to one of caution and denial towards veterans.

I have had many of my mates in the RAAF suicide, die far too early or get injured. Whilst in the Service they were treated with some care, but when leaving the Defence, the door is closed and DVA are the governors of NO.

I don't wish to see other veterans have to go through what the Deseal/Reseal workers went through. These men did as they were told and ordered, the Vietnam veterans also did their job and it took such agony and anxiety for those poor buggers to see a change. And now veterans from the war on terror are not getting it any easier.

A change must happen and DVA needs to move into a better mode of operation. The governments are sending people into conflict and enlisting people into dangerous professions and not taking responsibility. You can't penny pinch after making decisions to engage in conflict and expect people to accept it.

Many ex-service members I have come to meet that tell me their stories of injuries and how they are treated by Defence and DVA are terrible. That is the reason for this submission. Its not for my benefit, it is to address some pretty terrible processes and behaviours by Defence and DVA.

Defence Background

I enlisted in the RAAF on **14th October 1980** and completed a 9-month Surface Finisher Training course at Amberley after the initial recruit training. Surface Finishers are known as SURFINs and undertake aircraft refinishing which involves applying and removal of paint coatings and chemical and conversion coatings on aircraft. Most would know SURFINs as painters, and they cover all aspects of refinishing from aircraft, vehicles, marine craft, buildings and ground service equipment and signage within the RAAF. I had many years of experience as a house painter prior to my service and I have since enjoyed all aspects of my refinishing roles gained in the RAAF.

I was completely immersed in my role as a SURFIN and had achieved many milestones of the trade and had meet all the required promotional requirements aligned to the role and had been promoted to Corporal rank as a result.

I performed all the roles related to SURFIN duties whilst in service and the working environment involved confined spaces and the use of some significant chemicals in the form of paint, solvents and treatments used in everyday tasks.

After almost 11 years of service as a SURFIN my body had reached a level of toxic sensitivity to the paints and solvents used. Isocyanate Sensitisation is when the body has reached saturation level and can no longer sustain or tolerate any further exposure. My body had continually been embalmed with a cocktail of chemicals and coatings used on aircraft and roles within my service and understandably had enough.

Isocyanate sensitisation is permanent and affects the lungs and respiratory system of the body. The only method to resolve this is the removal from the environment in total and to then contend with the ongoing treatment of any and all conditions affected within the body.

Officially, my career as a SURFIN was terminated and the RAAF was taking action to declare me as unfit for service. This as you would understand and interpret indicated that I would be ejected from the defence. It was a devastating blow, and as well as that I had some serious health matters that needed to be managed.

I found employment within the service as a General Service Instructor (Recruit Trainer) for approximately 3 years, it permitted me to obtain treatment for Industrial Asthma, damaged vocal cords, continued ear aches, dermatitis, allergic rhinitis and gastrointestinal issues and to attempt to stay within the service where I had found purpose, a place that I loved to work and had become actively involved with.

The impacts on my health were significant and quite frankly debilitating. I had to learn how to use my voice and to control my breathing, had many hospital stays, had to regain my fitness level, adjust to loosing rank and seniority and my long term career path had been seriously impacted. I remained competitive and relevant to the service needs and found relevant employment whilst managing the medical conditions outlined above. The limitations experienced were quite difficult to manage as was the continued requirement for treatment and medical assessments at the time, whilst embracing the ever present threat of being not fit for service. I also had to combat the opinions and attitudes of work colleagues in regards to having to attend treatment and in not being able to meet their expected standards. I participated in all the roles expected of an instructor and completed all that was required of me and my illness was never used as an excuse. I had been the recipient of a few awards and a couple of commendations during my recruit instructor roles.

In January 1993 I was successful in gaining a remuster (re-categorisation into a job/trade) to the Air Surveillance Operator (ASOP) category. On completion of the initial training I was posted back to Amberley in March 1993. I lost all rank and the 13 years of seniority had been reduced to zero and I was starting from scratch.

In 1995 the RAAF had re-instated my fitness code for deployment which made me fit for service, this was a result of my continued commitment to my fitness and determination to remain in the RAAF. It also consisted of considerable engagement with the medical power centre of the RAAF to convince them that my medical condition which they focused on of asthma would only resurface if exposed to the previous environment of the SURFIN mustering.

This was the time of civilianisation within the RAAF and the focus of bearing arms and being fully deployable. I meet all requirements medically and within the parameters required of an ASOP which was meeting the quarterly role assessments and field training and weapons handling requirements.

I fully embraced this new role of ASOP, I saw it as a new challenge and was completely immersed in all aspects of it. I could see myself advancing and making this a new career direction and was completely content with service life and all it offered.

However, in 1996 I discharged based on increased depression through some terrible workplace issues within my new ASOP role. I am also certain that the depression I felt and experienced had resulted due to much of the chemical assault from my SURFIN role.

This ends the background of my RAAF service.

Material Safety Data Sheets (MSDS)

There is a serious lack of regard or reference to chemical and materials MSDS are the details of toxic and dangerous chemicals used by service personnel. DVA and medical specialist never refer to these in relation to claims in my view.

These are completely disregarded and dismissed as being relevant by medical specialist. Quite simply many medical specialists have said to me that they can't understand them and don't want to look them as they are medical specialist and not scientists.

When I have said that they give insight into the danger aligned to hazardous substances and the specific way the substances should be handled, stored or used. Medical specialist say they don't have the time and find the MSDS confusing. In many cases, trades with the defence are required to observe and understand these spec sheets. They also outline the health impacts of the chemicals or

solvents being used. They provide a great deal of insight into how dangerous misuse can be, or how volatile the products are.

If medical practitioners and DVA understood and referred to these they would have a better understanding of the dangers faced by defence personnel and the relevance to their injuries, and as specialist providing detailed medical reports and assessments for DVA you would think that these would be referenced or looked at credibly.

Additionally, many claims could be better verified as the health implications of prolonged use is detailed within the MSDS, although at a conservative level in some cases. Regardless these give great insight and credibility into what veterans have been exposed to as a result of using chemicals and materials as a part of the roles they perform.

It seems a very arrogant oversight by DVA and specialist providing medical reports that impact on future treatment and financial implications towards veterans and their injuries.

Ignoring these important and relevant documents creates a significant gap in understanding the implications and ramifications these toxic and aggressive chemicals have on service personnel. It also dismisses any hazards that members have to endure as a result of using or being exposed to them.

Instead DVA and Medico Legal rely solely on SOP compliance and medical knowledge in specialist fields. I think knowing what service personnel have used and been exposed to would enhance the medical experience of many medical staff and DVA.

Further, it is essential that it is understood that these hazardous substances are categorised by the MSDS, for example exposure to hazardous material may be acute or chronic. Acute exposure generally refers to a single high dose or high concentration over short periods; whereas Chronic exposure refers to repeated or continuous exposure over long periods. These exposures may have acute, immediate effects or chronic, long term effects.

The MSDS has been used extensively in the Deseal/Reseal reviews and many are cited in the Report of the "Board of Inquiry into F-111 (Fuel Tank) Deseal/Reseal and Spray Seal Programs – Volume 2" to provide a credible outline to readers and to give a valued and comprehensive understanding of what personnel were using and their health impacts.

This report details can be viewed on the DVA website at https://www.dva.gov.au/benefits-and-payments/f-111-fuel-tank-maintenance/inquiries-and-studies/inquiries and the report can be downloaded using the link below. These are not a DVA or RAAF link as the links on the official sites are no longer providing this report.

http://www.gooptroop.info/gtroop/BOI%20Reports/Report%20of%20the%20Board%20-%20Volume%202.pdf

To quote and publish these reference sheets in the above report has given insight and relevance into the dangers of substances used. As a SURFIN involved with the Deseal/Reseal program these MSDS have to be considered as they related to my role and assuredly have certainly compounded my injuries and has significant relevance on many on my health issues.

The MSDS for the Deseal/Reseal are indicated in "Chapter 7 – The Chemicals, their Toxicity and their Application" of the "Board of Inquiry into F-111 (Fuel Tank) Deseal/Reseal and Spray Seal Programs – Volume 2" report.

On page 7 – 5, Section 7.24 Risk Rating, Table 7.1 indicates that Methyl Ethyl Ketone (MEK) and MIL-C-68736 as having a risk rating of 6 and 5 respectively, on a 1 to 9 scale rating with 1 being the lowest and 9 being the highest score. These are everyday use items for SURFINs in their roles and many times they would be sitting in residue of them, saturated in it and at times doused in these

solvents when working on major aircraft servicing and component work. In fact, materials used by the SURFIN mustering is the sole reason why it is seen specifically as a male only environment as it is known that these substances do cause fertility issues for females. The RAAF certainly became fully aware of this after some legal action taken by an exposed female from the mustering.

The DANEK Report at Chapter 7 Annex D, outlines 12 hazardous substances of the 60 used during the Deseal/Reseal program as a major risk. Of these 12 major risk substances 6 are used by SURFINS on a daily, weekly, annual basis in their everyday tasks.

Yet the mustering of SURFINs were excluded from the initial Deseal/Reseal ex-gratia payment scheme by DVA along with many other trades who undertook work related to their trade on the F-111s.

The DANEK Report indicates that the MSDS of some of the hazardous substances used did not sufficiently outline the hazards or dangers of substances appropriately and further that many MSDS were not referred to or even considered for other substances.

In the case of the SURFIN mustering, habitual and continued use of the following substances are used in everyday work environments. Listed below is an outline of their purpose and the health impacts of each taken from the relevant MSDS for each item. The list below is not an exhaustive list of the substances used by SURFINS.

- **Deoxidine** (phosphoric acid) used to treat and condition metal surfaces prior to applying chemical conversion coatings and/or subsequent paint coatings. Specific handling requirements are to be observed and handling precautions are listed. Usually listed is what can occur with long term exposure of misuse. As SURFINs working on aircraft we were completely drenched in this as a result of refinishing aircraft.

  Should be used with specific protective equipment and causes corrosion of the skin and mucous membranes, causes respiratory disorders and damage to gastrointestinal tracts and disorders of the blood.

- **Alodine** (chemical conversion coating) is also indicated in the DANEK report and the MSDS is provided in Chapter 7 of the report indicated above. Alodine is used to provide a protective coating to aluminium surfaces against corrosion and to improve the bond of subsequent paint coatings. This item is susceptible to spontaneous combustion and must never come in contact with solvents as it would react violently. Specific handling conditions include face protection, skin protection and respiratory protection. As SURFINs working on aircraft we were completely drenched in this as a result of refinishing aircraft. This used to be applied using a pump and spray onto aircraft surfaces, which is indicated to be the worst method of application for respiratory health reasons.

  Cancer hazard, can cause blindness, contact with broken skin can cause ulcers, can cause ulceration of nasal and mucous membrane, inhalation by mist can cause severe irritation and burns to the respiratory tract, can cause skin irritation, damage to gastrointestinal tract if ingested, can cause irreversible damage including burns and blindness.

- **Strontium Chromate** - Primer used on aircraft surfaces prior to applying top coats to aircraft surfaces and components. Has great anticorrosive pigments for paint coatings with solid corrosion inhibitor properties. Do not ingest, do not breathe dust, wear suitable protective clothing and respiratory equipment. Splash goggles. Full suit. Dust respirator. Boots. Gloves. A self-contained breathing apparatus should be used to avoid inhalation of the product.

Suggested protective clothing might not be sufficient; consult a specialist BEFORE handling this product.

Very hazardous if ingested or on skin (irritant/permeator) or as inhalation. Proven carcinogenic and teratogenic and mutagenic effects and dermal effects. Can cause cancer and toxic to aquatic life. May cause sore throat, coughing, dyspnea, laboured breathing, damage to deep lung tissue and delayed pulmonary oedema, and depression. Chronic toxicity, nasal irritation from rhinitis to painless ulceration of the mouth and nose mucous membranes with bleeding and perforation of the nasal septum and a foul smelling discharge. Hepatitis with or without jaundice, gastritis, ulcers of the stomach and intestine, nausea, vomiting, anorexia fatigue, lassitude rheumatic pain, and liver and kidney damage possible. An excess risk for lung and Sino nasal cancer. Exposure has caused leucocytosis, leukopenia, monocytosis, eosinophilia and other blood changes. Corrosive by Inhalation. Local effects are dermatitis.

- **Grey Green Epoxy Primer** – simply known as grey/green and known for its excellent protective qualities, hardness and durability and its ability to have anything stick to it like glue (the proverbial shit to a blanket). Contains isocyanates.

  May cause moderate skin irritation, prolonged contact may cause dermatitis. May cause irritation to eyes; may cause sensitisation by skin contact, may cause irritation to respiratory system and may affect the central nervous system. Material may cause irritation to mucous membranes and respiratory tract. Repeated and prolonged skin contact may lead to allergic contact dermatitis. Irritation of the gastrointestinal tract (corrosion) and diarrhoea. An eye irritant. Has been classed as a respiratory sensitiser. Suspected of damaging fertility or the unborn child (defects). Avoid contaminating the environment and waterways.

- **Etch Primer** – etch primers are used because of their capability to maximise adhesion onto metal surfaces by etching on the metal, they are a single pack product and contain phosphoric acid and zinc based pigments. Excellent for use on clean bare metal applications.

  Can cause serious eye damage and skin irritation, dermatitis and allergic skin reactions, may cause drowsiness or dizziness. An inhalation risk exists and may cause dermatitis and eczema, serious eye damage and blurred vision and may cause damage to organs through prolonged and repeated exposure. Should not be allowed to enter drains, water courses or the soil. Can cause lung damage and respiratory irritation. Inhalation may cause central nervous system effects including depression, gastrointestinal issues are irritation, ulcers vomiting and abdominal pain. Women exposed in the first 3 months of pregnancy showed a slight increase of miscarriage and birth defects. Prolonged exposure may cause vertigo.

- **Polyurethane (isocyanate) Paint coatings** – these are a two pack isocyanate based paint system that are known for its durability, flexibility and toughness on aircraft surfaces that are capable of tolerating extreme conditions. Isocyanates are released in its liquid state as well as during its drying and curing state once applied to surfaces as coatings.

  High concentrations have a strong irritant effect on the respiratory tract in most people. Some may develop bronchial sensitivity whereas other may develop asthma-like symptoms in the form of chest tightness, wheeze and shortness of breath. Isocyanates are irritants and affect the skin and eyes, with other health effects to the liver and kidney, the may also result in pulmonary oedema. Inhalation may cause irritation to the mucous membranes of the nose, throat or trachea, headaches and gastrointestinal symptoms. Eye contact results in conjunctival irritation and result in dermatitis either irritative or allergic. Sensitisation may

be either temporary or permanent and has been connected to lung damage including the disease of lung function which may be permanent. Is a skin sensitiser.

- **Acrylic Lacquer Paint coatings** – is used in paint coatings for premium automotive finishes which gives a lustrous durable finish that is quick drying and has superior adhesion properties to base metals. Once dry it can be machine or hand buffed to give a showroom high gloss appearance.

  Harmful if inhaled or in contact with skin, may cause skin irritation or allergic skin reaction and dermatitis. Suspected of damaging fertility or the unborn child, and may cause damage to organs through prolonged or repeated exposure. May be fatal if swallowed or enters airways, and toxic to aquatic life. Vapour may irritate respiratory system or lungs and cause diarrhoea. In high concentrations can affect the central nervous system, prolonged skin contact may cause irritation. Conditions can be both acute and delayed.

- **Nitrocellulose Lacquer** – was mainly used on vehicle refinishing from the early 1920s and also used for doping refinishing on fabric aircraft skins and components like flight controls. It was later replaced with a better product being acrylic lacquer and then two-pack Isocyanate finishes.

  Is irritating to skin and can cause serious damage to eyes, harmful to aquatic life and environment. Can be harmful if inhaled, long term exposure may result in adverse health effects to mucous membrane and respiratory system and kidney, liver and central nervous system. Repeated and prolonged contact may cause the removal of the natural fat from the skin resulting in contact dermatitis. Splashes to the eye can cause irritation. The product contains solvent naphtha which may cause lung damage if swallowed. May cause irritation of the nose and throat and irritation to the digestive tract. Prolonged occupational exposure to solvent present in this product have associated brain and nervous system damage. Possible risk of irreversible effects.

- **MEK** – Also see "Chapter 7 – The Chemicals, their Toxicity and their Application" of the "Board of Inquiry into F-111 (Fuel Tank) Deseal/Reseal and Spray Seal Programs – Volume 2" report.

  Irritating to eyes and respiratory system, repeated exposure may cause skin dryness and cracking, vapours may cause drowsiness and dizziness, skin contact may produce health damage, may produce discomfort. An eye irritant, contact with skin will result in mild irritation, will have degreasing action on the skin, repeated or prolonged skin contact may lead to irritant contact dermatitis, material may be irritant to mucous membranes of the respiratory tract (airways), breathing in vapour can result in headaches, dizziness, drowsiness and nausea, breathing in high concentrations can produce central nervous system depression, which can lead to loss of coordination, impaired judgement and if exposure is prolonged, unconsciousness.

  Acute Potential Health Effects: Skin: Causes skin irritation. May be absorbed through the skin. Eyes: Causes eye irritation. Inhalation: high concentrations may cause central nervous effects characterized by headache, dizziness, unconsciousness, and coma. Causes respiratory tract irritation and affects the sense organs. May affect the liver and urinary system. Ingestion: Causes gastrointestinal tract irritation with nausea, vomiting and diarrhoea. May affect the liver. Chronic Potential Health Effects: Chronic inhalation may cause effects similar to those of acute inhalation. Prolonged or repeated skin contact may cause defatting and dermatitis.

MUTAGENIC EFFECTS: Mutagenic for bacteria and/or yeast. TERATOGENIC EFFECTS: Classified POSSIBLE for human. May cause damage to the following organs: gastrointestinal tract, upper respiratory tract, skin, eyes, central nervous system.

Liquid may cause moderate to severe eye irritation and corneal damage. Most subjects exposed to vapour concentrations of 150 - 300 ppm experience irritation to the eyes. Brief contact may cause mild irritation. Prolonged or repeated exposure may cause defatting resulting in dryness or cracking of the skin (irritant contact dermatitis). Due to its low toxicity and high volatility, this product is unlikely to be absorbed through the skin in harmful amounts unless evaporation is prevented. Vapour concentrations above 150 ppm are irritating to the nose and throat. High vapour concentrations (above 300 ppm) result in narcotic effects including possible headaches, dizziness, loss of coordination, nausea, loss of appetite and possibly loss of consciousness. This product is an experimental teratogen and affects the peripheral nervous system (arms and legs). People with pre-existing liver or kidney dysfunction should limit exposure to this product. The effects of this product in combination with n-hexane are potentiated (greatly increased). This means that the effects suffered by ingestion or inhalation will be increased, or experienced more quickly.

- **Toluene** – is a solvent that has high evaporative qualities and is highly toxic and flammable. Mostly used in removing paint coatings from nose cones of aircraft where specialist epoxy coatings were used. This is the area where aircraft radar devices are housed. Has also been used to clean aircraft surfaces and has been known to be mixed with other solvents.

  Toluene is a known carcinogen to both humans and animals and is an irritant to skin, eyes, gastrointestinal tract and respiratory system. May be toxic to blood, kidneys, the nervous system, liver, brain, central nervous system and prolonged use can produce target organ damage. Passes through placental barrier in humans, may cause reproductive effects and birth defects and may affect genetic material. Can be absorbed through the skin and eyes and cause dermatitis. <u>May also cause hearing loss as a result of noise interaction in the working environment.</u>

- **Xylene** – is a solvent that is widely used as a cleaning agent for metal and composite material surfaces. Is also used to remove coatings of nose cones of aircraft. Is used as a vehicle in paint coatings and is also used in pesticides. Its power as a solvent is well known for its cleaning properties and it has a slower evaporation quality.

  The substance may be toxic to blood, kidneys, liver, mucous membranes, bone marrow, central nervous system (CNS). Repeated or prolonged exposure to the substance can produce target organs damage and dermatitis or eczema. Toluene is a known skin and eye irritant and may cause irritation of the upper respiratory tract. Suspected damage to unborn children. Will have a degreasing action on the skin. Repeated or prolonged skin contact may lead to irritant contact dermatitis. <u>Repeated or prolonged overexposure to certain chemicals in this product may exacerbate the hearing loss effects associated with noise exposure.</u>

- **Paint Stripper** – The RAAF used three different types of paint strippers, two were thick types with one being known as yellow peril and the other is a pink transparent type that could be applied manually and the third is a liquid type that was used for immersion applications. The thick yellow paint stripper was applied to surfaces using a brush or atomised with a pump for entire aircraft stripping operations. The surfaces were then agitated with scrapers by hand and then aircraft skin was cleaned using MEK.

  Contains methylene chloride, phenol, sodium hydroxide and chromium compounds.

During these operations SURFINs would get burns from the work they were doing and at times had to run to the emergency showers to clean the stripper off and remove the protective clothing etc.

SURFINs would also be doused in the MEK as it involved working under wings and fuselage surfaces. It was not unusual to have your genitals and backside saturated with MEK for extended periods of time, especially if working in engine intakes and interior of wings. SURFINs then resorted to using air supplied hoods during stripping operations, the issue with this was that you could smell the stripper through the air entering into the air hood as it was impossible to eliminate stripper saturating the hoses as they were dragged across the floor and across the aircraft surface. This then pumped concentrated levels of the fumes and odours into your airways.

May of the substances cause cancer, may damage fertility of the unborn child, may cause allergy or asthma symptoms of breathing difficulties if inhaled, can cause severe burns and eye damage, may cause allergic skin reaction, may cause drowsiness or dizziness, may cause genetic defects, may cause damage to organs through prolonged or repeated exposure. May cause sensitisation by inhalation and skin contact, may cause heritable genetic damage, harmful to aquatic organisms, may impair fertility, may cause harm to unborn children.

What can be seen as an analysis of the substances listed is a recurring theme here, all of these substances can cause:

- ***Skin issues and sensitisation***
- ***Respiratory issues and sensitisation***
- ***Affect mucous membranes of the nose and airways***
- ***Affect central nervous system***
- ***Many are carcinogenic***
- ***Many can cause birth defects or fertility issues***
- ***Many can cause eye irritation or vision issues***
- ***Many can impact vital organs such as blood, kidney and liver or organ damage***
- ***Many can cause neuropathy***
- ***Some can even cause hearing loss***

Episodes of Allergic Reaction to Polyurethane

In October 1990 I submitted a claim for Episodes of allergic reaction to polyurethane, and this claim was with COMCARE, which was still part of the Department of Defence known as Compensation Section. As stated in my claim the parts of the body affected were listed as Airways/Lungs, and the nature of the injury/disease was listed as oedema of the vocal chords caused by exposure to polyurethane paints (Claim Form attached signed Oct 1990).

In November 1990 the Compensation Section make a determination to accept the claim in November 1990, letter attached, signed and dated November 1990.

In January 1991 the Compensation Department asked that a Doctor at Medical Section Amberley complete a Questionnaire. Diagnosis was listed as Asthma – allergic origin secondary to polyurethane and Allergic Rhinitis. The Impairments listed by the Dr were listed as Bronchospasm; irritated nasal airways and eyes; and respiratory system symptoms only. The Doctor described the extent of the impairment as 1) respiratory system symptoms only of wheezing, cough, irritation nasal airways and eyes; 2) Mild symptoms from sport; 3) Requires medication at 1/week (Questionnaire attached signed Jan 1991).

In March 1991 a report written by the Environmental Health Section was undertaken as a result my exposure. The report details the findings of the Flight Lieutenant which include that the environment

is not able to cope with the work undertaken; he also states that in the last 10 years 17 RAAF Surface Finishers have been diagnosed with sensitisation to isocyanates and either remustered or discharged from service. He strongly recommends that aircraft painting and sanding operations in this hanger cease and that SURFIN training be conducted under the following restrictions: Training of aircraft painting only be conducted on panels and placed within the confines of the spray booths; sanding operations only are conducted with the confines of the spray booths; mixing of iscocyanate based paints only be carried out in the spray booths; and instructors and students must wear supplied air breathing apparatus at all times when handling isocyanates paints. Full report attached and signed March 1991.

***Later in time DVA and Defence state that there were no issues found within the work* environment.**

In May 1991 Dr B, ENT Specialist was asked to complete a questionnaire and provides a letter detailing his other comments. His letter outlines the prescribing of Beconase and that the assessment for level of impairment was not possible as there was no part A or B Guides provided to make and assessment. Dr B suggested that this should be referred to the Lower respiratory physician. His final statement states, *"Should there be any other documents that would assist in my evaluation of his impairment I would be pleased to provide a supplementary report following provision of each document"* (Questionnaire attached signed May 1991).

In July 1992 Dr A was asked to provide a level of impairment for my airways. Dr A writes, *"I note the comments about the lack of discretion to choose impairment values not specified in the guide. I offer my opinion that this impairment might be considered of the order of 10-20%, and may vary from time to time according to exposure and trigger factors. I note that he has problems with exertion, some preservatives and of course the symptoms may be aggravated by viral infections. I note the Mr Robson has had pains in the chest. I do not expect that these are related to his asthma. Do not expect any reduction in life expectancy. I agree that there are reduced employment prospects as he should not be exposed to isocyanates fumes and may find other irritants as yet unspecified to be a problem in the future. It may be that his leisure activities could be reduced as result of exercise induced asthma."* (Letter attached signed July 1992).

In August 1992 the Repatriation Commission make a determination to pay a pension at 20%, Letter attached to Department of Defence and signed August 1992.

In December 1992 Dr A was again asked to be more specific as 10-20% is too large range, and outlines the payment that will be made under both a 10% decision and a 20% decision. Letter attached and signed October 1992.

In December 1992 Dr A responds by stating that, *"In Mr Robson's case I consider that the level of impairment should be considered 20%".* Attached is the signed copy dated December 1992.

Now to further complicate things

I sought advice from legal representation in 1991 on what I should do as I have the option of taking the assessed lump sum or to take legal action. My solicitor sent a letter to Compensation Section in July 1991.

January 1993 COMCARE make a determination of my impairment as a result of the injury, the letter states that the impairment is about 10%. Letter attached and signed dated January 1993. COMCARE also drafted up a letter for impairment of 20%, but was not sent out for whatever reason. Letter attached not signed or dated.

In June 1993 *I drafted a letter*, with the intention of sending a complaint to the Commonwealth Ombudsman as a result of protracted dealings with COMCARE due to having a solicitor asking for files and detail etc. My solicitor advised me to contact my local Federal member as he could no longer act for me due to me now being in QLD. He had contacted the office of the Minister and I followed this up. Draft letter to the Commonwealth Ombudsman letter, Solicitor and Federal member letters attached.

In July 1993 an internal memo was drafted with the Employee Rights and Military Compensation Section for background info. Another internal memo on the 19th August 1993 with an attached *Briefing Note dated 16 August 1993* which was instrumental in a letter from the Minister for Veterans' Affairs dated 27 August 1993.

The merry-go-round starts again.

In September 1993 Dr M was asked to complete a new questionnaire as the last one completed was for 2 years ago. Questionnaire attached and signed September 1993.

In October 1993 Compensation & Rehabilitation provide a decision as a result of Dr M report, the decision states that I am not entitled to a lump sum considering that the degree of impairment has been assessed as less than 10% from Dr M. Decision attached and signed October 1993.

To state that I was incensed with the content of this report is an understatement. I know exactly when the injury happened, I have never had asthma before or even hay fever and to state that I fulfil my spare time as an Amway agent, who on earth would find fulfilment in that? Many statements in this report have never been cited before to any specialist and the report is a wide diversion from previous physicians' comments. I asked for reconsideration attached and signed November 1993.

> *The mother of all frustration is when these specialists make up their own assumptions in decisions and present these to DVA. This is not the first time this will happen and I know of many other veterans who have had the same thing happen to them. It happens with so much regularity it seems that specialists are intimately in bed with DVA to ensure that veterans are never given anything more than what someone deems as reasonable.*
>
> *In many appointments by specialist I have been asked why I am getting a pension and why I think I should be entitled to it. I have also been told to not say anything and to only answer when spoken to. I have on many occasions not been permitted to speak and definitely not to cover what happened when the injuries took place and what chemicals were used. You simply get poked and prodded and a report is written. Is this how the medical profession and DVA conduct business?*

In December 1993 ADF Compensation ask Dr B to make a determination for impairment, letter dated and signed December 1993.

January 1994 Dr B provides a letter outlining, *"I would regard this man as having a 10% level of impairment. His attacks occur 12 or more times a year and cause minor interference with activities of daily living. During the winter months it could be said that his level of impairment was closer to 20%.* Letter attached and signed dated January 1994.

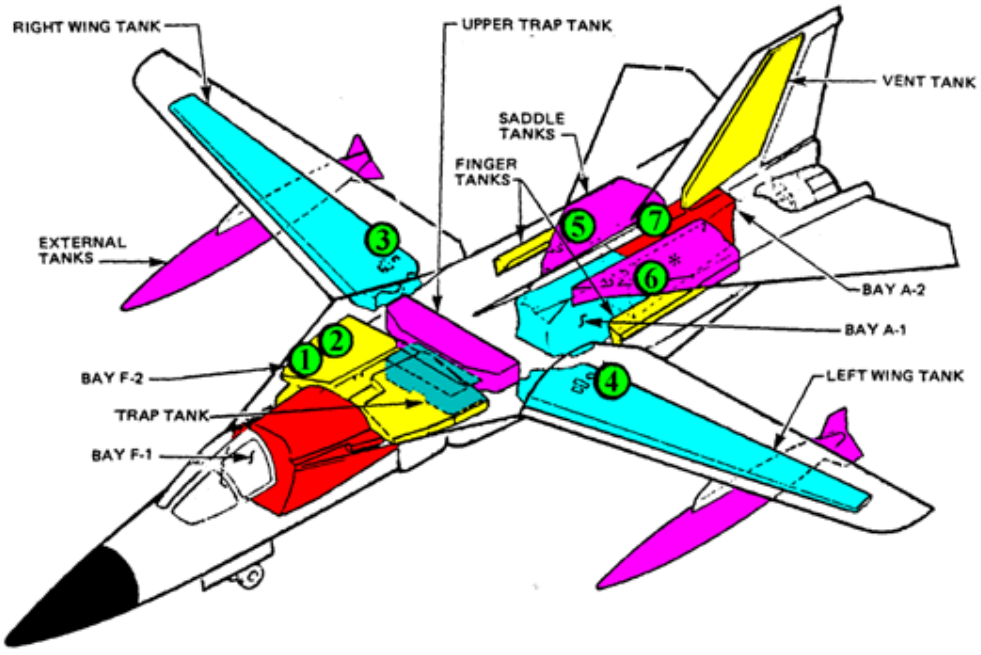
In February 1994 Employee Rights and Military Compensation Section send me a decision letter indicating that I have been assessed as having a 10% impairment. Letter dated February 1994.

F-111 Deseal/Reseal

Prior to the sensitisation from polyurethane paints described above, I was involved with the Wings Program of the Deseal/Reseal. I was the NCO for the Stripping Hanger which was preferably known as the Shit Pit. There was just three of us, the Sergeant, myself a very new Corporal and a Leading Aircraftsman (LAC). The SGT would stay in the office/donger all day and sleep or run riot at causing trouble with other staff and then run back to his donger and laugh at his capability to cause mayhem and relish in his conquests. He would also terrorise both myself and the LAC and raise bloody hell between us and then laugh at the calamity he had caused. In essence he was just a figure head and of no worthwhile purpose. Most days he was still sleeping off the remainder of a hangover and slept in the donger until he felt better.

The Sergeant allocated the wings to me to do and to also assist the LAC in doing the items that needed stripping and cleaning up prior to repainting. The LAC would be pretty occupied on most days and on those days that he wasn't he would sit in with the SGT and both would be laughing for extended periods of time. At times I would try to get the LAC to do other work but that would be met with confrontation either because the LAC didn't want to do it or because the SGT would stir up merry hell just for laughs.

During my 6 to 7 months there most of my days involved working on the wings in the hanger, or going to different areas of the base such as the Deseal/Reseal hanger to do some work on the F-111s or up to the main hanger to do some stripping in an access area under the vent tank inside the tail fin. It was a small cavity that I could only fit part of my shoulder and one arm into. It required stripping and cleaning for the metallurgist to check for cracks and any corrosion or wear. I have never had so many stripper burns to my face and upper body in all my life, and it was done around the other trades in the main hanger of 3AD.



My work on the F-111s during my posting was mainly on the wings and working on the wings was a laborious disgusting job and I hated it. I had to strip inside the wings to remove primer and coatings for the metallurgists to complete crack testing. It would take weeks to complete these things and it was uncomfortable and tedious work.

The wings were on stands that could be wheeled around the base and these were wheeled in and placed on stands so I could get to work. I had to clean the wings with MEK initially to clean off the goop residue covering the wings and that had been dripped down onto the side areas as a result of the Framies doing their dirty work, and consequently stunk of that horrible Deseal smell constantly. It also stained your skin and it was impossible to remove the black/grey colour from your cracks in the skin and nails.

No matter how hard you tried you could not get rid of it. People would ask if I worked with the Deseal and I had to say yes, most times others would smell you around them and avoid you. You would apologise to them for the smell when going for meals at the mess and they would move tables. I had washed and placed new overalls on to no avail we still stunk.

I would apply stripper to the inside of the wings using a small brush gaining access through one of holes in the side of the wing. At best you had a cavity that was wide enough to place your arm in and the top of your shoulder. I then used scotchbrite to agitate the stripper, and MEK to clean up the primer and coatings, the coatings would be so hard to move and the only other thing we could use to assist was a Bakelite scraper as we were not to score the metal or use other metals on the surface. I wore the white paper overalls over the top on my working white overalls during winter or my shorts and T-shirt in summer. To get sufficient stripper inside resulted in a mess as you would inevitably hit or drag the brush with stripper around the edges of the hole which would then cover your paper overalls. I would tape rags to my arms at this stage so I could continue to apply the stripper and then clean up the stripper mess around the cavity and on the floor so as to minimise the burns I would get. The paper overalls were disposable and we went through so many of these it was insane.

While the stripper was activating I was doing other component work sent to the stripping hanger with the LAC or doing paperwork for the jobs we had completed.

In winter it was bitterly cold and with only pink rubber gloves your fingers were constantly freezing and numb. During summer it was just as bad as the solvent would permeate your nose and the solvents would evaporate so quickly. We wore half face respirators but they were useless as they would be knocked off or dislodged from your face because of the work and the lack of space. It was filthy stinking time consuming foul smelling work.

It was at this time I started to get a rash on my face and experience gastrointestinal issues and reported these to medical. I was given a series of tests during 1989 whilst working on the F-111s. One was a barium enema which is an imaging procedure to check the rectum and intestinal tract as a result of the continued diarrhoea, bleeding and gastro issues. Additionally, I started to get more significant headaches and a repeated left ear ache. It was from this point that my role as a SURFIN began to worry me and I was beginning to worry about my health. Doctors at medical section told me that I was lucky that my body could expel in the form of diarrhoea and gastroenteritis rather than making me sick with regards to the gastrointestinal issues. I was also given a tube of Rectinol for a diagnosis of piles from medical section. Strangely, piles have never been an issue and the Rectinol was never used.

For my ears I was told that there is nothing wrong and that my issues are probably only muscular. A medical specialist that I was sent to confirmed that there was no infection in my left ear or anything to cause concern.

When I was working in the Deseal hanger with the Framies we would talk during the work being done and often the stinking job we were doing would come up, I told the guys to get out of this job as soon as they could as it is bad enough that us SURFINs have to put up with the toxic cocktail we have to use.

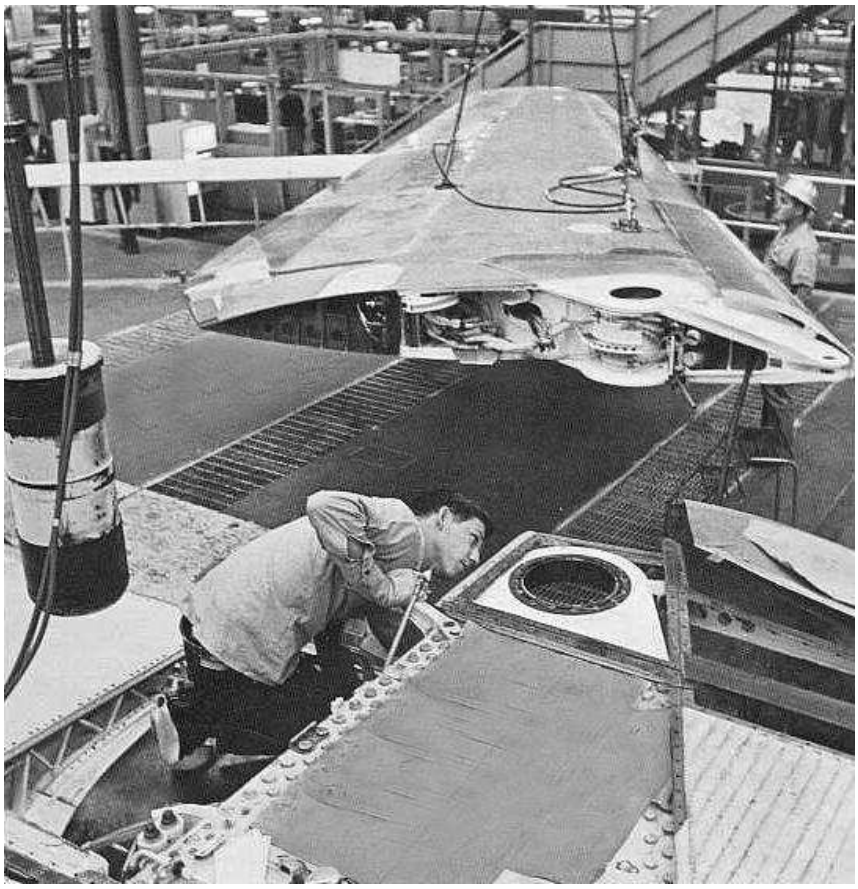
They told me that they had no way of getting away as they are here permanently in Deseal for at least 2 years, this was their posting. This just shocked me and we all regarded it as an insane decision.

I felt for these poor guys and remember vividly the same faces I used to speak to as the very same guys that are in the image above, I have also seen the same guys in newspaper articles and I don't know how they are or what has happened to them.

Personally, I would have rather done the main F-111 tanks then the Wings. At least I could have sat in a fashion or at least laid backwards rather than contort myself into un-natural and uncomfortable positions to get into the tight, shallow cramped space within the wings.

The cavities were only wide enough to get arms in and parts of your shoulders and having your face pushed up against the ribs and cavities of the wings framework. I had a lot more room within the Hercules C130 wings than I did doing this work on the F-111, and that work on the C130s was awful.

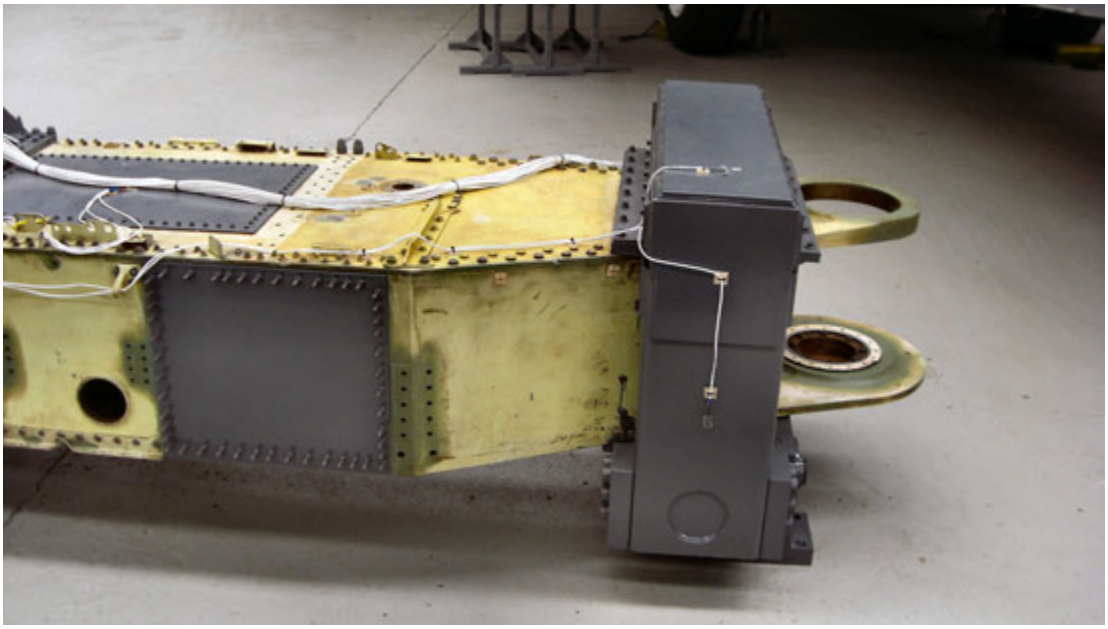
To give you an idea of the confined experience and contorting factors that were required to work on these wings the following images will give an indication of the space and size involved. The image of the guys on the previous page gives you an idea of how filthy they were and what you looked like with the stinking goop all over your arms face and body. It was like being coated in excrement all day only worse. The inside cavities of the wings were not a big space to work in.



This image above gives an indication of the thickness of the wing from a side perspective to give an idea of the limitations on seeing and gaining access of the internal space. Unfortunately, I never took any photos of the work. It wasn't necessary and we signed off on the work under the Deseal/Reseal

– Wings Program. We simply recorded our work on the F-111s into our RTAs in a generic fashion. Predominately as there wasn't a lot of detail expected back then.

Who would have thought that years later we would be faced with having to provide proof of working in these programs, with the Defence destroying all servicing documentation?



Applying for SHOAMP

I don't think there is any point in going into the difficulties of raising the issues related to the Deseal/Reseal program, such as the class action and getting traction for the workers. That is well documented and understood and this can be done with ones' own research. I was going to place my name down for the class action but this was cut short when the government at the time passed legislation to stop this.

I was watching and monitoring the approaches by workers and the reactions from DVA and the RAAF. Unfortunately, my time during this sequence was taken up with a separation and attempting to obtain contact with my son. I was already at my limit with that and I just would not have been able to contribute or take on anything more at that time.

In August 2009 I submit my claim under SHOAMP, I was submitting this claim based on meeting the eligibility criteria as outlined. Copy of claim attached, signed and dated August 2009.

In October 2009 I get a call from the Deseal /Reseal (DSRS) Ex-gratia Payment Scheme Team by a GM to undertake a phone interview. During this interview I was told I was only a SURFIN and my work would hardly constitute anything as compared to his work at Deseal. He also said that I was only there a few months which wasn't anything significant. He told me that he and others had done something like 5 years. My response is that I meet the eligibility criteria and how much time in his posting to the F-111s is inconsequential. Additionally, many of us also have conditions we are living with as a result of the work even though he may have spent 5 years there. I honestly thought how has this guy managed to get employed in DVA in this environment investigating these matters of other veterans. To me it is a conflict of interest. This conversation goes on for 45 minutes or more. G asked me to obtain names of people who could verify my involvement. I said I would try to recall the names and attempt to locate them to ask. I made a transcript of this conversation immediately after the call which is attached.

In December 2009 I received a letter of decision stating that I did not satisfy the definition of an F-111 Deseal/Reseal participant as I did not participate in one of the four specified programs. It also stated that there is no right of appeal. Letter attached, signed and dated December 2009.

In January 2010 I submit a complaint with the Commonwealth Ombudsman regarding this decision, which was an option open to me. A great many complaints had gone to the Ombudsman as a result of many decisions handed down by this team within DVA. Complaint attached, signed and dated January 2010.

In February 2010 I receive a response from the Commonwealth Ombudsman regarding my complaint. They have been told to cease investigating the DSRS cases by DVA until they could respond to the report handed down and the 18 recommendation by the Senate Joint Standing Committee on Foreign Affairs, Defence and Trade on the DSRS Ex-Gratia Payment Scheme. Letter attached dated and signed February 2010.

In early August 2010 I am sent a letter by DVA of changes to the F-111 health care and compensation package – we are going to reconsider your application. This is due to Parliamentary Inquiry report, sealing a just outcome: Report from the Inquiry into the RAAF F-111 Deseal/Reseal workers and their families. Letter attached, signed and dated August 2010.

In late August 2010 I received a letter from DVA referring to my application Tier classification as an F-111 deseal/reseal program participant or F-111 fuel tank entry maintenance worker. I am advised that I satisfy Tier 3 classification, but my duties as a SURFIN where my work included physical tank entry, but do not satisfy the definition for Tier 1 or Tier 2, because it was not part of the formal programs. Letter attached, signed and dated August 2010.

I hold no value in this new decision from DVA, I firmly believe that it would have only been made based on the previous file information from the original decision dated from December 2009 attributed by GM' and his investigation. This latest decision I believe had also failed to apply any evidence and test veracity by seeking confirmation from my superiors or peers within my trade.

I firmly believe that it would be imperative to test veracity and would have to be completely reinvestigated under normal guidelines considering that the rules have changed and also the Parliamentary Inquiry had found inconsistencies by DVA. Another consideration was that officially DVA DSRS delegates had been found seemingly intentionally excluding other trades from the Ex-Gratia payments.

My conclusion is that to save time and to rapidly resolve and finalise claims, DVA simply reviewed previous claims and the data held on file and made new determinations from the pre-existing poor investigative processes and decisions to formulate new decisions based on the new criteria and new rules for completely new Tier assessments. This is emphasised in the correspondence by stating, '…we are going to reconsider your previous application'. If this wasn't so, why then did they not attempt contact any members of my trade? And why has it only taken days to come to this new decision from their letter stating they would be reconsidering my application.

I am reminded of the statement by Mr K who was the Acting Secretary in DVA, "We are not reviewing any more claims for ex gratia payment. Most of the claims that have come forward have done so on the basis of the policies that were set down. So it unlikely that we will receive more claims unless the policy is altered. That said, we have done a 100 per cent quality assurance on all of the 1,215 claims to ensure that the decisions we made either to accept or reject, were correct and substantiated on the basis of the evidence that was provided. (Hansard

– Joint Standing Committee on Foreign Affairs, Defence and Trade, Defence Subcommittee, Friday, 19th September 2008).

I personally wonder at the integrity of that statement. Not because he at his level within DVA has said this, but because he would have been told this and have an element of trust in that advice. It is the level of authenticity to this quality assurance, that concerns me knowing that DVA in the past only permitted the mustering of Framies to qualify for the Ex-Gratia payment and excluded every other trade that performed work on the F-111s at that time of the report.

In April 2018 I submit a letter to DVA DSRS to have my Tier level reassessed. I advise that it has taken some considerable effort for me to submit this request as it is not an easy thing to wish to go through again for something that has been a laborious process in the past. I state that in July 2016 a delegate from DVA contacted me by phone to alert me to a decision the department has now made for a claim that I submitted in 2011. He apologised that this decision had taken more than 1,000 days. I also spoke about my dissatisfaction regarding the Tier 3 decision by DVA and he advised me I could request a reassessment. It has taken me this long to build the resolve to make this request, and this is based on the continual issues and anxiety that occurs with any interactions with DVA. This letter is attached, signed and dated April 2018.

On the 14th May 2018 I get a call from GM from DVA DSRS. He tells me he is investigating my reassessment and that I need to submit verifying data. I ask him why he is calling me; he re-emphasises what he has already stated. I asked if he has read the details in my letter, and he advises me he has. I state that if he has read it why he is calling me. The call drops out. The phone rings again a few minutes later and the call did drop out again before I can answer. I presume it is due to being in a shopping centre. I wait to see if DVA will send an official letter based on this contact made by GM with me, before I ask for the reason why GM has called me after the concern I raised in my letter for re-assessment.

In Mid May 2018 DVA responds with a letter requesting I submit a Statutory Declaration with specific criteria. Letter attached, signed and dated May 2018.

At the end of May 2018 I send a signed Statutory Declaration and a covering letter to DVA as requested. Attached, signed and dated May 2018.

Now, again, the waiting game and for the lucky dip decision from DVA.

<u>I do submit claims under SHOAMP for other conditions</u>

December 2010, I submitted claims under SHOAMP, they are:

- **Erectile Dysfunction** – Accepted and compensation paid of 10%. It involved test where they medically force a hard-on. When it doesn't happen after 2 injections into the penis this is the determination you obtain after having your manhood reduced to a hanging piece of flesh between your legs, it is determined that this functionality is a minor imposition on you and worthy of 10% compensation.

  Decision attached and signed and dated.

- **Depression** – Not accepted. I was however sent to a psychologist for an assessment; the findings from that appointment are attached, signed and dated.

  Based on this report the delegate has determined because the specialist states that I am not suffering any psychiatric conditions my claim is disallowed, yet the psychologist has not been

asked to make a determination as other specialist have in the other conditions listed under this area of DSRS.

The report from the psychologist is a completely different format than the other Medico Legal reports as they have been asked specific criteria to address. Apparently stress and anxiety are treated differently by DVA under SRCA.

- **Anxiety** – Not accepted. Same details as indicated above for depression.
- **Eczema/dermatitis** – Accepted condition as Defence caused as it is one of the 31 items listed under SHOAMP. No compensation awarded as medical decision from specialist stated that it is Seborrheic Dermatitis, the most common type and not service caused.

  This is a specialist that really encouraged you not to speak or offer anything by way of any of your working history, he made his determination based on his specialty, trying to discuss the MSDS and substances used in my service were dismissed and I was told he is here for my benefit. Decision attached and signed and dated
- **Impaired cognition** – not accepted, specialist indicated I was this way anyway and my education standard was validation.

  I requested feedback on this in September 2012, nothing heard until July 2016 with an apology from the delegate who called me to advise that this one has exceed 1000 days a DVA policy. My request letter attached and dated.

  Report attached, dated and signed.
- **Memory loss** – not accepted, nothing was uncovered by the specialist.

  I requested feedback on this in September 2012, nothing heard until July 2016 with an apology from the delegate who called me to advise that this one has exceed 1000 days a DVA policy. My request letter attached and dated.

  Decision attached, signed and dated.
- **Irritable bowel disorder** – disallowed and DVA change the claim to COELIAC DISEASE based on a report located in my GP files, gathered as directed by DVA as a part of the SHOAMP program. I do not have coeliac disease and I have no understanding why it was made a claim without my knowledge. Coeliac Disease was not accepted. Decision attached, signed and dated.
- **Vertigo** – not accepted, was determined that my vertigo is related to special issues as a result of hearing loss, and unrelated to service history. Decision attached, signed and dated.

  This was another specialist who was empirical in how you were to behave, drinking in his office was completely discouraged despite it being a hot December day and having medical conditions of dry mouth. You are to only sit quietly and only answer questions posed to you, he didn't wish to hear anything else.
- **Chronic Sinusitis** – not accepted, was determined that I also have Allergic Rhinitis, which is also not related to my work or the deseal/reseal program. Decision attached, signed and dated. This specialist decided to go further than the objective of responding to the vertigo and sinus claim he also dismissed that allergic rhinitis could be related to my work as a SURFIN and the work related to F-111s.

I do try to fight this over a period of time, DVA are adamant that the report from the specialist stands.

On 26th November 2013 I receive a letter from DVA indicating that allergic rhinitis has been approved in a decision dated the 14th June 2012 on the basis of the Statement of Principles (SOPs). For emphasis the delegate underlines, Please note: Although the Statement of Principles are binding under VEA, they have no legal standing under SRCA. Under SRCA all the available evidence has been considered.

> *What this means is that despite having evidence from other specialist and currently having treatment and providing this evidence with the claim the only factor that remains is the written opinion of the Medico Legal report from specialist who always manage to declare that there is no evidence of the condition and that it is unrelated to service. This one however went one further and emphasised that a condition he also diagnosed at the time of allergic rhinitis was also not related to service. How lucky for DVA to get this competent and smart Doctor to pick this up for them.*

This was the same specialist who provided the decision for Sinus and allergic rhinitis above. You are to only sit quietly and only answer questions posed to you, he didn't wish to hear anything else.

- **Peripheral Neuropathy** – not accepted, currently apparently I do not have any signs of neuropathy; I have Restless Leg Syndrome however as indicated in two sleep studies which were supplied but were not used or referred to. I was advised by DVA that restless leg syndrome is not a condition that is covered under SHCS, as it is a sleep disorder, not a sleep disorder with a neurological basis associated with either Parkinson's Disease or degeneration of the cerebrum. Decision attached, signed and dated.

- **Sleep disorders with a neurological basis** – not accepted, apparently I have no sleep disorders despite having Restless Leg Syndrome as indicated in two sleep studies which were supplied but were not used or referred to. I was advised by DVA that restless leg syndrome is not a condition that is covered under SHCS, as it is a sleep disorder, not a sleep disorder with a neurological basis associated with either Parkinson's Disease or degeneration of the cerebrum. Decision as above for Peripheral Neuropathy. Decision attached, signed and dated.

I am relisting the analysis from the MSDS I did above as a result of the decisions made here under SHOAMP.

What can be seen as an analysis of the substances listed is a recurring theme here, all of these substances can cause:

- ***Skin issues and sensitisation***
- ***Respiratory issues and sensitisation***
- ***Affect mucous membranes of the nose and airways***
- ***Affect central nervous system***
- ***Many are carcinogenic***
- ***Many can cause birth defects or fertility issues***
- ***Many can cause eye irritation or vision issues***
- ***Many can impact vital organs such as blood, kidney and liver or organ damage***
- ***Many can cause neuropathy***
- ***Some can even cause hearing loss***

I am finding it very hard to rationalise the outcomes and decisions for many of the above claimed conditions and others that will be indicated in this document on the following pages based on what my previous work involved and the documented health issues experienced from those roles, especially knowing the impacts I obtained with working with the substances I have shared in this submission and also the alignment with each MSDS.

I know I have no skill as a physician, however in using the terminology that DVA use, is there a causal link, or on the balance of probabilities is it likely that my work has attributed to any of the conditions claimed? I have an opinion that there is a basis that has not been considered.

Additionally, in reviewing the MSDS analysis above it seems very coincidental that I have managed to get these conditions that are now considered unrelated. To further compound my rationale is the fact that I am currently being treated for many of the conditions claimed by my specialist and physicians or that I do have medical referencing to having these conditions both to this day and from my medical records when in the RAAF.

But apparently DVA with using their compiled SOPs and inaccessible Rulebase lists that they use and the specialising skills of physicians where they either find no indication of the condition or declare that no aspect of my work was responsible for any of the conditions.

I guess I am so lucky that my erectile dysfunction has been related to the F-111s and I was paid 10% in compensation for now being incompetent, and that DVA have accepted my claim for dermatitis, but can't pay compensation due to no link to my work and no degree of impairment, all based on the specialist citing that it is a common type of dermatitis unrelated to the F-111s or my work history.

Despite these decisions I do not give up on the sinusitis or the issues relating to my gastro conditions. I deal with that my memory loss, impaired cognition, vertigo, sleeping disorders and neuropathy have been dealt with in this way and move on. I have bigger fish to fry, and those fish are in getting some credible recognition of the main conditions that I have and getting some relevant treatment.

If I was a jaded individual I would come to a number of conclusions, some of which are 1) that DVA and Specialist in the Medico Legal area are of the same opinion that veterans are attempting to claim too much, 2) that we can disprove claims for compensation but are a little bit more lenient towards paying a small pension, but not always, 3) it is a job for physicians to do medico legal work who have very little tolerance with communicating with patients or when assessing claims for conditions, 4) it is a process we officially have to go through but have to provide very little transparency or compliance with, or 5) all the above plus just being absolute pains in the backside to these people who think they are entitled.

Allergic Rhinitis

For this area, I am asking you to recall the detail above with the MSDS, the Material Safety Data Sheets and the sensitisation I suffered and having to leave my mustering or work category as a SURFIN.

That sensitisation was recorded as Isocyanate sensitisation and allergic rhinitis. The claim was submitted to COMCARE, which was the area handling rehabilitation and compensation prior to the

establishment of DVA. The claim submitted was for 'Episodes of allergic reaction to polyurethane', with a permanent injury of asthma.

The conditions recorded in this claim were for 'asthma -allergic origin secondary to polyurethane', and 'allergic rhinitis'. The following impairments were cited, bronchospasm; irritation of nasal airways and eyes; respiratory system symptoms only.

This claim was submitted in 1990.

As you know I then stayed in the service for another 6 years until I discharged in 1996.

While my asthma became more manageable due to not being around polyurethanes it did still react to other triggers and when I got a cold or flu I was rendered completely useless for days and at times hospitalised, which was all indicated by the specialists in their determinations to DVA in the early 90s. But the allergic rhinitis has stayed with me and has been a constant companion from my SURFIN days.

Attempting to get treatment for my asthma or the allergic rhinitis from DVA has proved to be impossible. It is easier to re-introduce the dinosaur than get anything by way of treatment. Even trying to get a Ventlin puffer for my asthma is impossible. DVA tell me to use my white card but pharmacists' have then stated that DVA will not approve this and I end up having to purchase out of my own pocket at full price.

My white card expired and I had to contact DVA a number of times to get it re-issued only to be told it should be issued automatically. On checking the officer stated that I have never used it and that they couldn't confirm my address was why it was not re-issued. I confirmed the address that they had was correct and why would this cause that a card was not issued, the response was because it was a PO Box, we don't validate these it is policy to not confirm PO Boxes. A complete joke, with no intention to notify a member of this you are just simply cut off and abandoned. A PO Box is a more secure form of address and if asked or if they had sent me a letter to confirm before making this decision I would have probably understood.

I got incredibly jaded in the capacity of DVA with accountability towards accepted conditions that are accepted especially regarding my asthma and allergic rhinitis. I requested an itemised listing from DVA of treatment and medication they have paid for. In April 2012, DVA provide a list of treatments (medical/allied and pharmaceuticals) related to my white card. That detail is attached signed and dated. The treatments are first recorded in December 2010. There is nothing since my discharge date of April 1996 that DVA have contributed to or accepted. That is 16 years of funding my own treatment and prescriptions. After having started the DSRS claims with DVA is the only time that DVA have stepped up and as you have seen this has been a difficult process. I thought that it was essential that I start getting them to assist with my accepted conditions.

Back to my constant companion the allergic rhinitis, it was causing some serious issues and affecting my sinus. My sinuses were regularly irritated were causing congestion and I was impacted by hay fever etc. my breathing was really affected as were my Eustachian tubes of my ears, but only on my left side. I was using Beconaise as this is what the RAAF had prescribed during my service as well as Rhinocort, when it was prescribed by specialist. The specialist I was seeing was a new ENT specialist as my original ENT was now only doing consultations and medico legal reports, he referred me to another specialist that recommended some surgery and suggested that I had a deviated nasal septum. His letter is attached dated 10 September 2010.

> *This new ENT recommended some surgery to rectify my nasal obstruction; he states that I have a significantly deviated septum to the right with quite marked oedema of the uvule (It is that thing that hangs in the back of your throat) consistent with mouth breathing, snoring*

etc. he still has his tonsils and these will contribute to obstruction and has some laxity of the soft palate. Scans revealed deviated septum and large concha bullosa and also some inflammatory changes in both maxillary sinuses. He recommended a Septoplasty (fix deviated septum), sub mucous resection of his inferior turbinates and the concha bullosa as well as a tonsillectomy and bilateral intranasal antrostomy, and another ethmoidectomy to ensure the recurring sinus infections don't become a problem and are not contributing to his mucosal congestion. Details of procedures attached dated 15 September 2010 with a copy of his recommendations (the report is a new copy dated July 2011, I had sent the original to DVA and then asked for another copy which was sent by fax, a list of procedures and their costs attached).

In November 2010 *and again in January 2011* I contact DVA about the surgery and I am told that they cannot see how it is related to an accepted condition and ask me to send a formal request by letter indicating how it relates.

The difference between September and January is taken up with some issues between my health fund and the codes that the new ENT has used. My health fund states that they cannot call up the codes to validate if they can contribute. A triad of liaison between Medicare, the ENT receptionist and my Health fund lasts this long.

On the 12th February 2011 I send a letter to DVA at the request of the Manager DVA outlining the relationship with my accepted condition of allergic rhinitis. Attached dated and signed.

This letter never received a response and the Manager DVA advised that she could not recall getting this. She advised me of this at the F-111 Deseal/Reseal Lifestyle Management Program, she also apologised for not seeing another request sent regarding my hearing loss claim from 1996. I was asked to resend, which I did immediately dated 24 June 2011.

<u>The fun begins</u>

On the 4th August 2011 DVA send a letter outlining that there is no liability for the Commonwealth to pay for the proposed procedure. Further, the CMA noted that these ENT procedures are not related to your accepted condition. DVA state:

> Reports on file of respiratory physician Dr IB clarify the diagnosis of the condition claimed in 1990 as "oedema of the vocal cords caused by exposure to polyurethane products" and accepted as "episodes of allergic reaction to polyurethane" to be a lower respiratory tract condition, described as asthma secondary to sensitisation with isocyanates resulting in a significant increase in bronchial activity.

The CMA has simply read the details as indicated off my claim for rehabilitation back in 1990, he has also read only a portion of the diagnosed conditions being only "asthma – allergic origin secondary to polyurethane" and failed to include the condition of Allergic Rhinitis as listed by the MO at Amberley at the time for COMCARE. What is also unusual is that vocal cords do not fall into the lower respiratory area. The MO also cited the following impairment as Bronchospasm, irritated nasal airways and eyes and respiratory system symptoms only. Treatments listed are Ventolin MA and Beconase. Hardy limited to a lower respiratory condition only. Copies attached.

I try to get some traction on this with DVA, but it is just taking so long, I want to get some relief, so I go ahead and fund the surgery myself as well as obtaining a second opinion from a new ENT that is now working in the rooms with my original ENT. He decides to do a conservative method of surgery

and wants to wait before doing the tonsils, as he believes it is a terrible operation to do on mature adults. He is conservative and cautious and I proceed in September 2011. Attached copy of the procedures he undertakes.

With further contact with the DVA manager, she suggests it is very hard for DVA to determine what falls under allergic reactions to isocyanates, she suggested submitting claims for this and any other conditions that I have that cannot be addressed effectively under allergic reactions to isocyanates, which I do.

I submit claims for hearing loss left ear, respiratory system, vocal cords, laryngeal oedema, pharyngitis, sinus, post nasal drip, pleurisy, sinus bradycardia, septum deviation, heartburn, pericarditis, and headaches, all items listed and treated for in my medical records.

In June 2012, DVA accept conditions for tinnitus, allergic rhinitis, laryngo-pharyngeal reflux, conductive hearing loss in left ear, past oropharyngeal Candida infection and left ear Attic cholesteatoma. Gastro-oesophageal reflux (GORD) and also coeliac disease are disallowed. I never submitted a claim for coeliac disease. Attached is a copy of these decisions signed and dated.

GORD was disallowed by DVA but was later overturned by the Veterans' Review Board (VRB) on February 2013. Delegates in DVA initiated the VRB in September 2012, when I asked what (of my items claimed) relates to what (conditions that were accepted) as they have used differing clinical terms. Attached copies of my letters dated September and December 2012 as well as VRB decision February 2013.

At last Allergic rhinitis and post-nasal drip and sinus are accounted for and accepted.

In December 2012 I send a letter to DVA to advise them that I require surgery to rectify blocked sinus. After a recent chest infection, I was sent to my ENT as I had also suffered infection to my ears with this current chest infection. My GP wanted his advice on my ears as he wanted to err on the side of caution considering that I have already had ear surgery previously. A scan of my sinuses indicated nasal blockages within the sinus area of the nose and he recommended some conservative surgery to remedy the problem of mucosal congestion. The ENT also indicates that I have GORD symptoms and he has also treated me for dermatitis in my left ear. I have booked a tentative place in the surgery line for the 25th January 2013.

Now you may recall that the first surgery undertaken as outlined above was to fix a deviated septum. The ENT specialist stated that it was to fix the deviated septum and to "*ensure that recurring sinus infections don't become a problem and are not continuing to his mucosal congestion"*. That to me indicates quite clearly that mucosal congestion was a problem, the deviated septum was maybe secondary. This was never focused on by DVA it was all about the deviated septum.

On 13th December 2012 I send a letter to DVA with a request for further surgery. I also outline that this is not the same surgery as previous as best as I could. Attached is my letter dated 13 December 2012 that included an itemisation of procedures.

On the 24th December 2012, a delegate from DVA calls me to advise me that the surgery request is not related to an accepted condition. I asked how this was determined and he explained that he was just advised by a medical officer to inform me. I acknowledge that he has been tasked but I inform him that I do have accepted conditions relating to this. The delegate checked my accepted conditions and said but you have allergic rhinitis accepted as service related. He advised he would put it forward again. I send a letter to DVA on the 8th January 2013 requesting an explanation. Attached is my letter dated 8th January 2013.

Accepted Conditions and Allied Health

On the 21st January 2013, which is a few days later I get a letter in the mail from KS that I have to submit a claim for sinuses and a deviated nasal septum to Compensation to have a claim accepted before surgery can be approved. Letter attached signed and dated 21st January 2013.

My specialist gets a similar letter advising that DVA will not be funding the surgery. From this time dealing with my ENT are strained and he has issues with using the DVA payment system and getting paid for some 6+ months for consultations. It is finally resolved that his receptionist was doing the process wrong and DVA finally pay for the consultations I have had. I no longer use this ENT as a result of the credibility left by DVA and the problems the receptionist has with the DVA payment system.

On 26th January 2013 I send a letter to KS for an explanation. Attached copy signed and dated 26th January 2013.

I also receive a call from KS from DVA South Australia, she indicated she was from Allied Services. She advises that the request for septoplasty and turbinates isn't approved because they are not accepted conditions. I attempt to inform K that she has mixed up the surgery as this is a different type of surgery as I had already funded the septoplasty earlier in 2012. K stated she didn't care what the surgery was for because nothing is accepted on my white card for sinuses. She said you have allergic rhinitis accepted and anything else is a compensation issue and nothing to do with Allied Services and hung up.

Nothing further heard from the above.

On 4th April 2013 I also see my Chest Physician, as I want to obtain his diagnosis on my respiratory condition. He provides two reports back to my GP. The physician indicates that there are still ongoing reflux symptoms. He also states that I have mild erythema in the oropharynx (tonsils or mucous membrane). He recommended I use steroids such as Alvesco and is undertaking some chest x-rays to exclude other underlying problems such as bronchiectasis. He also states that it is disappointing that my asthma symptoms have not settled more significantly following my removal from my workplace exposure in 1990. Attached is his report dated 4th April 2013.

On the 7th May **2013** is my follow-up appointment with the chest physician. He provides a report to my GP indicating that most of my symptoms relate to my post-nasal drip and throat clearing. He states that the major symptoms relate to his ears with frequent infection and the sensation of post-nasal drip. He states there was evidence in the post-nasal space of the oropharynx and the problem seems to be in the upper airway changes than lower airway reactivity. The ongoing issues does seem to be the continuing inflammatory changes affecting the upper airway more than the lower airway. Attached is his report dated 7th May 2013.

On 20th June 2013 I send a letter to the DVA Manager (Brisbane) asking for clarification and outlining that I have since had four infections to my ears as a result of blocked sinuses.

Now I have a number of specialists indicating the same conditions yet DVA are not wishing to treat or accept these reports and diagnosis.

I am now very angry and decide to send my complaint to the Minister for Veterans' Affairs.

On the 21st October 2013 I submit a complaint to the Minister. Attached copy signed and dated October 2013. With acknowledgement from the ministers' office dated 5th November copy attached. I do acknowledge to the minister that my outline is large and complex but to please consider reviewing.

On the 10th December 2013 I get a response from the minister regarding my complaint, which is a paraphrase of the nonsense that I have received to this time. It is apparent to me that DVA are not fully abreast of the facts and have simply briefed the minister based on the same response by letters received in the past to me. Attached is a copy of his letter signed and dated 10 December 2013.

On the 23rd December I send another letter to the minister as response to his 10th December reply. I outline to the minister that he has been served the same jargon that I have to date and it does not address how having an accepted condition results in being denied treatment. Attached singed and date 23rd December 2013.

On the 12th March 2014, the minister responds back. He apologises for his mistake. He asks that I get my surgeon to write to his department with clinical evidence to support reconsideration. He also suggested that I lodge a claim for sinusitis by completing the one he has provided. He also stated that the issue with obtaining pharmaceuticals, namely Beconase and Rhinocort (Budamax), which are for my allergic rhinitis I can use my white card. He apologised for his department and acknowledged his department needs to improve performance in some areas.

On the 25th March I forward an email to my ENT and ask him to send a clinical review to the Department, I also provide a letter of request for the surgeon to act on my behalf for this. Copy attached signed and dated 25th March 2014.

On the 7th May 2014 my ENT sends the Minister a clinical outline of the relationship between my sinus and the allergic rhinitis. Copy attached signed and dated 7th May 2014.

On the 12th May 2014 I send a letter to DVA after a rather confronting phone call by a delagte, accusing me for making my file too large and confusing to determine.

On the 4th June 2014 a DVA delegate contacts me by phone indicating he has been asked to send me a copy of the claim for to complete and sign. This is sent and dated 4th June by the delegate, copy attached.

This was forwarded to DVA the same day it arrived.

On the 29th September 2014 DVA advise that my claim for sinusitis is accepted. Copy attached.

Can I get Beconase or Rhinocort using my white card, No I can't. Beconase is an over the counter medication and chemist do not honour it against white card, Rhinocort is only available once a year through DVA and chemists are not permitted to provide it at reduced costs using the white card. Yet in the next section to discuss you will see that Beconase is reimbursed in June 2013.

The game with DVA still continues and they still hamper treatment and medication for accepted conditions.

You may have asked, did I end up getting the second round of surgery as recommended by my new ENT, No, I didn't. After the complete cluster by DVA as well as not wanting to have to endure another round of the same if I go to another ENT with DVA declining it is related to an accepted condition and the issues created with the relationship of trust with the ENT I chose to suffer. I still suffer sinus issues and my GP tells me to do the sinus rinse, which I do, and use Beconase and I fund that myself. I still have mucous issues and post-nasal drip that gives me a sore throat and have blocked sinus most days, I also have tissues in every location at home, the car and at work that I use daily. When it is worse I have to contend with enormous amounts of sticky clear discharge from my nose that blocks my sinus and gets stuck in my throat, which at time makes me gag and cough up this stuff. It isn't pleasant but neither is having to deal with DVA.

Prescriptions

I also believe that veterans should not be asked to pay for their prescriptions, which may be contentious for some, but whilst in the service our treatment and medication was at no cost. Yet after leaving the service we are now paying for our injuries, as medication for accepted conditions as you know does not get covered under DVA and if it does we have to pay at the PBS rate.

Why veterans have to pay for medications even at the level of PBS is another annoying factor. Veterans should have the treatment and medication at no cost for anything that is accepted.

Injuries that are recognised are service caused and therefore a veteran that has anything that is accepted does not have to pay for treatment but they do have to pay for medication, this should be at no expense to the verteran. I cannot believe that veterans have to pay, even gold card members are expected to pay as well and I am amazed that Veterans have not challenged this.

The SRCA pharmacy procedure

On the 4th January 2001 DVA write to me advising that medications have been approved under SRCA as nominated by my GP. As a result, I had to set-up and account with my local pharmacy that took forever for them to deal with. I showed them the letter and there was a lot of too and fro before they took this on. They have never undertaken a process like this with DVA and just didn't wish to do it. However, they finally did, and it was still a huge pain as I had to show the letters from DVA each time I went to fill a script and had to spend so long explaining this. I had to ask them to check the computer to see if there was an account as they thought I was trying to kid them and take medication without payment.

On the 10th February 2011 I sent a request for payment of medication as the pharmacy was not too certain as previously discussed. I thought it easier to do it this way until the pharmacy got on board.

On the 25th March 2011 DVA advise that they would not pay the full amount as they were purchased prior to my claim dated 24th December 2010.

On the 1st May 2011 DVA advise the pharmacy that two other medications have been approved which are Curam duo forte (short term dermatitis infection) and mometasone (Novasone for dermatitis).

On the 3rd May 2011 DVA provide a list of approved medications and they were;

1. Anagelsics (GP did not specify)
2. Antihistamines
3. Anti-inflammatories (GP did not specify)
4. Avanza – (I have never used this)
5. Claratyne
6. Clarinate
7. Efexor
8. Kenacomb ointment
9. Nasonex (Beconase)

This is so annoying, and already I am seeing holes of enormous proportions here, specifically the GP did not specify items? I can see a few holes in the above list, specifically in the area that only 3 are script related.

On the 19th May 2011 I submit another request for payment, as the pharmacy are still not on board with the request from DVA.

On the 24th October 2011 I send another request for payment as the pharmacist at the pharmacy are still not convinced about this. I try not to get upset and say that is fine I will request this from DVA personally.

On the 28th October 2011 DVA send a letter advising me to pay for two items placed on the pharmacy account. They are for Rhinocort and a Neilmed Sinus Rinse as they are not for the conditions of episodes of allergic reaction to polyurethane.

This letter also states that the approved medications are:

1. Analgesics (unspecified)
2. Avanza
3. Clarinase
4. Antihistamines (unspecified)
5. Claratyne
6. Efexor

DVA state that they have aso provided a copy of this list to the pharmacy as well as notifying me.

What is interesting is now the list has reduced as well from this original list.

On the 31st October 2011 DVA also send me a copy of the letter they sent to the pharmacy, to prove the point I guess.

On the 8th October 2012 I obtained a script from a skin specialist and I notified DVA of this in case there was issues, however on the 6th September DVA contacted my pharmacy to advise that the medication that was issued to me a month later was approved.

On a side matter, You may recall that in June 2012, DVA accept conditions for tinnitus, allergic rhinitis, laryngo-pharyngeal reflux, conductive hearing loss in left ear, past oropharyngeal Candida infection and left ear Attic cholesteatoma. This was highlighted above in my allergic rhinitis outline. Yet a script for Kenacomb, an ear ointment prescribed was challenged by DVA.

I had to justify that it was for an accepted condition. I indication that it was related to dermatitis which satisfied DVA based on the fact that it has been accepted under SRCA with my F-111 claims in December 2010.

On the 5th November 2012 I send a letter to DVA after a phone call outlining the reason the two items ended up on the pharmacy account, the duty pharmacist had issues understanding the account system. I wanted to pay cash for the two items but he just walked away and said he would place them on the account. I also asked why the approved medications list had diminished.

On the 9th November 2012 DVA wrote back regarding the diminished list of medications, an apology was provided as it was missed out in being placed on the list it was stated. However, Nasonex (Beconase) will not be added until it can be proved it relates to an accepted condition. Yet DVA advise the pharmacy of it as an approved medication only in May 2011.

On the 11th November 2012 I send a letter to DVA regarding their response on the 9th, above, advising them I am not happy with how they conduct this list and approved meds. This is a please explain letter as I am just annoyed at how I am being treated.

On the 6th December 2012 DVA send a response for me to my please explain letter above. The writer advises that VAPAC indicated that some of the medications on the list were to treat conditions to those I have accepted. *It is wonderful to be informed of these changes appropriately.* It is just more in the mind reading game with DVA.

On the 19th December 2012, the same writer of the letter dated 6th December from DVA writes to inform me that my condition of episodes of allergic reaction to polyurethane and my letter dated 13th December should be obtainable under the white card. *No wonder this is confusing for the pharmacy; I still have to use my white card for items but other stuff related to SCRA has to go on the account. Yet my claim for stress was under VEA and it is this that the script for Efexor was for, I thought.* Bugger me who really knows?

On the 18th June 2013 the DVA office in Tasmania writes to me advising me of the Patient Contribution policy with regards to submitting an application for a refund of medical expenses. Veterans' are required to pay a concessional co-payment of $5.80 for all pharmaceutical items. The writer also reimburses Beconase as it is related to accepted disabilities. Copy attached.

On the 18th July 2013 DVA ask me to advise them why I have listed Otocomb Otic Ear Ointment which is used to treat ear infections with compensable conditions. I respond that it was used to treat dermatitis in my ears (something that occurred since working in the trade and on the F-111s). Copies attached.

On 24th July 2014 DVA advise that funding pharmaceuticals via an account set-up with DVA and a approved pharmacy has ceased and all medications will now be through the white card for SRCA as a result of some legislation changes. Attached copy.

Hearing Loss

I submit a claim for my hearing loss, repeated earaches and infections for my left ear and left middle ear cholesteatoma under SRCA. Cutting to the chase, Dr A the ENT physician who did my surgery for the cholesteatoma in 2000 was the medico legal specialist initiated by DVA for my claim. Dr A was also the doctor who referred me regarding the deviated septum.

On the 26th May 2014 DVA send their decision, the claim has been rejected. Copy attached with the report.

On the 15th May 2014 Dr A undertakes the examination for this claim, his findings from his report are as follows:

- I have tinnitus but is regarded as a percentage of disability as 0%,
- I have poor speech discrimination in my left ear, perfectly normal in the right ear,
- The condition was not caused by Commonwealth employment,
- The condition is not aggravated by the claimant's Commonwealth employer,
- The condition is unrelated to the claimant's Commonwealth employer,
- The sensorineural hearing loss is 15.5%,
- The hearing loss attributed to Commonwealth employment is 0%,
- The condition has nothing to do with the Armed Forces.

Mr Robson is of the opinion that his exposure to isocyanates, which has caused him trouble, Is also the cause of his cholesteatoma. I would consider that the cholesteatoma was probably present and developing from 1981 onwards, in view of his medical history. The cause is chronic Eustachian tube insufficiency usually starting in childhood. *In fact, if the inhaled substances had caused this it would be bilateral.*

Copy of report attached.

To say the least, I am guttered and appalled.

On the 1st June 2014 I respond to DVA stating that I will be appealing as I am not satisfied with the decision of Dr A. Attached with my issues and concerns.

As a child I never experienced an ear ache, the first ear issue that is referred to in the report was when I was in the RAAF at Recruit Training. In 1981 I was in the service of the Commonwealth

undergoing training. It was after we came back from field training and weapons firing at Murray Bridge. It was pouring rain the entire time and we were completely drenched most times we were out there. It was also summer and we experienced many days of 40+ temperatures during recruit training and our graduation was cancelled due to the excessive heat.

To also state that is was probably starting during childhood is a long stretch. I was 21 when I joined the RAAF and the cholesteatoma didn't occur until 20 years later. That is a large stretch and a very late onset of a childhood illness. To also justify that it would also be bilateral is a stab as well. We are not unilateral in our design; our ears are different sizes than each other as are other parts of our bodies. People with Eustachian tube issues do not have bilateral complications.

Additionally, the appointment I was asked only one question as I was told to sit there and answer when addressed. He never asked me about tinnitus during the appointment, he asked me if he had done any other procedures since he undertook the surgery, to which I answered no, he then told me I could leave. Dr A always had a gruff bedside manner and this is well known.

So we have another specialist making untrue statements that impact veterans' injuries and further treatment they may need. This report certainly addressed the medico legal requirement for DVA.

It seems that when it comes to paying out compensation DVA pull out all the stops and their band of medico legal team make reports to ensure veterans obtain very little.

Why do I say this? Because for the claim under VEA of hearing loss and left middle ear Attic cholesteatoma where a decision was found in favour of having the condition dated the 14th July 2012, the delegate DZ was given the following from the CMA (compensation Medical Advisor) the following glossary in the outline of her decision;

"A cholesteatoma is a mass of squamous cells and cholesterol and fat debris which arises in middle ear, the mastoid air cells or in the external ear. Sorensen and Jafek (2001, p.67) states that the cholesteatoma can be congenital or acquired and that acquired cholesteatoma occurs through sequestration and inflammation of some squamous cells from the tympanic membrane as a result of otitis media or Eustachian tube dysfunction. The cholesteatoma can cause conductive hearing loss or chronic otorrhea.

This is not a malignant neoplasia. There is some academic merit in the assertion that the congenital variety is a benign tumour since it is said to have arise from embryonic ectopic rests of cells, but the acquired type is a chronic inflammatory lesion which due to its location within a cavity of the skull has an adverse behaviour."

How this apply to that claim, but in this claim a medico legal specialist claims it is a childhood onset, that began in 1981, during my service, but has not been attributed by service, not aggravated by service and not related to service despite using all those chemicals that cause dermatitis and allergic rhinitis, working around aircraft and using firearms. It is not related, end of story.

Further a study of hearing impairment undertaken on F-111 maintenance workers the study highlights that F-111 workers had higher levels of ototoxicity (hearing loss due to high level noise and the mix of solvents and jet fuel) than the main-stream public and also those tested in Richmond RAAF base.

This specialist Dr A did not ask for or do any lab tests on the mass taken during the cholesteatoma surgery he conducted in 2000, this should have been standard procedure and copies of the results shared with the patient.

On the 18th June 2014 DVA send a letter advising receipt of my request for reconsideration. In one letter it is an appeal, in another it is regarded as reconsideration. Copy attached.

On 3rd September 2015, yes, that is correct that is 15 months later, DVA advise they are not going to consider changing the decision and it stands as is and if I want to appeal then I have to take it to the Administration Appeals Tribunal (AAT). Copy attached.

On the 16th September 2015 I send a letter to DVA advising them that before exercising my right of appeal and progressing further I request copies of all written material, personal files, photographs and computer records relating to this claim under freedom of information.

On the 29th September 2015 I submit my application for review to the AAT. Copy attached.

On the 13th October 2015 DVA send a letter outlining that another delegate from Military Rehabilitation and Compensation Commission will be the review officer.

My reason for wanting to progress to the AAT is that I followed up on the successful claim made under VEA for my ears and the reference the delegate quoted that validated that the condition was service related. This was listed above under the date of 14th July 2012:

> https://www.hse.ie/eng/health/az/e/ear-infection,-outer/
>
> Factors that can provoke otitis externa are not direct causes, but they may make developing the condition more likely.
>
> ***Middle ear infection***, if you have had a middle ear infection, such as otitis media, your ear may have been producing discharge over a prolonged period of time. In some cases, the discharge may cause otitis externa.
>
> ***Seborrheic dermatitis***, is a common skin condition where the areas of your skin that are naturally greasy (sebaceous), such as the side of your nose, your forehead and your scalp, become irritated and inflamed (swollen). This may be a contributory factor in the development of otitis externa.
>
> ***Fungal infection***, the species of fungus that can cause otitis externa includes Aspergillus variety and the Candida albicans variety, which is also called thrush.
>
> If you have been using antibacterial eardrops or aural corticosteroids (ear medication the relieves swelling and asthma puffers) over a long period of time to treat another infection, you may develop a secondary fungal infection that can cause otitis externa.
>
> ***Ear damage***, your ear canal is very sensitive and can easily become damaged through scratching, excessive cleaning, ear syringing and the insertion of cotton buds. You may also damage your ear canal by incorrectly or excessively wearing hearing aids, earplugs or earphones.
>
> ***Excessive moisture***, you are more likely to get otitis externa if liquid gets into your ear canal. Swimming (particularly in dirty or polluted water), sweating and humid environments may increase your risk of getting otitis externa.
>
> ***Chemicals***, your chances of getting otitis externa are increased if you use products that contain chemicals in or near your ears, such as hair sprays, hair dyes and earwax softeners.
>
> ***Underlying skin conditions***, as well as seborrheic dermatitis being a potential risk factor for otitis externa, underlying skin conditions such as psoriasis, eczema and acne, can also increase your risk of developing the condition.

Allergic conditions, if you have allergic rhinitis or asthma, you may be at higher risk of developing otitis externa.

Weak immune system, if you have a condition that weakens your immune system, such as diabetes, HIV or AIDS, or if you have been having cancer treatments, such as chemotherapy, you may be at higher risk of developing otitis externa.

Most of these have been present in my treatment within the RAAF with the exception of the weak immune system.

The AAT process begins with phone conferences between a member of the AAT acting as a mediator and the Legal solicitor for DVA. I am asked whom do I have acting for me, I state myself. I am told that it would be much better if I got proper representation, as they prefer to deal with people of the same ilk.

I state that this won't happen and that I do not intend to fund someone's children through private school and overseas holidays. That this process can take its course in the manner it is starting and that the AAT and the DVA solicitors can take the time to explain things effectively and in a level that I will understand.

The mediator again affirmed that it would be better to have a legal representative, as it would be in my interest. Each time this was raised in the phone conferences I stated the same thing as above.

The brief that the DVA solicitor has shared is enormous and is in two volumes each about 2+ inches thick. I got this a few days before the conference. Its aim is to implicate you as a villain as it only has your claims and evidence related to this claim as well other claims and details from specialists on those conditions and claims that have no relevance to this are included.

Consequently, every error or mistake made by DVA is not included.

After a few phone conferences it was put to me that if I could get another diagnosis from another medical specialist to refute the original report then they would consider turning the decision around. They stated that they could see that I had the condition, that actually is not in question. They also agreed that Dr Anning's report was short, could be ambiguous and not concise with how he made his determination and decisions.

So, I attempt to get another specialist report. No one in Brisbane wants to even take up the task. All want to read the report and then say that he is a leading specialist in his field, we had him lecture us at Uni. What hope did I have?

I try to get a specialist appointment with a doctor in Sydney and Melbourne. All refuse as they say that they cannot do it as I do not live in that state and the expense would be unrealistic.

Unfortunately, I withdraw my application from the AAT as they are mounting pressure to present an additional report to contradict the report provided by Dr A.

A final matter on this issue, you may remember that Dr A stated "*In fact if the inhaled substances had caused this it would be bilateral"!* What Dr A does not fully explain is that throughout my RAAF career I was only ever getting issues with my left ear, he has now swung it over to both ears in this statement that he centres on the exposure of polyurethane. The issue is a cumulative effect of exposure over a 12-year period, not a once of from some polyurethane.

Otomycosis is a fungal ear infection also known as otitis externa and is and aggressive infection and is more common in tropical countries or in warm, wet climate. It can also turn into malignant otitis externa and if not treated or if left aggressive it can be life threatening.

A study undertaken and entitled *"Otomycosis; clinical features, predisposing factors and treatment implications – Khurshid Anwar, Muhammad Shahid Gohar"* cites that the infection is usually unilateral.

Not understanding the sensitisation aspects of exposure with the chemicals used and the environments worked in as a SURFIN renders his expertise, well, of limited value. The fact is the ear issues were becoming more regular and even an ENT specialist I was sent to said my ear was clear, WHY? He did not address this and this is from one of his own in his own field of expertise.

DVA win another round of the Compensation saga.

Advocate

You may ask why didn't I get an advocate to assist me. Well I did many years ago and I am still a member. When I went in and asked them for advice they asked me to round up my evidence and make sure it is ordered, and they would try to get to it once they get my detail. They also emphasised that it would take them time and would not be started immediately. They were so busy and are volunteers, I just didn't feel right asking them to help me. I was sure that they had a lot of others who needed it more than I did. That is why I decided to do this myself, I did however ring and ask for advice on some issues.

Greater than 1,000 Days for a decision

As you may recall I submitted a claim in December 2010 for memory loss and impaired cognition. I attended specialist appointments for a medico legal report to be undertaken for DVA. I have received no notification on the outcomes. I have contacted DVA Brisbane office on the matter with phone calls and also a visit to SS and GJ.

On 28th September 2012 I sent a letter requesting what the outcome was as I have not receive anything at this stage. Nothing further was heard. Copy attached.

On the 5th July 2016 I take a call from DVA regarding this claim, and the caller apologises for the delay and that it has taken in excess of a 1000 days to finalise. The caller also sent a letter to advise of the decision and it confirms that the appointments to these specialists were undertaken in September 2011.

That is an incredible 5 and 1/2 years. Got to be happy with that.

Claims for the following:

In December 2013 I submitted 3 claims for compensation consideration under SRCA as a result of ongoing issues from my SURFIN employment. These conditions were Post-oropharyngeal Candida infections, Laryngopharyngeal Reflux and Gastro-Oesophageal Reflux.

- DVA had arranged a MEDICO-Legal Report and assessment for **Post-oropharyngeal Candida infections** and **Laryngopharyngeal Reflux** for the 14th April 2015. Copies attached.
- DVA had arranged a MEDICO-Legal Report and assessment for exposure to isocyanate paint in 1991, for a claim that I had not submitted, a DVA delegate had decided to submit this without my knowledge for **Occupational Asthma.** An appointment was made for the 6th May 2015. Copies attached.
- DVA had arranged a MEDICO-Legal Report and assessment for **Gastroesophageal Reflux Disease** for the 2nd June 2015. Copies attached.

For some reason DVA had arranged for a claim for Occupational Asthma. I have no idea why this was done and in a responding letter I state I am unsure how I can apply for this (see below).

On 30th December 2013 I send a letter to DVA as apparently I had forgotten to sign the claims submitted. The letter also includes a form sent to me for an additional signature and details for my hearing loss claim. Copies attached.

Additionally, I spend a significant amount of time in that letter outlining that I don't think I can claim for asthma, there are two paragraphs on this matter with the last indicating that I would need to fully understand if there is an entitlement for me to be able to claim before doing so. I asked specifically for this to be explained to me.

I heard nothing back from DVA on this until being advised of an appointment.

On the 5th May 2014, DVA advise me that they have accepted liability for occupational asthma, post-oropharyngeal Candida infections, laryngo-pharyngeal reflux and gastro-oesophageal reflux disease based on the link between my military employment under SCRA. Copies attached.

On 30th March 2015 I am sent the appointment details to attend some of the medico legal appointments for the above conditions to determine permanent impairment. I am also provided some non-economic loss questionnaires to complete and return for each as well. Copies attached.

I attend each of these appointments.

On the 25th August 2015 a decision for each of the conditions it has been decided that no payment can be made. The reports are provided with each decision. Copies attached.

On the 31st August 2015 I send a response back to DVA requesting reconsideration.

On attendance to each appointment not one of the specialist had been provided any historical documentation of my past treatment or medication by DVA. With Dr K I left the appointment and drove home to get some x-rays and other data so she could have some information. The remainder of the information was provided verbally.

> **Asthma** – now I have no issue with the report provided for the asthma. My issue is that many aspects of his report actually contradict many aspects of the other specialist reports. Also, Dr R embarrassed me by asking, you currently get a pension paid for this don't you? I answered yes of something like $22 a fortnight. He then said and you want compensation as well? I refused to answer this and I am sure he could see the shock it had on me.
>
> I was inches away from telling him I never asked for this, DVA arranged this them selves and then telling him exactly what I thought of him. Instead I simply left when the appointment was finished.

Post-oropharyngeal Candida infections and Laryngopharyngeal Reflux – currently and apparently I am not suffering the Candida infection and she finds little evidence of a definitive diagnosis unless of course a person was taking large doses of inhaled steroids. I wasn't asked if I had taken or used inhaled steroids (asthma puffers).

Dr K does indicate that if Laryngo-pharyngeal reflux if present it also contributes to GORD, and her report does indicate that there is some residual sore throat and perception of oropharyngeal secretions and some residual sore throat are very common in patients who have suffered GORD even after successful treatment.

But her opinion is that the apparent undiagnosed Candida or the proven GORD were not contributed by my employment. Even though earlier she mentions combinations of the workplace irritant chemicals, my GORD and my asthma and its treatment contributed to this back then. But now that I am away from that everything is now manageable. She states that the diagnosis is often considered in cases of unresolved sore throat but is in fact quite rare unless individuals are taking large doses of inhaled steroids for asthma.

Has she missed the point of what she read from Dr RB, that is why he provided a spacer, because the large doses of inhaled steroids were causing the issue. Additionally, there has been other specialist that have treated me recently for these conditions and she has dismissed them.

Another compensation report that is written to discredit every other specialist diagnosis and meet the criteria of delivering a report that justifies no payment by DVA.

<u>This next one is gold, I'm sure you will be impressed by the skill of the physician involved</u>

Gastro-Oesophageal Reflux – Dr B provided a very short report, but in his conclusion does indicate a possible effect on my development and exacerbation of GORD. The biopsy showed some inflammation but no comment regarding the presence of reflux oesophagitis was made. He also refers to me as being unremarkable.

Something is there but he doesn't know what. To test categorically he recommends a further test of an oesophageal Ph. Study and manometry to confirm the presence of reflux and or oesophageal dysmotility.

The above tests have not been performed at this stage, as current evidence does not suggest the presence of reflux disease.

What a great man, not only does he contradict the report from Dr K above and his own diagnosis above, but the man wants to charge the taxpayer for an extra test to be sure. He just needs confirmation from DVA.

Apparently there is no evidence of GORD in the closing statement but in the beginning of his conclusion he indicates that my employment does indicate development and exacerbation or GORD. Also if the presumed GORD was proven it possibly would be permanent.

But I did have a fundoplication as undertaken by Dr G he says, which was to treat GORD that he referred to.

The final piece of gold from our illustrious specialist is that the "BA swallow" I had to undertake prior to his procedure under general for a gastroscopy. The staff on the day of

this BA swallow also confirmed to me that they had to get a second opinion and could not let me leave until someone confirmed the determination, it indicated to them that it referred to GORD and I was allowed to leave. He is stating that it wasn't.

Now, the clincher, the biopsy of the gastroscopy resulted in a report being sent to my GP. I asked my GP what this means, he simply said you have GORD, but we knew that anyway.

On checking the detail of this report it says, "*the presence of cardiac mucosa in a biopsy from the junctional region is to be used as a histologic definition of GORD."* According to this definition, patients without cardiac mucosa in a representative biopsy do not have GORD irrespective of any other criterion, and those who have cardiac mucosa have GORD.

On the day of the gastroscopy, I had to stay overnight as a result of being under a general. Dr B approved this as I live alone and drove myself into hospital. However, after recovery from the general and being processed to go to the ward, I asked Dr B when do I hear about the results? Dr B was sitting at a bulkhead with his laptop and what looked like motorbike gear. He told me at this point that I had mild reflux. His report states a mixture of determinations. This man is gold.

Yet DVA use this to make a determination that there is no GORD. Just amazing.

On the 4th July 2016, DVA responds back stating that their initial determination is being maintained, to affirm the previous determination of the 25th August 2015, that no compensation will be paid.

I am convinced that DVA are in partnership with medico legal specialist to ensure a minimal amount of compensation is distributed to veterans. I am also convinced that it is simply a process that is set-up as a compliance process that has no basis other than to reduce as much as possible the amount of compensation that is paid.

Based on the information provided in every one of these SCRA disallowed reports, especially the DR B report, this should have justified an enquiry by DVA, but they simply upheld his report. In my view itis fraud and incorrect practices. I simply cannot believe all that I have had to endure from DVA, specialist and the system for rehabilitation and compensation.

There is no authenticity or integrity with this department and the system of medico legal specialists. The medico legal structure is a rite-of-passage for a retirement plan with DVA funding it through medico legal reports.

At the very least from the detail that has resulted in these reports, it is a blatant withdraw from a fair and equitable process. It is too coincidental that every medico legal report for conditions where I am currently getting treatment or have other reports from credible medical specialist are rendered insufficient or lack relevant proof, yet it is enough for delegates to address criteria that it relates to service and complies with legislation before proceeding further for an impairment determination.

At the very least for the GORD report above, this should have resulted in an audit by DVA if in fact the process was credible.

Medico Legal Mandate: It is satisfactory that medico legal specialists are paid a couple of thousand dollars at public expense for their reports, that undermine the veterans claim, but it is not satisfactory that veterans are entitled to claim for rehabilitation and compensation for injuries or illnesses in their public service.

RAAF Occupational Health Assessments

For the category of Surface Finisher (SURFIN) in the RAAF, members are to undergo regular health screening and tests as a result of the environment and the chemicals used. The RAAF has scheduled these for every 12 months, and are required to investigate the following:

- Full blood examination
- Liver function
- Pulmonary function and
- Skin examination

The Service is aware of the dangers involved in this category and posts this notice (attached) on a SURFINs file. The notice lists the hazard and also the chronic health effect.

It is a shame that both Defence and DVA are now ignoring this requirement of the chronic health effects on this SURFIN.

This concludes my submission for the Productivity Commission.

Neil Robson