COMMUNITY DEVELOPMENT AND JUSTICE STANDING COMMITTEE

INQUIRY INTO THE RECOGNITION AND ADEQUACY OF THE RESPONSES BY STATE GOVERNMENT AGENCIES TO EXPERIENCE OF TRAUMA BY WORKERS AND VOLUNTEERS ARISING FROM DISASTERS

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 29 FEBRUARY 2012

Members

Mr A.P. O'Gorman (Chairman)
Mr A.P. Jacob (Deputy Chairman)
Ms M.M. Quirk
Mr I.M. Britza
Mr T.G. Stephens

Hearing commenced at 10.06 am

ROBERTSON, DR ANDREW GEOFFREY
Director, Disaster Management, Regulation and Planning, Department of Health,
189 Royal Street,
East Perth 6004, examined:

The CHAIRMAN: Good morning Andrew. Thanks for coming in this morning. Before we start, I will read you a statement, which tells you what happens during the hearing and, at the finish, I will read you a closing statement, which tells you what happens following the hearing and about Hansard.

The committee hearing is a proceeding of Parliament and warrants the same respect that proceedings in the house itself demand. Even though you are not required to give evidence on oath, any deliberate misleading of the committee may be regarded as contempt of Parliament. Have you completed the Details of Witness form?

Dr Robertson: Yes, I have.

The CHAIRMAN: Do you understand the notes at the bottom of the form?

Dr Robertson: Yes, I do.

The CHAIRMAN: Did you receive and read an Information for Witnesses briefing sheet regarding giving evidence before parliamentary committees?

Dr Robertson: Yes, I did.

The CHAIRMAN: Do you have any questions related to your appearance before the committee this morning?

Dr Robertson: No.

The CHAIRMAN: Before we start, you have sent us a submission. Have you anything that you would like to add to the submission?

Dr Robertson: Not at this stage.

The CHAIRMAN: Before I start, I should do the right thing and introduce Ms Margaret Quirk, member for Girrawheen. I am Tony O'Gorman, member for Joondalup, and I am chair of the committee. We are missing three members at the moment. Two should be arriving later but one is off sick; Albert Jacobs is member for Ocean Reef, and deputy chair of the committee, and he should be arriving shortly. Ian Britza is the member for Morley and a member of the committee, and Tom Stephens, unfortunately, is unwell today so he will not be with us.

Andrew, if you are happy, we will just throw some questions at you. In your submission, you mentioned the department's Disaster Preparedness Management Unit. Could you describe how many staff are in the unit and what activities the unit undertakes?

Dr Robertson: The unit has, at the current stage, nine staff. Its role is to, on behalf of the department, prepare and train for disasters and, in the event of a disaster that requires health input, to activate and run the operations from a state point of view.

Ms M.M. QUIRK: So when you say disasters that is everything from pandemics through to floods, cyclones, earthquakes and everything else?

Dr Robertson: That is correct. We also get involved in anything that is likely to have a statewide impact. If a hospital, for example, loses power, and where we may need to look at evacuating a

hospital or anything that is beyond just the hospital itself and requires some state coordination, then we would be involved in those kinds of activities as well.

The CHAIRMAN: Do you do anything with your emergency departments and the continuous trauma those staff see on a daily basis? Our belief is that post-traumatic stress can be an accumulation of a number of traumas over time.

Dr Robertson: The unit per se does not but, obviously, the hospitals provide support to any emergency departments through their EAP programs.

The CHAIRMAN: Your submission also says that St John Ambulance staff are provided training, and support services are available to them to deal with stress and trauma. Can you explain what that training is about and what it entails?

Dr Robertson: I cannot go into great detail because St John Ambulance acts as a contractor to us. Whilst we are aware that they carry out—and they actually do some of our training, which has a psychological element, but most of their training is carried out in house.

The CHAIRMAN: What about the Royal Flying Doctor?

Dr Robertson: We have even less connection to them. Whilst we deal with the Royal Flying Doctor Service all the time, again, as an independent agency, they actually run their own training and support programs, and we have no input into those. We do help train them on occasion on things like disaster medicine.

[10.11 am]

Ms M.M. QUIRK: Obviously, WA is a vast state and there are front-line health professionals throughout the state. Does the department have any mechanisms for assessing health professionals in remote areas in terms of their psychological wellbeing?

Dr Robertson: I believe so. We certainly have, in all of our area health services, including the Western Australian country health services, access to employment assistance programs. Obviously, the role of the various managers and supervisors is to assess their own staff and to provide support as required.

Ms M.M. QUIRK: How big a problem do you think critical incidents stress or post-traumatic stress is amongst health professionals in WA?

Dr Robertson: That is a very difficult question to answer. Certainly there are high-stress areas including the emergency departments and some of the more traumatic areas like the trauma wards and things like that. Certainly, there is some stress where we have had to deploy medical assistance teams or hospital response teams. Obviously, there is also the day-to-day stress in areas where there are may be high mortality or very ill people, for example, in oncology and other areas. However, it is fairly hard to quantify exactly what that is. Many people manage it very well but, obviously, we have in place programs to assist those who may need assistance in that area.

The CHAIRMAN: Can you describe what the EAP program consists of?

Dr Robertson: Basically the EAP programs are contracted programs to provide employees assistance for those who feel that they require it, and for families in certain cases. Each of the area health services subcontracts that. That is one area where we have been doing some work because they tend to be different programs for different area health services, and that causes some issues if people are working across health services, but there is some work within the department to try and standardise that.

The CHAIRMAN: Who do you contract that service out to?

Dr Robertson: I am not exactly sure of the individual contractors.

The CHAIRMAN: Is it possible to give us that information?

Dr Robertson: I can certainly get that information for you.

The CHAIRMAN: Do you keep records of Department of Health staff that get PTSD or stress-related issues?

Dr Robertson: Not specifically, no.

Ms M.M. QUIRK: During large incidents, it is usually the case that personnel are dragged in from everywhere—all hands to the wheel— and they then disperse once the emergency is over. Is there any formal debriefing of staff even though they might have moved on, or any follow up with other staff?

Dr Robertson: We have a regulated debriefing process. It depends on the incident but if, for example, we had a disaster where we had to deploy an Australian medical assistance team, then certainly when they returned they would have a formal debriefing. Even with another event where we use a lot of hospital staff, for example, the usual procedure is for us to have a hot debrief, which is done very soon after the event, ideally to capture all of the staff who are involved.

The CHAIRMAN: We are interested in that particular point because when we have spoken to overseas jurisdictions they have been of the opinion that that night not be the best way to do that anymore. They employ a system called psychological first aid, which is a different approach altogether. Are you aware of the psychological first aid programs?

Dr Robertson: There are two reasons why you do a hot debrief. I am very aware of psychological first aid. What I am talking about is not critical stress debriefing; that is, we do not do that. What I am talking about is operational hot debriefing, where we basically get the people in and talk to them about what went well and what did not go so well. It is not about their psychological fitness; it is about the opportunity to comment on how things went and what things we can do better next time. It gives people an opportunity to talk. If we feel that any of the staff need it, then psychological first aid is available, and certainly if people require any further psychiatric care then that can be arranged.

The CHAIRMAN: I think the debate that is going on is that a hot debrief, if mandatory, is actually forcing staff back into reliving what they have just come through, and that adds another layer of psychological stress. That is the issue that is being debated hotly around the world.

Dr Robertson: Sure.

The CHAIRMAN: Can you tell us what your psychological first aid approach is?

Dr Robertson: It is really about providing access to that care as required. We do not necessarily pull in—we have access to psychologists. We provide training on what the availability and access to that is. We do not necessarily bring anyone in to do psychological first aid.

The CHAIRMAN: What about the staff that are involved? Are any of those staff trained in monitoring and checking out their colleagues?

Dr Robertson: They are. As part of our disaster training we cover an element on the psychological aspects of disasters. As part of that, they go through some of the psychological first aid, what it actually means and some of the approaches to it, and obviously part of that is about identifying people who may be at risk.

The CHAIRMAN: How long does that course go for?

Dr Robertson: It is a part of a longer course. We have an element in a number of our courses. We run a series of courses but they usually vary from one to three days in length, but usually it is a session that goes from one to two hours.

Ms M.M. QUIRK: Is there any peer support system within the health department?

Dr Robertson: Not a formal peer support that I am aware of.

Ms M.M. QUIRK: Are people who may be exposed to high levels of stress subject to any requirement for health checks on a regular basis?

Dr Robertson: Not that I am aware of. It is hard—I cannot say for the department as a whole. The medical assistance teams certainly do, and certainly after deployments. When we have deployed teams overseas to—for example, we have deployed teams to—

Ms M.M. QUIRK: Aceh or somewhere like that—

Dr Robertson: Yes, Banda Aceh, to Java after the Yogyakarta earthquake, and to Pakistan last year. In all of those, people were briefed at the end and then followed up on a periodic basis to see how they were handling the situation.

Ms M.M. QUIRK: In the emergency departments there are high levels of stress on a daily basis, and people probably function on adrenalin anyway in those circumstances. Are there any particular arrangements for personnel in the emergency department? They are not necessarily dealing with disasters but they have the accumulative effect of being exposed to trauma after trauma after trauma.

Dr Robertson: Again, a lot of that is through employment assistance programs and the identification of people who are not handling the situation well by supervisors and managers, and then pointing those people into those programs.

The CHAIRMAN: In other jurisdictions as well we have heard that some first responder agencies use retired staff to assist during and after a disaster to provide support to staff, and the understanding is that retired staff understand their situation; they will listen to them. Some of those agencies do not use external counsellors. Is there anything in the health department that brings back retired staff during or after a disaster?

Dr Robertson: Not at this stage.

The CHAIRMAN: Do you see any value in that?

Dr Robertson: I think—

The CHAIRMAN: It actually came out of the fire department from 9/11 in New York. They used a lot of retired fireys. When hurricane Katrina hit New Orleans, they sent a team down and they set up the retired fireman peer-support group as well. That was impressed upon us as really important and it worked really well, so we are wondering if anybody else does it.

Dr Robertson: We certainly do not do it, but I can appreciate the value. Part of the challenge would be in getting a cohort of retired staff who have that expertise. It is probably a fairly small field, but it is certainly something that we would be happy to look at.

The CHAIRMAN: When you deploy staff to a disaster or emergency, do you limit the time that they are actually on call or at work on that emergency?

Dr Robertson: We do. Part of the management of the deployed team—it would obviously be dependent on the situation, but we are very cognisant that if they are not given rest and some form of down time, then they do not function very well. We fairly strictly limit the time that they are working. Even if it is frantic—they may work a 12-hour day but they will be obviously given time off and then, after a period of days, we would endeavour to give them a full day off or whatever the case may be, depending on the situation.

[10.23 AM]

The CHAIRMAN: Does the Department of Health have a role in the State Emergency Management Committee?

Dr Robertson: Yes. I am the Department of Health rep on the SEMC.

The CHAIRMAN: Are you called to every disaster or just the ones that have particular health issues?

Dr Robertson: When they call the State Emergency Coordination Group, if it goes to the stage where they have an SECG, Health is usually one of the agencies called. We generally go to most SECGs because usually if they are at that stage they have a health element of some type. For example, if a fire is threatening a town and there is likely to be an evacuation of a health facility or a nursing home or whatever, we get involved.

The CHAIRMAN: Earlier you mentioned the EAP and families. What support do you provide the families of your staff?

Dr Robertson: They do have access to our EAP program, is my understanding. It would principally be through that.

The CHAIRMAN: When your staff are deployed somewhere is there any communication with the families as to where their partners or family members are? How does it work?

Dr Robertson: What we have done has evolved over the years. If we deploy staff—I can use either Yogyakarta or the Pakistan floods as an example—part of my disaster unit will act as a home support unit. It communicates with people in the field, but it also keeps all the families informed about what is going on and what is actually happening. Sometimes there are restrictions from a security point of view. For example, there were challenges in Pakistan and they did not necessarily want anyone to know when people were moving across the country because they could have become a target for terrorist elements. Sometimes we have to be a little careful with information, but certainly we provide regular feedback to the families. We ensure that they are there to greet the various people when they come back and we usually arrange for greetings. We have done that a number of times. We provide support for them going and leaving.

Ms M.M. QUIRK: If money were no object—of course, it always is in the health system—and you had a wish list, what measures would you put in place to make your frontline staff more resilient or more disaster proof? I know it is problematic as to whether that can be done.

Dr Robertson: One of the aspects is training. We obviously train quite a few people, but we do not necessarily have the opportunity to do broader training. We have an online program. It is really about preparing people for what is coming—sometimes it is the unknown that scares people more than anything—so they have a better idea of what to expect. We do run some online courses, but we would certainly love to expand that so that we can build up resilience in that group. We are doing quite a lot of work with the Mental Health Commission. We had done previous work with it about developing a lot of different programs depending on support. A lot of that is for those people who are impacted in the field. It is not necessarily for staff, but it can be for staff if required.

Ms M.M. QUIRK: Often the issue is that it is not necessarily key personnel who are exposed to a lot of this stuff; it might be someone who is peripheral, who is dragged in for a particular job and who is not used to being exposed to severe trauma.

Dr Robertson: Certainly that is our experience as well. We try to avoid that and to minimise that as much as possible. Our AUSMAT teams are screened. We do both medical and some psychological screening. It is very difficult to screen people psychologically, apart from saying that this is the kind of environment you may be exposed to and asking if they have had any experience in similar environments. For example, have they worked in a developing country or done charity work in more austere environments. We do team exercises to see how people work together as a team living in tentage and things like that. It is difficult to prepare everybody. As you said, if a major event occurs in a city, it might start coming through our emergency department doors with very short notice and people are not always necessarily prepared.

Ms M.M. QUIRK: It terms of the hot debriefs that we have talked about, are there any recurring themes about the way things are handled? For example, do people say, “I appreciated that, that was

good" or "I thought we could do that better, it wasn't optimal"? Each incident is different, of course.

Dr Robertson: Each incident is different. But the usual complaints are that they did not have enough information early on. That is always a challenge with any disaster. We have spent a lot of time and effort on improving our communications. Sometimes it is a governance issue in that people are not sure who they were reporting to. We have done a lot of training so people have a good understanding of our role and the role of FESA and the police. Those tend to be the concerns. Obviously, there may be some specific to the incident, such as the availability of supplies and equipment.

The CHAIRMAN: Do you have cross-training with FESA and the police?

Dr Robertson: We do. We put our people on a number of courses that are either run by the police or FESA. Similarly on our disaster course, we train people from St Johns Ambulance, FESA and the Australian defence forces. We have had some police on those courses. We make them open to all of the agencies. We are great believers in them understanding our business and, obviously, us understanding their business.

The CHAIRMAN: You mentioned communication being a problem. Is that a hardware issue where you cannot hear police or FESA on the radio?

Dr Robertson: No, it is the usual in the so-called "fog of war". There is so much happening that sometimes various groups do not get as much information as they can. We have done a lot of work in that area. We have dedicated systems. We have our own radio network. We have satellite phone networks and IT and other networks. We have a dedicated State Health Incident Coordination Centre, which is activated in the event of a disaster. We have utilised that a number of times in the last six months. It is all about how we can continue to improve that. We accept that at different times there will be a breakdown in communication. But we are a lot better than we were even four or five years ago.

The CHAIRMAN: The police use a coordination system called WebEOC.

Dr Robertson: Yes, so do we.

The CHAIRMAN: You are on that as well?

Dr Robertson: Yes, the police and ourselves were the first two to use it. FESA is now looking at using it.

The CHAIRMAN: I think FESA is more than looking at it.

Dr Robertson: Which we are very happy with because it has a lot of potential. We used it extensively during CHOGM. We now use it for any disaster. We used it during the heatwave. It is a very useful system and once FESA and all the other agencies are on it, it will have the benefit of making sure information flows between coordinators.

The CHAIRMAN: How does it work? If you have people in the field, how do they log onto the system and put information in?

Dr Robertson: It is a web-based system. Provided they have some form of internet link, either Wi-Fi or a satellite link —

The CHAIRMAN: They now have it so you can do it on your Smartphone. You might want to buy that module.

Dr Robertson: We already have. We can use it on Smartphones and iPads. It can be utilised in any of those forms.

[10.32 am]

The CHAIRMAN: We have been told that certain research shows that about 20 per cent of staff and volunteers suffer a long-term effect from trauma following a disaster and need ongoing assistance. Do have any idea if the Department of Health percentage is as high as 20 per cent? Do you track those people?

Dr Robertson: We keep an eye on the teams we deploy and the teams that have been involved in AUSMAT deployments. I would be very surprised if it is anywhere near that percentage in those teams. We probably have a small number of people from those teams, but nowhere near 20 per cent.

The CHAIRMAN: Do you track people who leave the Department of Health following a major trauma because of the trauma?

Dr Robertson: No, we do not.

Ms M.M. QUIRK: Symptoms of post-traumatic stress disorder can include drug or alcohol abuse, domestic violence and suicide. Do you have the capacity to monitor staff who might be more vulnerable?

Dr Robertson: Yes, we certainly have capacity to do that through both our EAP programs and our mental health programs.

Ms M.M. QUIRK: So EAP is pretty much self-identifying and then going off to the program?

Dr Robertson: Yes, that is my understanding. But people are encouraged as well or at least informed that it is available.

Mr A.P. JACOB: Would it be fair to say that the Department of Health, out of all the responders, has a more equal gender mix and that, if anything, it is slanted towards women?

Dr Robertson: I think that would be correct.

Mr A.P. JACOB: Do you think that gender roles can play a difference in response to trauma and incidents?

Dr Robertson: That is a good question. Not that I am aware of. Certainly we deploy a lot of both genders to disasters. We have a small percentage of people who are probably traumatised by an event, but it does not appear to be particularly male or particularly female. It seems to be distributed between both genders.

The CHAIRMAN: Does the Department of Health conduct annual health checks, including mental health checks?

Dr Robertson: No. We certainly do not. I am not aware of any of the area health services that do.

The CHAIRMAN: I go back to the accumulative effect of trauma. Again, I refer to paramedics, St John Ambulance people and people in emergency departments, particularly when the death of a child is involved. Do you monitor staff in those areas to see how they cope with trauma after trauma? Every week we hear about deaths on the road, which is quite traumatic. Many of those go to our emergency departments. How do you make sure that people are coping with that all the time?

Dr Robertson: A lot of it is really focused on the supervisors and managers in those areas and with them identifying people who are not handling it. You raised the issue before that it could be their behaviour at work or that they appear to be developing alcohol or other drug-type problems. It is really up to the supervisors and managers. As most of them are trauma nurses, ED nurses or ED physicians, they are cognisant of that, and it is about them offering those people the opportunity through EAP or mental health programs.

The CHAIRMAN: Do you use external assistance from physiatrists or academics to design your internal processes to deal with staff trauma and stress?

Dr Robertson: We work closely with mental health to look at the various responses to disasters. From a mental health point of view we have been developing the mental health sub-plan, which

looks at how we best respond. Again, a lot of that sub-plan is very much focused on the victims of a disaster rather than staff, but it can be applied to staff as required.

Mr A.P. JACOB: We had evidence early in the piece—it might be a bit different for health because a lot of work is dealing with emergencies that happen on a daily basis—about significant incidents. One of the places we went was Christchurch. Often the issues that come out of it take six months or even years to surface. We were told that by a professor in New South Wales as well as the anecdotal evidence on the ground from Christchurch. While departments are generally quite good at responding in the first instance and in the immediate weeks afterwards, what sort of long-term programs are there?

[10.40 am]

Dr Robertson: Again, the programs tend to be around the employment assistance programs. They are available not just immediately, but obviously in a longer term way. We can obviously work with them through our mental health programs to provide whatever mental health support is there. We do have good connections into the mental health program, so we can streamline if we feel there is a need to bring them in, if there is something particularly traumatic that really requires assistance, accepting that critical stress debriefing is now no longer considered—in fact, it may be useful, but it may be harmful. There may be circumstances where, for example, somebody who already has a current mental health disease where this has basically just exacerbated that disease and they may need urgent assistance from a mental health practitioner. We have certainly got quite close links with them and we can organise that very rapidly if required.

Ms M.M. QUIRK: One of the issues we have found elsewhere is that quite often the first responders are victims themselves. For example, in Christchurch there were firefighters who were going out and rescuing other people while their own homes and families were affected. Are there any specific protocols within the health department as to standing those people down or not using them or whatever?

Dr Robertson: I do not think there are any specific protocols, but certainly we are very cognisant of that issue. With the recent Margaret River fires, for example, we had a number of staff who were either impacted or threatened by the fires. So we are very cognisant of working with those and standing down who we can. Part of our role is, really, if we need to deploy additional staff, and we have done that as well. For example, in cyclone George, with the number of casualties there, we deployed the medical team. Part of their role as the medical team deployees is not only to provide sometimes specialist expertise—surgical expertise, for example—but also to provide support to staff and to allow them to take time off and deal with their issues. It is a big problem. We may deploy a team where you would think, from a disaster point of view, there are not that many casualties, but from a support point of view, it is actually critical that we get it to keep the hospital functioning and to allow people time off. That would be factored into our planning.

The CHAIRMAN: Andrew, in your submission you say that that psychological support is and has been provided to staff and that the effectiveness of this support has not been formally evaluated. Do you have any plans to undertake any research into the effectiveness of that support?

Dr Robertson: We certainly would like to. Through national committees, we are very cognisant of some of the research being done out of the University of Western Sydney and others on the support of staff and the evaluation of that. We have been involved in a number of research projects that have looked at surveying staff afterwards and looking at what kind of support they felt they received. We have not done a comprehensive evaluation, but we have done some work on aspects of this. I think it is certainly an area we would like to do further work in.

The CHAIRMAN: Finally, do you ever send your staff to other disasters to learn how staff trauma is being addressed in those other jurisdictions?

Dr Robertson: Not specifically. We send them to other disasters in other states, but it tends to be on the request of either that government or an international government; it is not specifically to look at the traumas. We certainly have worked with mental health. With the Mental Health Commission now sitting separately to us, we certainly work quite closely with them. For example, after the Toodyay fires, we worked with both DCP and our mental health division to make sure that they were up there. I think we had a psychiatrist and a mental health nurse. We probably did not actually require them because a lot of the counselling was being done by DCP, which would be their primary, initial role. But it had two benefits. One is obviously if there were more serious cases of concern, they could be seen, but also to give them some experience in dealing in that kind of environment. We have not done it beyond that.

Ms M.M. QUIRK: Quite often we see on television—I think you must do it annually—a bit of a simulated disaster and you have volunteers with bandages and simulated blood and what have you. As part of that exercise, is any, if you like, mental health first aid deployed, or is that part of the exercise or does it tend to be purely transactional, I suppose?

Dr Robertson: It depends on the exercise. I suppose we have moved a little bit away from the field exercises, because they are fairly majorly time consuming and resource consuming, to more Emergotrain exercises, which are, I suppose, simulations. Because they are true simulations, certainly in a sense we are looking at simulating surgery, simulating diagnostic testing and all those things that may cause some issues on the day. We can certainly look at simulating mental health issues. I do not think we have done that particularly comprehensively, but certainly it is an area where we want to continue to look at involving them so we get that interaction working.

Ms M.M. QUIRK: Is that some online thing? How is it done?

Dr Robertson: Emergotrain is one of those things that you need to see. It is a Swedish system which was based on blackboards or whiteboards and small fridge magnets. That does not sound too good! They actually represent all the patients and you then have the real staff who would normally be dealing with those patients and it is done in real time. The problem with a lot of other systems is they do not use real staff and are certainly not done in real time. It is done with the real resources that you know at the time. You cannot create a couple of extra operating theatres you do not have. If you put somebody in the operating theatre on this board, then that theatre is full and you have to deal with it. It looks at the flows, it looks at the communication between different areas, and it looks at transport to and from areas and all of those things. It is a very effective system. We introduced it into Australia. It is now utilised in most states for hospital training because it has a lot of utility. You can actually have subsets. You can have it just looking at a chemical incident or a flood or whatever the case may be.

The CHAIRMAN: How often do you conduct one of those exercises?

Dr Robertson: Most of the major hospitals do them at least once a year. We have probably got one of those types of exercises going every few weeks.

The CHAIRMAN: Is there one coming up that we could observe?

Dr Robertson: Yes. I would have to check the times, but it should be an opportunity.

The CHAIRMAN: Can you let David know?

Dr Robertson: Yes. It is worth seeing.

Mr A.P. JACOB: Just to go back even a bit earlier, do you find generally that your clinical staff, as they are coming up through university and through their studies, are quite well prepared by the time they come into the health department for what they are going to be dealing with?

Dr Robertson: I think they are. I think some of the psychological aspects and the resilience aspects of this are increasingly being taught within the various universities. Once they get into a hospital, the first few years is when they will pick up a lot of that as well, and I think it is supportive. In those

few years when they are interns or new registered nurses or whatever the case may be, I think the support from the more senior staff and the registrars et cetera does help them prepare for that.

Mr A.P. JACOB: And most of them will go through at least one rotation in emergency on their way through.

Dr Robertson: That is correct. Usually they will, yes.

Mr A.P. JACOB: I know of some students who, even as students, had some fairly horrific experiences in ED but have gone on to become quite good nurses, I think, as a result.

Dr Robertson: They do grow from those experiences. They understand that this is part of that role and that they need to be exposed to that.

Mr A.P. JACOB: So, in your opinion, do you think that the universities are doing quite a good job of that in preparing people?

Dr Robertson: I think they are probably doing a better job than was done in previous generations. They are accepting that that is a role to prepare them coming through. I think, as part of their education, they at least provide the framework and the building blocks that they can build on so they understand what they are getting themselves into.

The CHAIRMAN: Andrew, thanks very much for that. Thanks for coming in this morning and giving us the benefit of your experience. A transcript of the hearing will be forwarded to you for the correction of minor errors. Could you please make these corrections and return the transcript within 10 working days of the date of the covering letter? If the transcript is not returned within this period, we will deem it to be correct. New material cannot be introduced via these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional information or elaborate on particular points, could you please include a supplementary submission for the committee's consideration when you return your corrected transcript of evidence? Again, thanks very much for coming in this morning.

Hearing concluded at 10.51 am