

## Assessing the veterans' compensation and rehabilitation system

Understanding the objectives or purpose of the compensation and rehabilitation system is important for determining how well the current system is performing, and what an improved system would look like.

The legislation underpinning veterans' compensation and rehabilitation does not outline principles on which support should be based. However, past reviews outlined various objectives that Australia's military repatriation system should aim to achieve for veterans, including that the system should:

- appropriately, adequately and fairly compensate those who have suffered incapacity that could be related to their service — both financially and by the provision of high-quality medical and hospital care

I would like to address inequities in the DVA/RMA system applicable to Ex-Service Personnel.

I qualify to contribute to this study as I served in the RAAF from 16<sup>th</sup> March 1965 to 15<sup>th</sup> July 1985.

I was a Radio Technician Ground.

I have been failed by the system on many levels and I appreciate the opportunity to highlight just one person's grief knowing there are many others in a similar situation.

The 20 years I spent in the RAAF were the best and worst years of my life. I worked mostly in support of Air Traffic Controllers in a high stress environment and witnessed many aircraft mishaps, one fatal. I was on duty and watched a Canberra disappear behind a hill and explode killing all onboard. I can still see the white faces of the Fire Crew as they returned to the base of the Control Tower. I was on duty when the Sabre severed the Lamington National Park power line, the F-4 Phantom arrester cable mishap and crash, witnessed an F-4 upside down narrowly passing over the tower and recovering, the F-4 that was lost off Evans Head, the Navy Skyhawk landing on its fuel tanks. All these are still vivid memories, but none are as stressful as when I immersed my arms into the transformer oil of the SURAD TA-23 Radar situated at the back gate of RAAF Base Amberley.

September 1981 I was repairing a faulty EHT Transformer which required removing wooden rods located at the bottom of the transformer tank. We had no tools to reach that distance, so I reached in held up the rods so that the faulty coils could be replaced. There were no warning signs, no protective clothing and it was just a nice looking yellow oil, like cooking oil. Should not have been a problem, right? My overalls and shorts were saturated in oil. I washed my lower arms initially and showered 6-8 hours later at home. My wife handled the PCB soaked overalls for approximately 10 minutes and then washed my clothes in the family washing machine. Animal studies show that with immediate washing with soap and acetone, 57% of PCBs are removed meaning 43% is instantly absorbed creating a huge body burden. After 24 hours only 1% is left on the skin, such is the penetrative nature of PCBs.

October 1981, I had flu-like symptoms (PCB immunosuppression). January 1982, I was posted to Support Group 6 at Command Logistics HQSC as a Spares Assessor for the SURAD system.

February 1982, I experienced Prostatic burning for the 1<sup>st</sup> time (PCB excretory pathway) and the persisting flu-like symptoms gradually worsened.

1982 my Coolaroo, Broadmeadows married quarter was broken into 3 times in 10 days and we were relocated to Dallas, Broadmeadows. This was the beginning of the end of my RAAF career. I could not believe the RAAF thought so little of us by placing our families in such hell holes. That would change but I never stayed to see it.

March 1983 a Special Technical Instruction was issued advising the transformer oil I immersed my arms into contained Polychlorinated Biphenyls (PCBs) and was a suspected carcinogen. Warning labels had to be affixed and anyone who may have had contact with the oil were to annotate the exposure on their medical records which I did. My heart sank, I kept looking at my arms and chest for tumours, not giving a thought or realising it could possibly impact on my family.

I expected contact from Occupational Health and Safety for ongoing health monitoring – never happened.

I also assumed they would contact DVA and advise of chemicals in use – never happened.

Around August/September 1983 the soles of my feet began to burn after walking around for lengthy periods (30 minutes or more). I had a hearing test and it was noted my hearing had declined (PCB hearing deficits). My BMI had increased, and it was recommended I exercise more (my body was encapsulating a toxin it could not metabolise, so it was storing it my liver (PCBs NAFLD) and fatty tissues (PCB obesity). I was experiencing cysts on the back of my Neck (PCBs Chloracne). Headaches which I thought was related to my sore eyes due to the Admin role I was now performing (symptomatic of PCB exposure and degenerating neck).

25<sup>th</sup> December 1983, while attempting to play tennis with my children I experienced extreme pain in my right shoulder. I naturally assumed I had strained my shoulder and subsequent medical investigations focussed on that premise. Reality was I was experiencing spinal degeneration and early Rheumatoid Arthritis. The pain in my right shoulder eventually subsided enough to sleep on 7 years after my discharge (1992) with the help of an anti-inflammatory.

1984 my teeth began to break (PCBs Caries and broken teeth), Physiotherapist altered treatment of my right shoulder to my neck and advised anti-inflammatory meds due to inability to improve my pain.

15<sup>th</sup> July 1985 I was discharged, and I asked the Medical Officer “what should I be looking for re the PCB exposure?” and he said, “he didn’t know”. He advised me to contact DVA if I had any problems later. I was later advised by a DVA Assessor that he should never have said that.

So, who should I turn to if not DVA?

My perception at time of discharge was DVA would provide medical support through the Repatriation Hospitals if I needed it. I never related my shoulder soreness to the PCB exposure because of the nature in which it materialised (tennis). I should have realised there was a bigger picture when the pain persisted way beyond my discharge. It was referred-pain from the neck which I eventually realised in 2010 after undergoing C7/T1 fusion.

It is important to note that my symptoms, which in hindsight can be related to my PCB exposure, were not obvious to me or my Medical Officers at this time.

PCBs are highly penetrative, thus the need for protective clothing and should be disposable as PCBs have been shown to affect the wife who handles them for laundering. My washing machine was now polluted, and my family was also experiencing low level exposures.

June 1987, my wife was diagnosed with advanced Breast Cancer and subsequently died January 1995 (PCBs are an oestrogen mimicker).

**• suitably rehabilitate those who have served, and support them to re-establish themselves into civilian life at the conclusion of their service**

After discharge, I was constantly experiencing upper respiratory infections (PCB immunosuppression), biliary tract burning (PCB excretory path), burning soles of my feet (PCB Neurotoxicity) and prostatic burning (PCB excretory path) after exertion.

If some sort of OHS intervention was conducted before and after my discharge, this health pattern may have been connected to my PCB exposure sooner, but there was never going to be a guarantee of that due to inadequate Toxicology training of the Medical profession in general.

October 1996, the burning feet reached a crescendo during my employment with DEC, which entailed replacing PC Monitors, some weighing 47Kg. It was painful depressing the clutch of the van and fortunately for me, I was recruited into their workshop for Laptop repairs. My GP at the time was at a loss as I was negative to Diabetes and Gout. April 1998 my GP reluctantly referred me to a Rheumatologist as my Rheumatoid Factor was 2800 (normally 0-40). I was diagnosed with rheumatoid arthritis 17 years after exposure. I rarely display classic symptoms of Rheumatoid Arthritis and anti-ccp levels vary between 56 and 325 (0-6) which means I have an increased risk of erosive disease. October 2004, I applied for a Disability pension due to extreme pain in my hands and wrists denying me use of a screwdriver for any length of time. I have had mixed results from medications prescribed, none have resulted in remission. Many had severe side effects. I am currently on Mabthera infusions with 10mg Methotrexate.

- **promote health and encourage veterans to take responsibility for self-help measures**

Early 2005, I rang DVA and asked, "what should I be looking for re my PCB exposure". I was asked if I had spoken to my GP. I spoke to my GP who shrugged her shoulders and said have you spoken to DVA. She hadn't heard of PCBs and promised to "look into", it but never did. I contacted QLD OHS and was advised to contact DVA or do my own research as they had limited reference data.

I have been referred to the following types of Specialists so far to eliminate possible underlying conditions (none found): Rheumatologist, Infectious Diseases, ENT privately and publicly, Haematologist, Immunologist public and private, Ophthalmologist, Respiratory, Neurologist, Orthopaedic Surgeon, Dermatologist, Allergist, Endocrinologist, Hepatologist, Cardiologist, Dermatologist and Gastroenterologist. I am currently seeking help from a Nutrition and Environmental Medicine Doctor (NEMQ) privately.

Whenever I have mentioned PCB exposure, it was normally met with silence, a deflection, glazed look or a shrug of shoulders. When asked if they have toxicology knowledge, they admit to a brief mention on Medical School training but otherwise no knowledge.

The knowledge of PCBs and treatment protocol of the afore-mentioned Specialists is almost zero and yet these are the people DVA refer you to and make judgements about your health. These are the people who form SMRC and VRB panels of expertise without having any expertise and make judgements accordingly.

The Haematologist was the exception, he understood the obscure nature of chemical exposure symptoms and blood anomalies recommending some OHS Doctors who may be able to help.

I approached some OHS Doctors but was turned away as they only deal with Companies. Initial fees are between \$1200 and \$3000.

I rang the Qld Medical Board to find a Toxicologist in Qld. They asked me for a name. I advised that is why I was calling to get a name. They said they could only search their database by name and then they could tell me their specialty. They advised me to contact the Poisons Hotline.

The Poisons Hotline advised me there were no Toxicologists in Qld as they had all departed interstate.

My GP approached DVA re funding of a visit to an OHS Practice and it was denied.

My research indicated PCBs were related to many of my symptoms and conditions.

PCB exposure related symptoms and conditions: Rheumatoid Arthritis, Hearing, Spinal degeneration, Dental (broken teeth), Liver (NAFLD), Sjogren's Syndrome like symptoms, Endocrine disruption (Hashimoto's), Lowered Testosterone, disturbances to Gall Bladder/Biliary system, Prostate, Peripheral Neuropathy, High

Blood Pressure, Atherosclerosis, Obesity and potential for storage/excretion path cancers. As an oestrogen mimicker it is also linked to Breast Cancer.

Only Peripheral Neuropathy currently appears in a SOP.

I approached DVA with this knowledge and was advised to seek an Advocate

1st Advocate (volunteer) took note of all medical issues I was experiencing noting PCB exposure was not listed on any SOPs. The next step was to find other reasons for hearing loss, tinnitus, RA and spinal degeneration. **LOOK FOR WAYS AROUND THE SOPs** to achieve an outcome because trying to amend the SOP could take 4-5 years (currently 12 years and counting). I had worked in noisy environments and I had worked in the Control Tower environment where equipment was located above head height. This satisfied the SOPs and DVA, but not me. My hearing was good prior to exposure and 12 months after exposure it had deteriorated while working in an office environment. 18 months after exposure I was experiencing headaches and then extreme shoulder pain. Physiotherapist at the time started on my shoulder but changed focus to mainly on my neck as he thought this was the area causing the pain. I had never experienced or understood referred pain until 2010. The Advocate tried to get Rheumatoid Arthritis recognised through smoking (weak case as I was smoking 10 a week on enlistment and 35 a day on discharge) – rejected along with sore feet and shoulder issues.

I wasn't happy with the spinal and hearing recognition because I felt I had cheated the system. People were telling me you are entitled because the injuries are directly related to my Service career and "does it matter how or why you are compensated, as long as you achieve recognition". It does for me as it weighs heavy on my conscience and I can see anomalies in the system. You can't go through the system, so you try to go around it. 1st Advocate left.

2nd Advocate (paid) wanted to close my cases but I wanted to challenge the decisions through the VRB. Apart from the odd phone call to see if my case could be closed, I was offered no help from the 2nd Advocate.

3rd Advocate (Volunteer), offered assistance, and after looking at every symptom throughout my RAAF career, fired a salvo of claims at DVA, all were rejected, and he quit Advocacy.

4th Advocate made it clear that the SOPs are his guide and my conditions don't satisfy the SOPs.

VRB experience was one of rejection but not devoid of hope. I had researched PCBs on-line and used the arguments during the board hearing. They said I had a case, but this hearing was about the DVA Assessors decision with reference to the SOPs, and as PCBs weren't in the SOPs, they apologised and said they had to rule in favour of the Assessor. They encouraged me not to give up and suggested I seek other avenues through DVA. I now realised that the SOPs needed to reflect a PCB exposure before I could get help.

The F-111 Deseal/Reseal saga weighed heavily on my mind. Department of Defence had already rejected recommendations from a study by an Adelaide Toxicologist which I saw as crucial in gathering statistical data on exposures, and thus a greater understanding of medical outcomes from chemical exposures.

Repatriation Medical Authority (RMA).

My 1<sup>st</sup> attempt at amending the Rheumatoid Arthritis Statement of Principles (SOPs) resulted in outright rejection as I had submitted about 6 website links, one of which is no longer available, Fox River Watch. It contained every news and scientific article on PCB exposure. I assumed they would research the links and amend accordingly.

The reason for rejection: I had submitted several links, none of which contained scientific data sufficient to warrant change. They were basically saying I had to do the research!!!

In hindsight, this raises some very disturbing questions.

Did they ever look at the links contained within the links I had provided?

If the SOPs are constantly under review, who is doing the research and how?

Are they skilled in research?

Are they skilled in Toxicology?

Are they interested in helping ex-service personnel?

Do they expect ex service personnel to have computer skills, an aptitude for research, medical and toxicology knowledge to provide them with the material? This is what is required if you want to submit an amendment.

2<sup>nd</sup> attempt: I spent the next 2 years researching and presented the extensive research for consideration. They rejected my submission by citing not enough scientific evidence.

Specialist Medical Review Council (SMRC) Appeal #1.

Not knowing what to expect, I fronted a panel of 4 Rheumatologists and a DVA representative. During that process I realised I had omitted a reference which cited Rheumatoid Factor (RF) after exposure and another which cited patients should be monitored for Rheumatoid Arthritis. Mass exposures in Japan and Taiwan were used as references and I emailed the link to the DVA representative after the Appeal, but it was rejected anyway.

It was rejected, and I was dejected. For several years I was borderline depressed, and I hated everything DVA.

A couple of years ago after seeing a Psychologist who suggested "Have you ever thought that you could never win". That was the catalyst I needed to kickstart my need to change the system. I wrote to the Minister for Veteran's Affairs and received a response from one of his Administrators and he was quick to highlight a SOP did exist with PCBs and Dioxins (Peripheral Neuropathy). I was excited and then deflated. It stated you had to have symptoms within 30 days of exposure.

From an Advocate and Assessor's viewpoint, did I have any record of Peripheral Neuropathy on my medical records? Answer: No.

Did the onset of symptoms you are experiencing occur with 30 days of exposure? Answer: No.

My Problem: My exposure 9/81, symptoms (burning feet- peripheral neuropathy) 9/83, 2 years after exposure and 3 months before undiagnosed but apparent Rheumatoid Arthritis symptoms. I could never qualify under those rules. At this point I had never heard of rheumatoid arthritis or peripheral neuropathy. Who goes to the doctor when your feet occasionally burn when you are out shopping? Also, on day 1 in the RAAF, we were told the RAAF does not tolerate malingerers, so unless you were near death you didn't front up to Medical.

RMA Problem: What scientific/medical evidence is there to support the unrealistic criteria as laid out in the SOPs, i.e. symptoms 30 days after exposure? Answer: None

My respect for RMA is now zero as they are a "do as I say, not do as I do" organisation. Total credibility failure.

2017, I noted Rheumatoid Arthritis was under review again. I submitted more evidence supporting PCB exposure to RA which was again dismissed. After analysing their reasons for dismissal, I realised their PCB toxicology knowledge was also limited. They were rejecting mass PCB exposure symptoms because of furan

and dioxin presence. If they had focussed on transformer oil as I requested, they would have realised that dioxins and furans co-exist with the PCBs as a by-product during manufacture. The other area of rejection was the use of the term arthralgia as it was too general. My logical brain tells me that if you have oranges and apples you can say fruit. If you have spinal degeneration (osteoarthritis or early RA) and Rheumatoid Factor (Rheumatoid Arthritis) and joint pain (both) present, you could use arthralgia (joint pain) as a general term for both conditions. Too general for RMA. In other words, they are not looking for a possible connection. They need it stated in black and white and are not interested in other signs such as "should be monitored for RA". That was a defining moment for me.

It steeled my resolve.

I researched multiple sources of proof that dioxins and furans are an unwanted by-product of Transformer oil PCBs. I paid for a document that lists the diseases and symptoms from the Japanese mass exposure and it lists rheumatoid arthritis above controls. I have forwarded these additional references to the SMRC. This is information that could have been sourced by RMA but wasn't for reasons unknown to me.

I have since been warned that the SMRC only rule on submitted evidence at the time of amendment request.

This means that the absolute proof I have submitted could be rejected as it wasn't provided during the initial amendment request. A technicality. If that is the case then it is clear the system is obstructionist, the reviews are conducted by unqualified practitioners and rubber stamped at the top.

I have no confidence in any review process conducted by the RMA.

The system demands change at the RMA level as it prevents any access to medical support for me that should have been provided from 1983 onwards. This applies to all chemically exposed personnel.

In my case there has never been any duty of care by either the RAAF or DVA. The RAAF were misguided in thinking DVA would provide after-Service support and DVA are restricted by the SOPs. The Repatriation Hospitals have disappeared. To make matters worse, the medical community are not equipped to handle chemical exposures and need guidance. Who provides the essential guidance necessary to provide safe and effective palliative care. All the PCB knowledge my medical advisors have has been provided by me.

Because PCBs/Dioxins/Furans are hard to metabolise, they are bio-accumulative in animals and humans. For rheumatoid arthritis (RA) sufferers exercise is recommended, especially aquarobics and hydrotherapy. Because the toxins in my body are stored in my liver and fat cells, exertion breaks down the fat cells and releases toxins which can't be metabolised and therefore are re-encapsulated in fat and stored again. This results in constant low dose exposures until the body/target organs eventually break down. Therefore, crash diets and excessive exercise should be avoided due to ongoing releases of toxins.

3 attempts over several years at hydrotherapy, great for RA sufferers, not for PCB exposed people. The pools are highly chlorinated to guard against infection but toxic to a body already full of chlorine derivatives. Extreme nervous system response resulted on each occasion despite taking 20mg Methotrexate, 2000mg Sulfasalazine and 150mg Diclofenac. Completely overrode my medication requiring additional Prednisone 50mg to control the level 10 pain.

As soon as I become active, roughly 4000+ steps per day, changes occur not only in my blood, but the glands in my neck, throat and groin, wheezy chest, sinusitis as well as an inflammatory response.

Around 8000+ steps the symptoms intensify including electric shocks through the head, dizziness, unsteady gait, muscular spasms, twitching, burning, itching, numbness and shortness of breath. That was the case 3-4 years ago. Now numbness and burning of the soles of both feet are permanent.

How much exercise is too much exercise? Whenever I ask that question, I get shrugs and don't know. It would require hospital-controlled diet and exercise and blood monitoring several times a day after exertion to detect adverse results and thus set safe parameters for future reference. A Nutrition and Environmental Medicine Doctor at NEMQ advises it can be done but it will be expensive.

Can you imagine what it is like to look at your chest and arms for 37 years wondering where or if cancer is going to strike. My research tells me skin cancers are a possibility, but it is the kidney, liver, biliary and other excretory paths where cancer is likely to occur. I am having a tumour removed from my hand presently and a liver lesion is being monitored for growth. Additionally, I have had polyps removed from every colonoscopy conducted so far.

That permanent low level of stress must have taken its toll on my body. I requested a referral to a Psychiatrist as I was experiencing extreme anger at the very thought of RMA and DVA. These are institutions that are supposed to help me yet all I could see was obstruction. I vented my anger for an hour and he offered to help me with a submission. I never took up the offer. On leaving his office I was experiencing extreme burning in waves all over my body. It was like jumping into a hot bath and not being able to get out. These symptoms lasted approximately 8 hours. An experience I never want to repeat again. I was aware that stress increased my neuropathy but never to that extent. I don't qualify for PTSD although I know I suffer from it occasionally.

Everything related to my PCB exposure has been at my expense. I have had no assistance from DVA whatsoever and with the current SOP system, none in the future. I am supposed to avoid hepatotoxic medications which is impossible for RA treatment. If I become too toxic the neuropathy increases. This information has been fed to my Medical Advisors from me and they are genuinely in compliance with my requests.

Do you get the problem here? I am the advisor!!!

It is just as well I have a computer background with administrative skills. I almost completed a 3-year Mental Retardation Nursing course which assessed my psychological profile in the 6% of population skilled at research. It also gave me pharmacology, anatomy and toxicology training. It is with these eyes I see the failings in the current system.

What if I had been a General Hand with none of those skills. I wouldn't know where to start.

Too many people have died from service related exposures with little or no help from DVA and that is the dirty stain on the Veteran's Affairs Ministry. The service they are providing has good intentions but if you can't access it, what is the point. Too much back slapping has gone on over the wonderful services offered but not enough follow-up on appropriateness and accessibility to those services.

If somebody is exposed to an immunosuppressive chemical as I was, you are vulnerable to every known disease. DVA should have been alerted by RAAF that people with compromised immune systems are headed their way.

If I had served in a war zone, I would have been looked after by DVA according to a DVA Assessor. Bad luck for me.

Question: What war zones are recognised by PCBs, Dioxins and the myriad of immuno-suppressant chemicals used by the branches of service? Answer: None

Handing out Gold Cards to war zone Veterans with no illnesses and nothing for an immunosuppressed Veteran is more than a slap in the face. That Gold Card overrides most SOPs and is the key to getting appropriate care from DVA. So, there are many war zone Veterans walking around with Gold Cards and no illness, while the immunosuppressed are denied access because of the SOPs system. It should not be the case that you should have to strive for a gold card just to receive your medical entitlements and monitoring.

During my research I noted Quercetin was used successfully to block the inflammatory effects of PCBs in laboratory experiments. I asked numerous Doctors if they knew about quercetin or where I could get it and what dosage. No knowledge. By chance a Specialist gave me a name of a clinic if all else fails. That clinic was NEMQ, a nutritional and environmental medicine group and after several years of looking at the note I decided to see what they had to offer. My initial consultation involved answering lots of questions and completing questionnaires. Then there were scans, blood tests, urinalysis and stool tests. A lot of these tests and consultation are outside of Medicare but maybe it would give me a better understanding of the effects PCBs were having on my body. These tests highlighted imbalances in my system and indicated oxidative stress. Further tests eliminated usual suspects, mercury, lead etc leaving PCBs. Because my inflammation levels were high, I was prescribed Inflammation Intensive Care for acute pain and joint inflammation. This has had a dramatic effect on lowering my inflammation levels and on reading the contents I noticed each tablet contains 250mg Quercetin. I take 6 a day. They are not cheap.

Resveratrol was also able to dissolve some PCBs in laboratory experiments. Brisbane PA Hospital Hepatology Clinic conducted a resveratrol study on NAFLD patients, but I was rejected due to taking methotrexate. I tried to find out results and was advised the results were indeterminate. I tried to find the source of resveratrol they used but they were unco-operative. It could have had a positive result for me.

I need help.

So far, the cost has been enormous to my health, my wife, my employment and my quality of life.

Please feel free to contact me if you need further substantiation.