Transport Accident Commission (TAC) – Long-Term Claim Experience

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1. Overview

This submission relates to my lived experience as a TAC claimant following a serious motor vehicle accident in 2010, resulting in permanent and complex disability.

At the time of injury, I was employed in a senior executive role (General Manager / Chief Operating Officer) with total remuneration exceeding $200,000 per annum and a clear upward career trajectory.

Since the accident, I have experienced long-term physical impairment, loss of employment capacity, and ongoing dependence on multidisciplinary medical care and support services.

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2. Core Issue

While TAC accepted liability, my experience demonstrates ongoing challenges in the **timeliness, transparency, and consistency of decision-making**, resulting in:

- Delayed or non-explicit treatment determinations
- Escalation of low-cost clinical requests into high-cost administrative processes
- Repeated reliance on independent medical examinations and legal escalation
- Breakdown in continuity of established treating practitioner relationships

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3. Treatment Escalation and Cost Inefficiency

Several treatment matters illustrate systemic inefficiency:

- A physiotherapy-based annual pain management plan (~$1,200) was neither clearly approved nor rejected, instead escalating into multiple specialist referrals and investigations.
- This ultimately resulted in a multidisciplinary rehabilitation program exceeding **$10,000**.
- A separate low-cost dispute (~$110) escalated into approximately **$12,000** in legal and administrative costs.

These patterns suggest that delayed decision-making can significantly increase overall system expenditure.

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4. Access to Care and Practitioner Participation

There is increasing difficulty maintaining continuity of care due to:

- Administrative burden placed on treating practitioners
- Reduced willingness of specialists to accept TAC-funded patients
- Complexity and time requirements associated with approvals and reporting

This has impacted continuity, efficiency, and accessibility of clinical care.

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5. Home Modifications and Functional Needs

I experience significant ongoing disability, including:

- Impaired thermoregulation
- Continence loss
- Chronic pain and mobility limitations
- Frequent falls

A request for essential home modifications, including air conditioning and electrical upgrades, was not determined in a timely manner, resulting in partial self-funded installation.

These supports are essential for safe daily functioning and independent living.

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6. System Navigation and Decision-Making Concerns

My experience indicates:

- Uncertainty where decisions are not clearly approved or rejected
- Limited practical pathways for timely review of inaction
- Increasing reliance on legal processes to resolve clinical and administrative matters
- Inconsistent alignment between treating practitioner recommendations and insurer outcomes

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7. Personal Impact

The cumulative impact includes:

- Loss of high-level career trajectory and income capacity
- Breakdown of family structure and divorce
- Social isolation and reduced community participation
- Ongoing need for daily assistance with basic tasks
- Reduced independence and quality of life

I currently live alone in a large property, with intermittent informal support from friends and a multidisciplinary medical team.

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8. System-Level Concern

This submission does not seek to criticise individual staff, but raises concern that structural features of the system may be contributing to:

- Increased administrative and legal costs
- Delays in treatment access
- Reduced provider participation
- Greater claimant distress and uncertainty

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9. Conclusion

I respectfully submit that improvements in **decision-making transparency, timeliness, and continuity of care** would significantly enhance both claimant outcomes and system efficiency.

The intent of this submission is to assist in identifying opportunities for reform within the TAC scheme to better balance cost control with effective rehabilitation and humane claim management.

Background

My transport accident occurred on 30 December 2010. The other driver was at fault, and liability was accepted at the scene.

I have since been assessed as having a 32% whole person impairment, meeting the legislative definition of a Serious Injury.

Systemic Pattern: Delay, Deny, Defend

Over the course of my claim, I have observed a consistent pattern of:

- Delaying decisions
- Denying reasonable requests
- Defending disputes through litigation

This tactic is a strategy first implemented by McKinsey and Company with Allstate Insurance in America to prioritize profit over fair treatment to policyholders.

This approach appears inconsistent with the purpose of a no-fault statutory insurance scheme.

Medical Expense Dispute – Oral Surgery

This matter relates to a dispute with the Transport Accident Commission (TAC) regarding reimbursement of a minor out-of-pocket medical expense arising from treatment for accident-related injuries.

As a result of my motor vehicle accident (MVA), my jaw and mouth alignment were affected. This caused a small portion of my tongue (approximately 1–2%) to repeatedly catch on my teeth, leading to ongoing discomfort.

The TAC approved surgical treatment to remove the affected portion of my tongue. I was provided with three options for the procedure:

- Specialist practice under local anaesthetic
- Day hospital under sedation
- Private hospital under sedation

I elected to undergo the procedure at the specialist's practice under local anaesthetic, as this was the **lowest-cost option** available to the TAC.

Billing Issue and Short Payment

The specialist practice advised that they would not bill the TAC directly due to prior issues with:

- Payment delays
- Short payments
- Administrative approval processes

As a result, I paid for the procedure upfront and subsequently sought reimbursement from the TAC.

Upon reimbursement, I was **underpaid by $110.34**.

I raised this discrepancy with my claims manager and their team leader. I was informed that:

- The outstanding amount would **not be paid**
- My options were limited to:
    - Internal review (which upheld the decision)
    - Legal action or application to **Victorian Civil and Administrative Tribunal (VCAT)**

Legal Escalation

I engaged Maurice Blackburn Lawyers to act on my behalf.

During the course of the dispute:

- The TAC legal team arranged for an independent medical report from my treating surgeon
- The cost of this report was **$825.00 ($750 + GST)**
- The purpose of the report was to justify the disputed **$110.34**

Despite multiple discussions, the TAC maintained its refusal to reimburse the outstanding amount. When questioned why the TAC would not simply pay $110.34 rather than incur significantly higher costs, the response provided was that the matter had become legal in nature and would proceed accordingly.

It is important to note that had I elected to undergo the procedure in a day hospital or private hospital setting, the cost to the TAC would have been approximately **$2,000 higher**.

VCAT Proceedings and Outcome

The matter proceeded to mediation at VCAT.

During the final mediation:

- The mediator initially believed the claim amount of **$110.34** was a typographical error, assuming it was **$11,034.00**
- Upon clarification, the mediator acknowledged the disproportionate nature of the dispute

My legal representatives presented the following:

- I had been underpaid by $110.34
- I had chosen the lowest-cost treatment option
- The TAC had incurred $825.00 in medical reporting costs to dispute the claim

Following this:

- The mediator agreed with my position
- The TAC's legal representatives agreed to settle the matter

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Outcome and Cost Implications

The TAC ultimately:

- Paid the outstanding **$110.34**
- Covered **100% of my legal costs and expert fees (~$7,000)**

It is estimated that the TAC also incurred:

- Approximately **$5,000 in its own legal costs**

Total estimated cost to the TAC: ~$12,000
Original disputed amount: $110.34

Conclusion

This matter demonstrates a disproportionate escalation of a minor reimbursement dispute.

Despite:

- My decision to minimise costs to the TAC
- The relatively insignificant amount in dispute

The matter was prolonged and escalated to formal legal proceedings, resulting in costs significantly exceeding the original claim.

Flooring Dispute

This matter relates to a dispute with the Transport Accident Commission (TAC) regarding flooring replacement necessitated by injury-related continence issues.

Due to my injuries, I experienced ongoing continence problems, resulting in blood, faecal, and urinary contamination of carpets in my main bedroom, hallways, and study. The TAC accepted liability for continence aids following an informal review.

I repeatedly requested approval for a specialist enzymatic cleaning product (initially *Urine Away*, later replaced by *Enzyme Wizard Urine Stain and Odour Removal*), which breaks down biological matter and prevents odour and contamination build-up. The TAC refused to fund this product, despite its modest cost of approximately $50 per year.

Over time, the untreated contamination led to severe deterioration of the carpets, including black mould growth. This resulted in significant odour (urine and faecal), unsanitary living conditions, and respiratory symptoms. The condition of my home became unliveable.

Picture of black mould on hallway carpet. More photos available.

Initial Discussions and Verbal Agreement

Prior to COVID-19, discussions were held regarding potential co-contribution for flooring replacement.

On 11 March 2023, the TAC claims manager ([redacted]), following consultation with the Home Modification Team, verbally confirmed that the TAC would:

- Contribute 50% of flooring costs (based on $110/m², equating to $55/m²)
- Fund the removal and disposal of mould-contaminated carpet (requiring specialist handling)
- Cover removal and reinstatement of furniture

The total TAC contribution under this agreement was approximately $7,931. I accepted this offer verbally.

Delays and Change in Position

There were extensive delays throughout the process:

- 27 May 2022 to 11 March 2023: delay in obtaining Home Modification Team involvement
- March 2023 to March 2024: further delay in assessment and decision-making

On 6 March 2024, nearly one year later, the TAC revised its position. A different Home Modification Team representative determined that:

- Only $2,400 would be funded
- The proposed solution was linoleum flooring
- The prior agreement would not be honoured as it was “verbal only”

Additionally, the TAC refused to fund:

- Removal of contaminated carpet
- Furniture removal and reinstatement

Written confirmation of this decision was received on 14 March 2024. Requests for product specifications were not answered.

Issues with Proposed Solution

The TAC’s proposed linoleum solution was unsuitable because:

- It would create trip hazards due to height differences between rooms
- It would not be level with existing tiled areas
- It was inconsistent with the rest of the home

The originally discussed solution was to match existing bamboo flooring. The TAC later claimed bamboo was unsuitable for wet areas due to warping. This contradicts existing bamboo flooring installed in my kitchen in 2010, which remains in excellent condition with no warping.

Health Impact and Self-Funded Action

During the prolonged delays, my home environment significantly deteriorated:

- Persistent odour of urine and faeces
- Widespread mould growth
- Respiratory issues and coughing

Unable to tolerate the conditions, I arranged and paid for removal of the contaminated carpet at my own expense.

Within four weeks of removal:

- My breathing returned to normal
- My cough resolved
- My mental health improved significantly
- I was able to have visitors in my home again

Legal Proceedings and Resolution

Due to the TAC's refusal to engage meaningfully, legal proceedings were initiated.

In June 2025:

- Initial TAC offer: $5,417.50 (rejected)
- Final offer (26 June 2025): $5,973.00

I was advised that if the matter proceeded to court and resulted in a lower outcome, I could be liable for both parties' legal costs. On that basis, I accepted the offer.

The final settlement included:

- $5,973.00 (flooring-related compensation)
- $9,640.00 (legal costs paid by TAC)
- Total: $15,613.00

Conclusion

This matter took approximately five years to resolve. At least four of those years involved avoidable delays unrelated to COVID-19.

Had the TAC honoured the verbal agreement made on 11 March 2023 (~$7,931), it would have:

- Reduced overall costs significantly (by approximately $6,000)
- Prevented prolonged exposure to unsafe living conditions
- Avoided legal escalation

I note that I do not attribute fault to the individual claims manager. The delays and decision-making issues appear to have originated within the Home Modification Team.

Independent Medical Examiners (IMEs)

I wish to raise significant concerns regarding the role, oversight, and accountability of Independent Medical Examiners (IMEs) engaged by the Transport Accident Commission (TAC).

Regulatory Gap

IMEs play a critical role in determining access to treatment, services, and ongoing support. However, there appears to be a **regulatory gap** in their oversight.

The Australian Health Practitioner Regulation Agency is responsible for regulating health practitioners and ensuring professional standards across Australia. Its purpose is to protect the public by ensuring practitioners are competent and accountable.

In practice, however:

- IMEs engaged by insurers are often treated as operating in a **private medico-legal capacity**
- Complaints regarding IME reports are frequently **not investigated through standard AHPRA pathways**
- This creates a situation where practitioners influencing critical decisions may operate **without effective external oversight**

I submit that this gap requires urgent review, and that **all medical assessments influencing statutory entitlements should be subject to consistent regulatory standards**.

Case Example – Occupational Therapy Assessment

I refer to an occupational therapy assessment conducted on 12 February 2025 by [redacted] of Occupational Therapy Services (Preston South). This assessment was recorded and is available for independent review.

This matter is currently subject to legal proceedings, and I will avoid commentary that may prejudice that process. However, I wish to highlight several procedural and factual concerns relevant to this inquiry.

Accuracy and Reliability Concerns

The report contained multiple inaccuracies, including:

- Incorrect details regarding the date of my accident
- Descriptions of my home that were partly accurate and partly materially incorrect

- Statements regarding household items that do not exist (e.g. kitchen trolley, full transition to plastic crockery)

Of particular concern was the assertion that I have **two daughters**, when in fact I have only one.

Despite:

- Written requests to both the TAC and the assessor to correct this
- The significant personal distress caused

The statement has not been withdrawn. This raises serious concerns about:

- Verification of information
- Willingness to correct factual errors
- The impact of inaccurate reporting on claimants and their families

I need this information to be verified or withdrawn by the TAC. Whilst they still refuse to, the damage this has caused is immeasurable.

Unverified Clinical Claims

The report also stated that the assessor had communicated with my general practitioner. My GP has confirmed that:

- No such communication occurred
- No contact was made by the assessor

Additionally, the assessor was requested (via TAC) to contact other treating providers, which did not occur.

This raises concerns about:

- Whether reported consultations are being accurately represented
- The evidentiary reliability of IME reports used in decision-making

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Selective Reporting and Omission of Recommendations

During the assessment, a number of matters were discussed and observed, including:

- Recommendations for minor home modifications (e.g. grab rails, entry access improvements)
- Consideration of additional domestic cleaning support
- Pool maintenance and therapeutic use considerations

These were **not included in the final report**, despite being discussed.

This creates a concern that:

- Reports may **selectively include or exclude information**
- Recommendations supportive of the claimant may not be documented

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Concerns Regarding Independence

The assessor was instructed not to engage on a current flooring dispute, yet:

- Demonstrated detailed knowledge of the matter
- Suggested a resolution range (~$5,000–$5,500)

Subsequently, the TAC made an offer within that range.

This raises questions about:

- The **independence of IMEs**
- Whether information is being shared inappropriately between TAC and assessors
- The integrity of medico-legal boundaries

Control Over Provider Selection

I have historically used an occupational therapy provider for over ten years, originally appointed by the TAC. However:

- I was directed that I could no longer use my existing provider
- The TAC instead appointed an assessor of its choosing

In a separate conversation, a TAC team leader stated that:

- They would arrange an occupational therapist specifically to **reduce services**

The recommendations in the subsequent report aligned with those stated intentions.

At the same time:

- I was informed that I could not rely on my own occupational therapist
- Yet was told I must source my own specialists in other disciplines

This inconsistency raises concerns about:

- **Control of medical opinion**
- Potential bias in assessor selection
- Lack of procedural fairness

Key Issues for the Inquiry

I respectfully submit that the inquiry consider:

- Whether IMEs engaged by statutory insurers should be **fully subject to AHPRA oversight**
- The **independence and selection process** of IMEs
- Mechanisms to ensure **accuracy, accountability, and correction of reports**
- Whether claimants should have **greater choice in selecting assessors**
- Safeguards to prevent **selective reporting or omission of relevant findings**

Conclusion

IME reports carry significant weight in determining access to essential services. Where those reports:

- Contain inaccuracies
- Omit relevant information
- Are produced without clear accountability

There is a risk of **unfair outcomes and erosion of trust in the system**.

Greater transparency, oversight, and balance are required to ensure that IME processes operate in a manner consistent with the objectives of a fair and claimant-focused scheme.

Influence Over IME Outcomes

A further serious concern relates to the **potential influence exerted over IME outcomes**.

In communications with a TAC Team Leader ([redacted] on 29 August 2024, I was informed—prior to the assessment—that the outcome of the Independent Medical Examination would include a **reduction in my in-home services**. This statement was made before the assessment by the appointed occupational therapist had even taken place.

Following this, the recommendations contained within the IME report aligned with what had been articulated to me in advance.

In addition, through my own discussions with various IME practitioners, I have been advised that:

- Insurers may request **amendments to reports**
- These amendments can range from removal of "irrelevant" material to changes that influence overall conclusions

While I acknowledge these statements are based on practitioner feedback and may not apply universally, they raise concerns about:

- The **independence of medico-legal assessments**
- Whether reports are subject to **external influence or expectation**

There is also a perceived structural issue whereby:

- IMEs receive ongoing work from insurers such as the Transport Accident Commission
- If reports are not aligned with insurer expectations, the volume of referrals may decrease

This creates a potential **conflict of interest**, where financial dependence may indirectly influence professional opinion.

Recommendation

To address these concerns, I submit that:

- All IME reports used in statutory insurance schemes should be subject to oversight by the Australian Health Practitioner Regulation Agency
- Clear standards should be introduced to ensure:
    - **Independence of opinion**
    - **Transparency in any requested report amendments**
    - **Accountability for factual accuracy and omissions**

Such reforms would help ensure that medical opinions relied upon in decision-making are:

- Clinically sound
- Independent
- Free from real or perceived external influence

Requests for Services – Delay and Escalation of Costs

I wish to highlight concerns regarding the handling of reasonable treatment requests by the Transport Accident Commission (TAC), particularly the practice of **failing to make decisions** and instead allowing requests to remain unresolved.

Failure to Make a Decision

My treating physiotherapist submitted an annual pain management treatment plan in a format previously accepted by the TAC. The annual cost of this plan was approximately **$1,200**.

The new claims manager advised that:

- The request would **not be approved**
- However, it would also **not be formally rejected**

This effectively left the request in limbo. As no formal decision was made:

- I was unable to seek an internal review
- I was unable to escalate the matter through legal or tribunal pathways

This approach appears to **circumvent procedural fairness**, as it prevents claimants from exercising their rights of review.

Escalation of Requirements

Following this, I was directed to obtain further medical evidence, including:

- Reviews from my shoulder surgeon and neurosurgeon
- Additional imaging, including CT and nuclear medicine scans
- Consultation with my pain specialist

This resulted in significant additional time, cost, and administrative burden.

Replacement with Higher-Cost Treatment

Following these steps, my pain specialist referred me to a program at Victorian Rehabilitation Centre, involving:

- A multidisciplinary team (occupational therapy, physiotherapy, psychology)
- Initially, a two-day-per-week one-on-one outpatient program
- Subsequently, a three-month, two-day-per-week group program

The total cost of this program exceeded **$10,000**.

Inconsistency and Inefficiency

This outcome is difficult to reconcile with the original request:

- A **$1,200 physiotherapy-based pain management plan**
- Delivered by a treating physiotherapist who regularly consulted with my surgical team
- A program that was already **effective and ongoing**

Notably, the multidisciplinary program ultimately delivered replicated many elements of the original physiotherapy-based approach—albeit at a significantly higher cost.

Key Concern

This raises a broader concern regarding TAC decision-making:

Why are lower-cost, effective, treating-provider solutions being withheld, only to be replaced with significantly more expensive, TAC-directed alternatives?

It also highlights a pattern of:

- Delaying decisions
- Requiring unnecessary escalation of evidence
- Increasing overall scheme costs

Conclusion

In this instance:

- A modest and effective treatment plan was not approved
- No formal decision was issued, preventing review
- The matter was escalated into a significantly more expensive treatment pathway

This approach appears inconsistent with:

- Cost efficiency
- Timely access to care
- Supporting established treating relationships

Air Conditioning Request – Failure to Determine

I wish to raise concerns regarding the failure of the Transport Accident Commission (TAC) to make a determination on a medically supported request for home modifications relating to impaired thermoregulation.

Medical Basis for Request

As a result of my accident-related injuries, I experience significant difficulty regulating my body temperature. This presents as:

- Feeling excessively cold on hot days
- Feeling excessively hot on cold days
- Episodes of profuse sweating and discomfort

Impaired thermoregulation is a recognised complication associated with:

- Spinal cord injuries (particularly above T6)
- Traumatic brain injury
- Neurological impairment

This issue has been consistently raised with treating practitioners and has been observed during multiple assessments, including those arranged by the TAC.

Initial Request and Supporting Evidence

On 4 April 2022, I submitted a formal request to the TAC for:

- Installation of air conditioning throughout my home
- Upgrade to three-phase power (required due to the size and electrical demands of the system)

This submission was supported by input from my treating providers, outlining the clinical need for a stable and controllable indoor environment.

Lack of Decision

Despite the medical justification and formal submission:

- **No decision has been made** by the TAC to date

This has resulted in:

- Ongoing uncertainty
- Continued self-management of a medically recognised condition
- Inability to exercise review rights due to the absence of a formal decision

This reflects a broader pattern where requests are neither approved nor declined, effectively preventing procedural escalation.

Self-Funded Interim Measures

Due to the lack of progress, I proceeded at my own expense to install:

- Air conditioning in my bedroom
- Air conditioning in my family room

Prior to this, I managed my condition through:

- Portable cooling systems
- Running heating during summer
- Using portable air conditioning during winter
- In extreme cases, using my swimming pool for temperature regulation, even during colder months

These measures are not sustainable long-term solutions.

Cost and Practical Considerations

It is worth noting:

- The cost of whole-of-home air conditioning has **reduced in recent years**, partly due to government energy transition incentives away from gas systems
- However, to implement an appropriate system for my home, an upgrade to **three-phase power remains necessary**

This is a reasonable and foreseeable requirement for a property of this size and for managing a medically documented condition.

Key Concern

This matter raises a fundamental issue:

Why has a medically supported home modification request remained undecided for an extended period, despite clear clinical need and relatively standard installation requirements?

Conclusion

In this instance:

- A legitimate, medically supported request has not been determined
- I have been required to partially self-fund essential modifications
- The absence of a decision has prevented any formal review or resolution

This contributes to ongoing difficulty in managing my condition and reflects a broader concern regarding delays and non-decision-making within the system.

Interaction with TAC Claims Management (29 August 2024)

On 29 August 2024, I had a conversation with a Team Leader within my current claims management group.

During this discussion, I was informed—prior to any formal assessment—that the outcome of an upcoming Occupational Therapist review would likely result in a reduction of at-home support services.

I found this deeply concerning, as it gave the impression that the outcome of clinical assessments was already being anticipated or influenced before the assessment process had been completed.

During the conversation, the tone became highly direct and emotionally charged. I was told words to the effect that I was a "burden on the system" and that my ongoing care represented a cost to the public system.

I expressed concern that comments of this nature could be extremely damaging to a person in my position, particularly someone living with chronic injury, pain, and significant life disruption. I raised that such language risks compounding distress for vulnerable claimants.

I was also left with the strong impression that the focus of the discussion was primarily on cost reduction and limiting expenditure, rather than rehabilitation outcomes or quality of life improvements.

In that context, I asked whether the system would prefer that I were no longer alive, given the way the conversation was framed around cost burden. The response I received reinforced my concern about how the system can feel, at times, dehumanising and transactional.

Broader Concern Raised by This Interaction

My concern is not limited to a single conversation, but rather what it reflects about the broader culture and approach within the claims management process.

From my lived experience, there appears to be:

- A strong emphasis on cost containment
- A perception that clinical recommendations may be influenced by administrative expectations
- A breakdown in trust between treating practitioners, independent assessments, and claims management decisions

This has contributed to my feeling that decision-making is not always centred on rehabilitation or patient wellbeing.

Impact on Me

As a person living with long-term injury, interactions of this nature have a significant emotional impact.

I live with chronic pain, continence issues, and ongoing disability. In that context, communication that feels dismissive or focused on financial burden can be deeply distressing and can exacerbate feelings of isolation and vulnerability.

I raise this not as a personal complaint about individuals, but as an example of how the system is experienced by someone navigating long-term injury and ongoing dependency on support.

Personal Background and Impact

Personal Background and Life-Altering Impact

At the time of my accident in 2010, I was at the peak of my career. I was employed as a General Manager and Chief Operating Officer of a large food company, earning over $200,000 per year including benefits. I was on a clear upward trajectory in my profession, with genuine prospects of moving into executive roles in the $500,000–$600,000 range.

My career was not just a job—it was my identity, purpose, and financial foundation. That was taken away in a moment.

In the years since, I have had opportunities that I could not take up because of my injuries. On one recent occasion, I was approached for a senior dairy industry role in Melbourne at a level consistent with my experience and capability. I was unable to pursue it because of my condition. That reality is one I live with repeatedly—knowing what I once could do, and knowing what I can no longer do.

Loss of Life as I Knew It

The impact of the accident did not stop at my career. It dismantled my entire life.

My relationship broke down, ultimately ending in divorce. While there were multiple contributing factors, the reality is that my injuries fundamentally changed the structure of my life and my ability to function within a family environment.

I now live alone in the home I once shared a future in.

It is a large family home on a one-third acre block that I have lived in for over 40 years. I love this home deeply. It represents continuity in my life. But it is also a constant reminder of what I have lost.

I have considered downsizing, but the financial reality makes this extremely difficult. The costs of selling, stamp duty, and relocation would place me under further pressure. Just as importantly, leaving the only community I have known for decades would be another significant loss layered on top of everything else.

I have therefore remained, not out of comfort, but because change would bring further harm.

Daily Reality and Invisible Struggles

My daily life is shaped by constant physical and emotional challenges.

I live with:

- Chronic and ongoing pain
- Partial loss of feeling in arms, hands, legs and feet
- Spinal Cord Damage
- Brain Injury
- Loss of bladder and bowel control
- Regular falls, approximately once a month, sometimes resulting in further injury or hospitalisation
- Ongoing fear and unpredictability in simple daily tasks

The continence issues in particular have been devastating on a personal level. They affect dignity, confidence, relationships, and social connection.

There are days where I cannot control what is happening to my own body. That is not something I ever imagined having to live with.

At times, my home environment has also been affected in ways that are extremely distressing, including hygiene challenges that have made it difficult to have visitors. This has contributed to isolation and embarrassment, and has affected friendships over time.

Isolation, Support, and Resilience

Despite everything, I am not without support.

A close LQBTI friend assists me weekly with essential tasks such as shopping, cooking, and household support. I also have a small but important group of friends who remain in my life and provide help when needed.

However, there is no escaping the fact that my world has become much smaller.

I have also experienced the loss of friendships over time, not because of conflict, but because of the nature of my injuries and their impacts. That type of gradual social withdrawal is difficult to describe—it is not a single moment, but a slow narrowing of life.

Living Within a System That Feels Adversarial

I am supported by an extensive medical team across multiple specialties, including neurosurgery, gastroenterology, psychiatry, urology, orthopaedics, colorectal care, pain management, occupational therapy, and physiotherapy.

I am grateful for these clinicians.

However, accessing and maintaining this care has become increasingly difficult within the framework of the Transport Accident Commission.

Over time, I have experienced:

- Long-standing treating practitioners being removed or excluded from my care pathway
- Difficulty maintaining continuity of care
- Specialists declining to take on TAC patients due to administrative burden
- Increasing delays and complexity in obtaining approvals for treatment

In practical terms, accessing healthcare has often felt less like a recovery pathway and more like a process that must be continuously justified.

At times, it has felt like I need to fight for every element of support, even when those supports are already known, established, and clinically justified.

The Human Cost of Ongoing Disputes

I have now been involved in ten separate disputes regarding my care.

While I acknowledge that systems require review and governance, the lived reality is that this process has become exhausting and emotionally draining.

Even where outcomes have ultimately been 100% successful, it has required legal intervention, time, stress, and persistence that most people in my situation simply would not be able to sustain.

I was assessed as meeting the threshold for Serious Injury impairment. On paper, that should have reduced complexity and provided stability in care. In practice, it has not.

Instead, I continue to experience a system that feels uncertain, inconsistent, and at times, adversarial.

Where I Am Now

I am now 58 years old.

I live alone with significant ongoing disability, chronic pain, continence issues, and a reduced capacity for independence. I rely on a small network of support and a large number of medical specialists to maintain basic functioning.

My life is no longer defined by career, family structure, or independence in the way it once was.

It is defined by management of injury, navigation of systems, and endurance.

I am not looking for sympathy. I am asking for recognition of what long-term injury actually means in practice—not just in reports or assessments, but in real daily life.

It has required me to repeatedly fight for support that should be accessible within a no-fault system.