Inquiry into volunteering in Queensland

Submission No: 281

Submitted by: Cheryl Pershouse

Publication: Making the submission and your name public

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Submitter Comments:

With 74% of injured workers becoming defrauded just going to paid workplaces, why would anyone volunteer. WorkCover misuses the medical term "degenerative" to defraud the workforce. This leaves the injured not able to access Qld Rehabilitation Standards; Risk Mitigation or compensation mechanisms. Those on $30-$50/hr cannot afford to fight these fraudulent processes with lawyers costing $690/hr. WorkCover misuses the medical term degenerative which actually refers to Radiologists seeing deposits on medical imaging equipment. These inflammatory mediators which occur after trauma, causing a post traumatic arthritis which alters the mechanical loading of joints, SHOULD BE COMPENSATED. However the vulnerable injured are forced to transition back to work using "annual leave offered as flexible working arrangements" after the medical term "degenerative" is misused for fraudulent exploitation of the workforce. Consequently with all injury costs bankrupting the injured, dismissed as "personal and degenerative", the workforce return to unsafe workplaces, to extend their injuries to chronic pain and permanent disabilities. SafeWork closes investigations without producing reports or notifying the injuries. The 1995 Onus of Proof is another insurer biased sham. If you cannot satisfy the Onus of Proof with 3 consultants and definitive MRI evidence, how is satisfying this fraudulent law possible. In my case, WorkCover on TWO occasions accepted unsubstantiated evidence over substantiated proof. The 2015 unscientific Blackwood vs Toward decision permits the exploitation of paid workers by allowing the legal misuse of the medical term "degenerative" to perpetrate fraud. Therefore 30 years of fraud is the reason why Queenslanders have had a gutful of exploitation and fraud that leaves them permanently maimed.

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WHO ACTUALLY PAYS FOR WORK RELATED INJURIES, A HEALTH SYSTEM "DISC" GRACE!

The 1995"Onus of Proof legislation" exploits injured workers by leaving them with chronic pain and disability, paying for their own rehabilitation (1). The Work Health and Safety Act, along with the Workplace Compensation and Rehabilitation and Other Legislation Amendment Act 2013, contribute to the lack of justice in the legal system, which is comparable to the lack of safety in the health system. In 1978, Cheryl, this Registered Nurse (RN) was taught to use the "Australian lift", where a patient's arm is placed down a nurse's back, for upright positioning, creating the dual danger of lifting with a bent back and hazardous disc loading (2). However, when injuries occur, the "Onus of Proof" legislation permits employers and insurers to dismiss repetitive bending, lifting and manual handling injuries, as "personal", by impossibly requiring the vulnerable employee to prove their disability was work related, rather than recognising the impact of chronic mechanical forces from repetitive straining injuries.

Cheryl, funded her injury costs for 30 years after a 1987 witnessed, work related injury occurred, while preventing a confused mechanically ventilated patient, from getting out of bed. This injury progressed to a disc rupture in 2006, requiring surgical stabilisation in 2016. Although this RN's compensation claim was initially accepted, it was closed abruptly because she was "working full time", despite chronic pain, muscle wasting and radiological evidence of a facet joint injury, due to the Insurer's intention to reduce liability, before facet injury arthritis developed. Consequently from 26 years old, Cheryl wore either a sacro-iliac belt or a lumbosacral brace.

After another 20 years of full time clinical shift work, Cheryl experienced a severe burning in her right foot, when cleaning and organising drugs into a newly installed wall sized cupboard. The severe burning persisted, despite regular Paracetamol, anti-inflammatory drugs, orthotics with metatarsal bars, a Rheumatologist Consultation, feet xrays, and blood tests. Eventually, when a Magnetic Resonance Imaging (MRI) revealed a disc tear between the lumbar 4 and 5 vertebrae, at the original injury site, the hospital insurer refused to recognise the foot pain as resulting from an "exacerbation of a pre-existing injury". After receiving notification of the disc tear, via a medical referral to the only spinal surgeon in town employed at her hospital, Cheryl's employer placed her on a 3 month waiting list, leaving her to extend the injury on 12 hour shifts, doing bed to bed transfers, without hovermats. Six weeks later, an urgent spinal surgeon review was required for nucleus pulposis (disc herniation), as part, or the entire soft, gelatinous centre of the intervertebral disk was being forced through the disc tear, producing feet pain from sinuvertebral nerve root irritation (3).

This employer's negligence was further highlighted, after an independent audit by Safework Queensland led to an improvement notice, requiring 3 inspections before the hazards were addressed. This ICU exhibited many signs of inadequate Occupational Health and Safety (OH&S) support. Even after the ICU was evacuated twice for mould spores creating a risk for ventilated patients, the OH&S team paid more attention to the removal of cork notice boards, than providing an adequate space for equipment storage, to allow floors to be cleaned adequately. According to the Work Health and Safety Act 2011, section 19, Employers have a Primary Duty of Care to ensure "the provision and maintenance of safe systems of work"….and to ensure that the workplace conditions are "monitored for purpose of preventing illness or injury" (4).

Yet, weekly, one Australian is dying or left with terminal illnesses (like Silicosis or Coal Miner's lung), just from going to work. More workers are left with chronic pain and permanent disability, when repeatedly exposed to unsafe workplaces, when no risk mitigation occurs.

Instead poor products choices like non-stitched non-invasive mask head bands migrate into patient's eyes damage, unless nurses constantly bend to resecure them. This cost cutting negatively impacts on the physical, psychological, social and financial wellbeing of employees, as unethical employers only need to purchase equipment and products that are "Therapeutic Goods Act" approved based on price, rather than reviewing whether purchases satisfy an ergonomic design appropriate for an aging workforce, caring for a bariatric population. Simple strategies like purchasing different coloured slide sheets, enables those on either side of the bed to easily identify whether they are all lifting holding the top sheet, to reduce back, shoulder and hip injuries. Battery powered trolleys should replace hydraulic trolleys with a capacity of 220-240kg, which require this phenomenal weight to be transferred to a single hip or knee joint. Similarly, cardiac monitor remote controls are a safer alternative to overstretching for touch screen monitors, for Australia's ethnically and gender diverse, workforce. Although Cheryl had the height of mechanical ventilation water poles reduced by 30 centimetres to prevent hyperextension, little could be done to rectify the purchase of ventilators with humidifiers mounted 30cm from the floor, with even lower alarm reset buttons.

Cheryl's employer also breached section 47 of the Work Health and Safety Act 2011, which states that they have a duty to consult workers, on any issue likely to affect their health and safety at work (4). Without consultation, the only cupboard in Cheryl's office that she could reach, was abruptly removed and replaced with a ladder, to climb (after spinal surgery complicated by hip nerve compression and 5 collapses). In addition, Cheryl's desk was replaced with a wide table, with no draws, with the expectation that Cheryl would climb or lean over this table, to access the shelves above, 3 meters from the floor. Although these actions were designed to increase the shared office space, these decisions made without consultation were detrimental to Cheryl's wellbeing.

Cheryl's employer also breached the Queensland Workplace Rehabilitation Standard after both the disc tear in 2007 and 2016 surgery, as she received no entitlements like "early contact", "paperwork assistance", "suitable duties plans", "workplace investigations after a serious injury", or her right to transition back to work(5). Instead, the Insurer forced Cheryl to pay $550 for flights to Brisbane, where she was examined from the other side of a desk, by a Consultant producing the hideous second opinion, that Cheryl had an "over medicalised, entirely benign, Morton's Neuroma" in her foot! Despite the Staff Spinal Surgeon, Rheumatologist and Pain Consultant confirming the disc tear diagnosis with MRI evidence this unsubstantiated opinion was accepted, to facilitate claim rejection, despite no Morton's Neuroma being found on 2 ultrasounds or MRI.

With a diagnosed disc tear, Cheryl should never have been assisting with bed to bed transfers in the ICU without hovermats, as disc pressures are 100% standing and 500% leaning forward pulling critically ill patients onto Intensive Care Unit (ICU) beds (2,6) . Unfortunately, with no clinical OH&S support for 10 years following her disc tear, Cheryl was frequently assisting with lateral transfers, without hovermats reducing the mechanical stress of lifting (6,7). Ironically, 50 meters away, for over 20 years, the Operating Theatre RNs employed hovermats for all patients exceeding 90kg, for transfers to and from much narrower theatre tables to narrower trolleys.

Despite evidence showing that hovermats produce less shearing forces when transferring those over 90kg, few are available in the clinical areas, especially for ICU and palliative care nurses, regularly transferring debilitated patients, when their care is escalated or palliated (8). Best practice should be eliminating the need for lateral transfers altogether, with the provision of high quality electric and battery operated beds to all clinical areas. Keeping the patients in the same bed during ICU stepdown would provide sustained risk mitigation.

Cheryl's case amplifies the findings of the Safework Australia 2013, which identifies that 74% of the cost of work related injuries are paid by the worker themselves, with one in five claims, being a back related injury (9). It is not a coincidence, that there has been a 10% decline in the Insurer Grant Funding to Workplace Health and Safety Queensland from 12.46% in the 2006/7 financial year to 2.49% in 2016/2017(1). For injured workers, health costs spiralled again in 2015, when new taxation legislation prevented offsetting health expenses against income, as tax deductions. The synergistic effect of the "Onus of Proof" legislation, taxation changes and health funding arrangements such as "outsourcing" and "gap fees" is financial strain and bankruptcy. The injured are either forced to rent out their homes to pay mortgages, by moving their families back in to their parent's homes or as in Cheryl's case, cashing in their entire long service leave to fund medical gap fees. With no access to Legal Aid, the injured on $25-50 per hour cannot afford Lawyers costing $690 per hour, to challenge this insurer biased industrial relations system that covers no Australian worker, constantly lifting and sustaining repetitive strain injuries.

Nurses are commonly affected, as Safe Work Australia 2013 (p.12) found hospitals recorded the greatest number of serious injury claims, with two thirds of all serious claims being initiated by health employees (9). Classically, forty percent of hospital claims had a mechanism of injury, related to body stressing injuries (9). Similarly, the 1998 USA Bureau of Labour Statistics found nursing to be the occupation most at risk, of work related musculoskeletal disorders with most injuries sustained lifting, transferring patients or making beds (10,11). Naturally, with an aging workforce caring for the 63% of the population classified as obese or bariatric, the majority of those lifted will exceed the 40kilograms considered safe for workers, doing repetitive lifting (8,10,11). For ICU RNs, manual handling and back injuries are high, due to their repetitive bending when caring for patients with critical illness neuropathies and myopathies, during 12 hour rotating shifts (11,12). When compared to other occupations, nurses were identified by the 1998 US Bureau of Labour Statistics to be 48% more likely to experience work related wrist, back and ankle strains or sprains (10). This dismal quality of life will continue, unless university courses prioritise safety education over leadership and management subjects, as 60% of nurses report chronic lower back and feet discomfort, of which 53% were associated with overexertion (10,11). Little has changed since this 1998 trend, as the Australian Workers' Compensation Statistics (2016) found that 90% of workplace injury claims were related to musculoskeletal injuries (13).

Financially compromised after funding their own rehabilitation, the injured are often prematurely returned to unsafe workplaces, where injuries are exacerbated. The Best Practice Review of Workplace health and Safety Queensland (3/7/17) found that in 2016, there were only 1.1 qualified safety advisors, inspectors or investigators per 10,000 employees in Queensland (1). Instead, in many instances, workplaces have OH&S Representatives qualified with only a 5 day workshop, responsible for supervising the spinal health of a female dominated workforce carrying pregnancies.

Another concern is that The Workers' Compensation and Rehabilitation and Other Legislation Amendment Act 2013 states that "rehabilitation and return to work coordinators no longer need to be certified" (14)!

Realistically, the only support provided for Cheryl, after 6 weeks when she could no longer walk was a spinal surgeon emergency consultation, where she was prescribed pregabalin for neuropathic pain, a Freeman's spinal brace and a medical certificate for 3 months sick leave, to reduce the risk of Nucleus Pulposus herniation. Unfortunately, her employer instructed a junior doctor to override the spinal surgeon's instructions for sedentary duties, by directing he issue an alternative medical certificate to satisfy their funding arrangements, despite disc tears taking up to 2 years to heal. The spinal surgeon's letter and MRI result were then removed from the compensation claim by the employer, and replaced with the junior doctor's letter, to facilitate claim rejection. Therefore, Cheryl was abruptly returned to 12 hour full clinical duties with rotating shifts, when her employer overrode the Spinal Surgeon and Pain Consultant's opinions, and seven medical requests for suitable duties, to demand a medical clearance for what they insisted was a Morton's Neuroma.

Maintaining mobility from 2006 until the 2016 surgery required 6 to 18 monthly bilateral Rhisotomies under general anaesthethic, to prevent the pain signals of sinuvertebral nerve irritation, being transmitted from the lumbar area. Although the Insurer's nominated Consultant stated the right foot pain could not persist when the medial branches at the lumbar level were severed by heating them to 60 degrees, pain can still be transmitted via sensory nerves down the stenosed spinal canal, via sacral nerves too small to be cut (15). When a Rhizotomy for facet joint pain is performed, the radiofrequency ablation of medial nerves prevents **some** sensory nerves transmitting pain (15). On the 10 occasions when Cheryl's Rhizotomies were performed, she paid gap fees for the general practitioner referrals, $200 Spinal Surgeon Consultations, $200 for "outsourced" Medical Imaging fluoroscopy services, Radiologist gap fees and $200 hospital admission fees. With the nerves regenerating, requiring repeated neurotomies at 9 monthly to 2 yearly intervals, these costs exceeded $6000 (15).

Another reason for Cheryl's claim dismissal was her reporting her foot pain was worse on leaning forward, to turn off alarms on the touch screen cardiac monitors. While the Insurer's Consultant insisted "there is no such condition", the Spinal Surgeon investigating this symptom with flexion and extension xrays and a stationary MRI found a moderate to severe bilateral Lumbar (L) 4/5 facet arthropathy causing buckling of the ligamentum flavum, with a 6 millimetre (mm) degenerative anterolisthesis (forward movement) of L4 over L5. At this level, the intervertebral disc height was reduced, the disc was bulging and an indentation of the posterolateral thecal sac was found. Flexion and extension Xrays revealed a **10 mm displacement of L4**, was compressing Cheryl's left hip nerves, causing a left tendonopathy, evident by interstitial gluteus minimus tears, a joint effusion and trochanteric bursitis. Although already booked for spinal surgery to relieve hip and bladder nerve compression, the vertebral instability progressed to bilateral paraesthesia medially, from Cheryl's knees to feet, after her spinal column was unable to withstand the force of a vomit.

Despite neuropathic pain analgesics, sleep was problematic due to a sharp diagonal pain under her right foot, exacerbated by lying on the right side. Sleeping on the left was an uncomfortable alternative, after the aspirated left trochanteric bursa reformed rapidly again, due to the Lumbar 4 instability compressing the left hip nerve supply.

Cheryl's sleep was also constantly disrupted by neurogenic bladder spasms, as compression of afferent and efferent nerves supplying the bladder at the spinal cord produced a continual desire to urinate (16). Mirabegron was prescribed to relax detrusor muscles spasms and menopausal symptoms were treated with oestrogen and progesterone supplements (16,17, 18). Next, a Dental Surgeon diagnosed Cheryl's neck muscle spasms and teeth aches as being severe bruxism, causing Cracked Cusp Syndrome, after 6 molars were found extensively cracked on xray.

Bruxism refers to a tendency to grind or clench teeth during sleep, from stressors like pain (19). With each porcelain crown restoration, incurring over $700 of out of pocket costs, Cheryl required $4200, along with an additional $450 gap fee for a 3 cm anterior dental guard, to prevent contact between the top and bottom molars during sleep. For long term management, Cheryl's Neurologist injected Botox, to atrophy the right hypertrophied spasming masseter, temporalis, splenius capitis muscles, sternocleidomastoid and trapezius muscles. When these botox doses were adjusted at three monthly intervals, to reduce tongue swelling, Cheryl incurred further Neurologist, and Botox laboratory gap fees.

Six weeks prior to her surgery, Cheryl had 4 syncopes. Each time, Cheryl regained consciousness on the floor with knee abrasions or became acutely dizzy. A pre-excitation syndrome was diagnosed, when the Electrocardiograph revealed a short PR interval of 114 milliseconds (ms), a right bundle branch block, low voltages in all leads and a corrected QT interval (QTc) of 498ms. Holter monitoring revealed supra-ventricular tachycardia (SVT) at 170-194 beats per minute reverting to a heart rate of 40 per minute. This pre-excitation syndrome was caused by an accessory conduction pathway, that allows impulses to be conducted via intranodal or paranodal fibers, bypassing all or part of the atrioventricular node, connecting the left atrium and His bundle producing palpitations or collapse (20,21). Since Cheryl had always had this undiagnosed congenital defect, the Cardiology team believed the anticholinergic Mirabegron, had precipitated the arrhythmias. Since Cheryl's QT interval (corrected to age, gender and rate) exceeded the normal 450ms, medications restrictions were imposed to prevent lethal arrhythmias like Torsade de Pointes (22). Precautionary conductive gel pads were placed on Cheryl's chest during the anaesthetics, to enable an emergency cardioversion to be performed, should arrhythmias occur.

Surgery:

During spinal surgery, other rare complications like blindness from prone positioning producing traction on the optic stalk have been reported (23). Cheryl's lumbar decompression, fusion and fixation surgery was performed using two sterile donor bone grafts from an Organ and Tissue Bank, inserted bilaterally, to prevent the joint mobility in the Lumbar 4 and 5 vertebral segments (24). Bone marrow from Cheryl's ileum was transferred to the bone graft site, to grow into the graft, fusing the Lumbar 4 and 5 vertebrae (24). For further stabilisation, 2 screws with rods attached were placed into vertebrae on each side, with a metal basket containing bone marrow placed between the vertebrae, to prevent nerve compression (24). Post-operatively Cheryl wore a 30 cm brace for 3 months until the bone grafts strengthened, and funded physiotherapy to tone her abdominal muscles.

Investigations into the persistent numbness Cheryl described in the 2 lateral fingers of her left hand, associated with shoulder and neck spasms, via a cervical and thoracic MRI identified a 7th cervical disc tear may have occurred during intra-operative lateral neck flexion, causing a moderate stenosis

between the 5th and 6th cervical vertebrae. This C7 disc tear may have resulted from pre-existing degenerative disc disease or collapses, and then progressed after prolonged lateral intra-operative positioning. However, since this pathology, along with a congenital hemangioma found at the 4th cervical vertebrae raised concerns of a risk of quadriplegia, Cheryl has lifelong 10kg lifting restrictions, and is unable to ever perform cardiopulmonary resuscitation. Fortunately, the moderate stenosis found at the 10th and 11th thoracic spine level, affords less risk, due to the stability afforded by the rib cage.

Cheryl became increasing exhausted by the hourly urges to urinate, after the indwelling catheter was removed early, to reduce the risk of bone graft infection. When the Spinal Surgeon advised her that the spine regenerates at 1 millimetre per month post-operatively, Cheryl was "hoping those bladder nerves were more athletic", as bladder spasms occur when 20 millilitres of urine accumulates in the bladder. These symptoms remained, as although Cheryl was offered a botox cystoscopy by the Urologist, which reduces 50% of urinary symptoms within 7 days, with effects lasting 3-9 months, she could not afford the urodynamic studies, Gynaecological reviews and further anaesthetic gap fees (25). Instead, Cheryl needed to prioritise paying off a car (with an electric adjustable driver's seat and reversing camera) and an electric bed, following several antibiotics for aspiration, caused by sleeping supine, whilst taking baclofen for neck spasms.

Prior to discharge, Cheryl's finances were further compromised by a $420 fee for an "outsourced" Ventilation Perfusion scan, to eliminate a pulmonary embolism, after a further dizzy episode. With SVT the most likely cause, Cardiology consultation and QTc measuring holter monitoring were organised. While most spinal surgery patients complying with Jet's law cannot drive for at least 3 months, until leg strengths normalise, the arrhythmias prolonged this interval another 9 months (26). Cheryl's recovery was also challenging, when her inability to take proton pump inhibitors with the anti-inflammatory medications, due to the prolonged QTc intervals, lead to gastro-intestinal bleeding, requiring an endoscopy, a colonoscopy and Gaviscon for gut protection.

The management of Cheryl's turbulent recovery with 6 consultants demonstrates how claim rejection for work related injuries financially stresses and limits the treatment options for employees left funding a "never ending circus of needles and knives". After Cheryl's legal right to transition was again refused after her spinal surgery, she had to deplete her annual leave by having Mondays off, offered as "flexible working arrangements", despite having 1484 hours of sick leave accrued. The use of this sick leave was refused to satisfy the health service's funding arrangements, since the sick leave was valued at $74,000. Cheryl's four permanent injuries were deemed "personal" rather than work related, after 2 episodes of proven collusion. There was nothing "personal" about being negligently left on a 3 month spinal surgeon waiting list, with a MRI diagnosed disc tear.

Appeals to the Industrial Commission Review Unit, were futile as the Regulator instructed the insurer to investigate their own decisions with a directive to "provide procedural fairness to both parties", as though fairness would be likely in a system that for 29 years left 74% of workers self-funding work injuries. Had qualified OH&S Officers improved the work place practices following the 2006 disc tear, Cheryl may not have been subjected to the 27 interventions which included 12 anaesthetics for 10 rhisotomies, spinal fusion; 6 crown restorations; 4 series of 6 botox injections, a left hip and right foot bursa aspiration, endoscopy and colonoscopy.

After such a torrid rehabilitation, complicated with a cervical 7 disc tear, neuropathic pain, arrhythmias, gut bleeds, bladder and neck spasms Cheryl may still require future iliofemoral banding for the left hip tendinopathy, or neck surgery. Rather than her employer complying with the Workplace Health and Safety Act, by providing an ergonomic workplace design, equipment, products and policies like stopping bed to bed transfers on ICU admissions, they actually weaponised the Public Service Act directing two Doctors to assault her. The instructions that "Our employee is not required to consent to your medical examination … your examination should proceed irrespective of consent" sanctioned the assault, of a mentally competent nurse already funding the management of six consultants. After ignoring 7 medical certificates, the Public Service act was weaponised by this employer alleging "concern for her safety"! Despite Cheryl funding the management of 6 consultants, these non-independent Occupational Physicians were instructed to assault a nurse, when the Public Service Act is only intended for "personal injuries" under the Rehabilitation Standard. When Cheryl cashed in 40 years of long service leave to finance the $20,000 medical gap fees, car and electric bed payments, she could still not afford the Botox Cystoscopy required, as these funds had to be diverted to Lawyers to protect her from this employer's exploitation.

A Physiotherapist was also directed to adapt Cheryl to a hazardous workplace design, injuring others. This Physiotherapist's grossly inaccurate report was then withheld for 5 years, before being obtained by lawyers after Cheryl was forcibly medically retired abruptly, for restrictions that had been in place for four years after she had returned to work full time, without any risk mitigation or rehabilitation support. The only suitable duties plan ever offered arrived 12 years after the disc tear, 3 years after spinal surgery and 3 months after the weaponized Public Service Act assaults, due to the action of lawyers. Even then, the suitable duties plan was never complied with. Like several Human Resource Department letters, this Physiotherapist report erroneously suggested that Cheryl would be able to get a medical clearance that was never possible without a significant risk of quadriplegia.

When Cheryl diminished her superannuation savings by appealing for re-instatement in the Australian Industrial Relations Commission (AIRC), this employer labelled her a "vexatious litigant" to successfully lodge an Interlocutory Application. How can you be a vexatious litigant, if your four permanent injuries are validated by MRI? The Interlocutory Application was filed to prevent a fair AIRC hearing, by skewing how Cheryl's case could be presented in a biased manner. Instead of Cheryl's employer defending their negligence of leaving Cheryl on full 12 hour clinical duties on a 3 month Spinal Surgeon waiting list, with a MRI diagnosed disc tear, the Interlocutory Application forces defendants to impossibly prove their injury is not "degenerative".

The term "Degenerative" although mostly abused by the insurance industry to suggest age related wear and tear, actually refers to deposits visible on medical imaging by Radiologists. This medical definition also includes causes like the post traumatic arthritis caused by inflammatory mediators following injuries, is known to alter the mechanical loading of joints. In Cheryl's case the 1987 facet joint injury, should have been processed as an exacerbation of a pre-existing injury, when she experienced foot pain, when repetitively bending to load a pharmacy cupboard, 20 years later. For this employer to succeed in this filing of an Interlocutory Application, would suggest that she was forcibly medically retired for trivial injuries? However, unless Cheryl withdrew her AIRC application for re-instatement, she would have been bankrupted funding both her own and the Respondent's legal team costs, as Interlocutory Applications are considered unwinnable.

Conclusion:

This case demonstrates many inconsistencies. If you cannot satisfy the Onus of Proof legislation with 3 consultants validating a disc tear with MRI, then how is such a feat possible. If you cannot use accrued sick leave after spinal surgery, with complications like arrhythmias, aspiration, gut bleeds and a cervical 7 disc tear requiring the management of 6 consultants, what is sick leave for? A Public Service Act directed assault by an employer refusing to comply with 7 medical requests, alleging concern for safety, was only surpassed by this nurse being slandered as a "vexatious litigant" for serious permanent injuries validated by MRI! The only personal aspect of this injury was the cost! Nurses are not disposable and do not go to work to negative gear! The lack of successful Workers' Compensation claims indicates Workers' Compensation figures do not accurately reflect the injuries or substantial costs borne by workers. Although Cheryl had payroll evidence proving she was left working 12 hours shifts for 6 weeks with a MRI diagnosed disc tear, and ward meeting minutes demonstrating the employer's refusal to provide hovermats, the employer and insurer avoided accountability, knowing Cheryl was unable to finance prolonged legal challenges.

Vulnerable injured employees are readily exploited as it is impossible for those on $25-$50 per hour to fund legal challenged to the insurer biased AIRC, with lawyers costing $690/hr, since only criminals are entitled to access Legal Aid. This financial strain is even more extensive for employees who are forcibly medically retired, still funding University HECS fees, car payments and mortgages. Tragically taxation laws also prevent health costs being offset against income, in a political climate challenging overtime and penalty rates. Political strategies advocating an aging workforce should remain employed longer, to support the demands of an aging bariatric population, have failed to provide safe practices, products or ergonomic environments.

The lack of governmental intervention on the Safe Work 2013 statistics, and abuse of the "Onus of Proof" legislation exacerbate the damage sustained by manual handlers, by failing to engage qualified OH&S personnel in clinical areas. If Insurers won't finance compensation claims, then Employers needing to retain a functional workforce should provide Staff Health Clinics, to prevent staff compounding injuries by lifting, while on Specialist waiting lists. Future RNs entering employment with higher education debts exceeding $30,000 will not be able to sustain work related health costs, on temporary contracts in an unjust system, that neither **fuses** employee's rights nor employer's responsibilities. This playing field needs to be evened with "pay as you win" legal services, or the provision of Legal Aid for injured workers to hold Insurers and employers accountable (9). Removing the Onus of Proof legislation should be a priority, as this law discriminates against manual handlers, by dismissing the impact of performing repetitive tasks, at awkward postures around medical equipment or caring for delirious clients. If you cannot satisfy the Onus of Proof, with MRIs that have been considered definitive since 1988, how is satisfying this law possible. While the cost cutting bureaucrats are looking after their bottom line, nurses are getting titanium implanted in theirs!

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