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, 16 MAY 2012

SESSION ONE

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 10.03 am

JACOBS, PROFESSOR IAN
Director of Clinical Services, St John Ambulance, examined:

The CHAIRMAN: This 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 a Details of Witness form?

Prof. Jacobs: I have.

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

Prof. Jacobs: I do.

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

Prof. Jacobs: I did.

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

Prof. Jacobs: None whatsoever.

The CHAIRMAN: Before we start, have you any opening statements you would like to make?

Prof. Jacobs: Not particularly. I suppose in terms of resilience and disaster, St John Ambulance has about 4 500 volunteers within the state of Western Australia, to provide both ambulance services and first aid services. So from our perspective, this is one of our key areas and key work plans in terms of being able to support our volunteers who are facing natural disasters.

The CHAIRMAN: Does St John normally take any psychological screening of your applicants, volunteers or career people?

Prof. Jacobs: No we do not. There is no psychological screening of volunteers. For paid paramedics there is a psychological screening and assessment undertaken prior to employment.

The CHAIRMAN: Can you give us a bit of an overview of what that looks like?

Prof. Jacobs: Psychological screening for the paid ambulance paramedics—before employment they are brought into an assessment centre. It is an assessment process that is based around leadership, working with other people, and aptitude—trying to determine whether they have a suitable aptitude towards working in a pre–hospital care environment, which involves working with patients in the routine transport area up to complex emergency situations including disasters. That assessment process has been undertaken through consultations with psychological services, and private psychiatric and screening services.

Ms M.M. QUIRK: You talked about paid paramedics. What is the total number of personnel that, if you like, are frontline at St John?

Prof. Jacobs: We have about 2 500 to 3 000 volunteers in the country providing services. In terms of paramedics in both metropolitan and rural regions, it is in the order of 650 to 700.

Ms M.M. QUIRK: So your last answer was in relation to your paid personnel only?

Prof. Jacobs: It was in relation to paid personnel only. As I mentioned, we do not screen our volunteers. We do have a medical form, which they complete, and they need to declare whether

they have any psychological disability. If there is any of that concern, we would then refer them to their general practitioner for a medical clearance.

The CHAIRMAN: In your psychological testing, is that something that is negotiated and agreed to by the union?

Prof. Jacobs: The selection process has been a longstanding process and at this point in time as they have not actually been employed yet, there is not a significant union involvement. The unions are certainly aware that we undertake this process in order to get what we consider the best candidate for a role as a paramedic. Again, I emphasise, as Margaret mentioned, this is for paid paramedics only, of which the vast majority would be in the metropolitan area, not in the country.

The CHAIRMAN: Is there any annual follow up on staff health and mental issues?

Prof. Jacobs: We have a structure that is called a MAPS program—Maintaining Awareness and Peer Support—which is an assistance program for our staff. It is available to paid and volunteer staff members. If they go to a situation where there has been a natural disaster, a road accident or a tragic situation, or a situation they feel they cannot cope with, then we would refer them to our MAPS program, which is a peer support program where they can talk to one of their colleagues who has had some training in psychological support in this area. We can then refer them to Prime Services, which is an external organisation—we have nothing to do with that organisation; it is removed from our organisation—to provide more psychological support for these individuals. We also have a fulltime chaplain, which again will be used to provide that sort of counselling and support. In situations where we clearly know, and it reports back, that this is potentially a substantial burden for an individual, be it paid or volunteer, the chaplain will often make contact independently just to see how things are going. We have sent the chaplain to parts of the state a number of times to talk to the volunteers and ask how they are coping and talk about things we can do. This is more based around tragic things like multiple traffic accidents and so forth.

Ms M.M. QUIRK: Do other organisations have the capacity for employees or their families to contact an employee’s assistance program directly? It seems to me, from what you have told us, there is a slightly different process —

Prof. Jacobs: No, they can go to an employee’s assistance program directly. We have multiple processes that they can chose to take ranging from peer support, which one would argue is probably one of the best supports that can be provided in these sorts of circumstances, to deciding that they want to go to their general practitioner or to an employee assistance program.

Ms M.M. Quirk: You have mentioned motor vehicle crashes, and one of the issues in regional areas is that the same volunteers tend to be the ones who turn out each time for the crashes, and so there is an accumulative effect —

Prof. Jacobs: An escalating effect, yes.

Ms M.M. QUIRK: Is there anything special that you have in place for people in those circumstances? Do you, for example, keep a record of exposure to incidents of —

Prof. Jacobs: To my knowledge, and I will take that question on notice, we do keep a record of volunteers going to specific accidents? We can get that information off our patient care records forms, so we know every ambulance paramedic volunteer who attends any call in the state and we can pull out that information retrospectively and say, “Gee whiz, you have gone to three bad traffic accidents this year!” So we can tag that sort of thing. I do not think we systemically do it but I will take that on notice and confirm if we do have that process. In the last 12 months we have moved into a regionalisation framework for the ambulance service. Now that we have regions that are aligned with the Department of Health regions where we have regional officers, regional training coordinators and community support paramedics based in those regions, there is a lot more support at a regional level. It is the regional managers and the regional support staff that will now tag these matters rather than it being very head office centric.

The CHAIRMAN: You mentioned peer support a few times. Can you tell us what the peer support involves in St John?

Prof. Jacobs: The peer support is particular paramedics and volunteers who nominate to be a peer support person, and we bring them in. I will take it on notice the actual length of training, but I think it is four days of training in terms of understanding critical incident, how people are supported for that, and what resources are available to be able to guide that individual to peer support or to resolve their issue. Some of the issues are resolved. At the end of the day, a lot of it is just about talking and communicating, and we are not necessarily in the framework. I think it would be wrong to say—especially with some of the more recent evidence and more recent literature—that if you have gone to an incident you need to be debriefed or whatever the case may be. I do not think that is the right path, but having the facilities and the pathways for people to move to is important. The peer support is an immediate support mechanism, and it is confidential between the peer person and the individual who is requesting that support.

The CHAIRMAN: We have been in the US, New York and New Orleans, and they use retired fire officers for peer support for their fire brigade people. Do you have any programs where you bring in retired ambulance people?

Prof. Jacobs: No, we do not, and again I think there is a potential, I imagine, to use retired people, but I think what people want to know is someone doing the same thing with them at the same time. A true peer support is not someone who might have been there 10 years ago. It is someone who may have done that job instead of me, or who may have done a similar sort of job last week and has got a really contemporary understanding of what the situation may be.

The CHAIRMAN: You also mentioned it is probably not appropriate to do debriefs and things like that. Some of the other jurisdictions are taking what is called a psychological first aid approach. Has St John gotten into that yet? You were saying that debriefing is probably not the —

Prof. Jacobs: We are moving to that sort of process, and I think the psychological first aid is raising awareness amongst our staff of being able to provide that information and that instant support. I think part of the issue is that because we are a health service, our training automatically has a focus in being able to provide that pastoral care and that psychological support, because we do that for patients on a daily basis. We want to have those little sets of skills that it may be the partner. When working within the ambulance service, and it is likely to be exactly the same in the United States and around the world, you build up a rapport with your partner and it is that sort of rapport that often becomes the link to addressing some of these issues.

Mr I.M. BRITZA: What about the families of the personnel? Is there any plan to keep them informed because we have understood that a lot of these workers do not share anything when they go home, and obviously there is tension around that. Is there any plan for families?

Prof. Jacobs: We include families, and certainly within our employee assistance program that extends to the family as well; it is not just for the employee. Again, I will take that on notice about how much we are involved with the family. It is a very fine line because some people do not want their families involved. They want to have work left at work and they want their family life left alone. I think it is the psychological first aid approach where you can try to tag where the issues are brewing. From our perspective, we see the partners they are working with—because they are not working alone—who are often the ones who bring it to the surface and say, “You need to see someone. You are not functioning right. There are clearly issues. You are not present at work.”

[10.15 AM]

Mr I.M. BRITZA: I accept that, however I know from experience that when spouses are left out of the loop the divide can get bigger and it is something that really cannot be ignored.

Prof. Jacobs: I could not agree with you more but I think the issue is not about leaving them out, it is how to engage them within the overall process. It is a bit like psychological counselling and

critical incident debriefing. You can bring them in and they can be part of the whole process straight off, but then there is a risk that people will withdraw even more.

The CHAIRMAN: Do you have any figures on how many of your staff actually experience post–traumatic stress?

Prof. Jacobs: No, I cannot comment on that. If you like I will take that on notice and try to provide that information.

Ms M.M. Quirk: From time to time with other agencies, you have disaster scenario training exercises. Are you aware within those training exercises whether there is any briefing or consideration of how something like post–traumatic stress is dealt with?

Prof. Jacobs: There is, and certainly when we do our exercise we do them quite frequently and certainly every two years. We have a large disaster exercise at Perth Airport. We have previously done them in the Avon Valley. There was one we did recently—I think last year—up at Karratha, which certainly involved our volunteers in that sort of respect. We debriefed the event and how people performed within the event and, as always, there were people who were trying to look. We usually have our chaplain there and our peer support people trying to encourage if there were any sorts of issues that would arise from that, but it is probably not done as routinely and as methodically as it should have been done.

Mr A.P. JACOB: Given the nature of your day–to–day work, are PTSD incidents more or less likely to arise in a disaster scenario as opposed to day–to–day traffic accidents?

Prof. Jacobs: Fortunately, I can only revert back to the literature, and that indicates there seems to be more during a disaster that comes out of that. In Western Australia we are pretty fortunate that we have not had a large–scale disaster, which is akin to something like Christchurch or whatever the case may be. It is very hard to answer that question.

Mr I.M. BRITZA: That leads to one of the statements that we heard in America where they said to plan for the worst, and this is what you should do. Do you have a scenario or does St John have a scenario where they plan for the worst possible situation?

Prof. Jacobs: We do, we certainly have our own internal disaster plans. You can plan for the worst situation but you can only plan so far. We had some debriefing just recently from our colleagues in New Zealand regarding the Christchurch earthquake and how all their planning was based around Wellington. They thought that Wellington would be the centre that would suffer the earthquake, not Christchurch. Like every disaster, when we go back and debrief how it unfolded and the issues around them, there are common issues that come through, and one is that we just do not know the scale of it. However, we can mobilise large numbers of staff at very short notice, and in terms of a state disaster plan and our own disaster plans.

Mr I.M. BRITZA: Without going into major details—just a headline—can you tell us what kind of disaster would be our worst?

Prof. Jacobs: If we were looking at the worst major disaster that we could probably have, it would be a substantial structural fault in the CBD on a peak afternoon where the CBD population increases by 120 to 130 per cent.

Ms M.M. QUIRK: The overseas experience is that during a disaster there are quite strict controls on how long the personnel are out on the frontline. Has that been factored into your planning in terms of the rostering of staff and have there been discussions, for example with the—

Prof. Jacobs: That is mandated within our plan. We have a dedicated safety officer within our plan and the safety officer's role is entirely to look out for the welfare of the staff: "You have been here for 10 hours. You need to be out of here and get some rest, some food and some water and the rest of it." Naturally in a disaster, particularly with emergency care workers and health workers, they would want to keep on going to address the disaster, and we have certainly seen that in overseas

processes where we debrief overseas. You see the people staying there far too long. We have a safety officer who is looking at the logistics; staff who are in and staff who are out, and how you rotate the staff through. On top of that is also the continuity of the normal business.

Ms M.M. QUIRK: St John is effectively an independent agency, but from your observations is there anything more the health department can do? Obviously you have close links with them in terms of inputting for disaster management to mitigating critical incident stress or putting new programs into practice, which would certainly reduce the incidence of the stress.

Prof. Jacobs: I will give credit to the Department of Health. Over a number of years it has improved and its disaster management and its preparedness unit, and Andy Robertson, have done a great job in bringing in the ambulance service to part of that overall health and disaster planning. There is always more. I could say, get some more funding from the health department in terms of the equipment we use and things of that nature —

Ms M.M. QUIRK: What sorts of things?

Prof. Jacobs: We would require further equipment in terms of just our logistics and our vehicles that we use and so forth. We currently have two logistic support units, which we can roll out which has a whole stack of stretchers and bandages and things of that nature, which we can undertake and deploy very rapidly. In essence, we probably need to have more disaster command-type units. We need to have more access into the health department's WebEOC program, and it is not to say it is just the health department; it is also with the ambulances. As an executive, we have now made the commitment to review our disaster preparedness from top to bottom, and we have had two consultants in from Victoria just recently to do that.

Ms M.M. QUIRK: So you are not part of WebEOC I gather.

Prof. Jacobs: We are part of it. We can get access to WebEOC, but some of the information that we get from WebEOC is not that helpful to us.

The CHAIRMAN: What sort of information are you hoping to get from WebEOC that would help you?

Prof. Jacobs: The current status of health facilities. In the first two hours of any disaster—until recently where the health department can actually ramp up its facility early, it would take a couple of hours before health actually ramped up their incident response unit in their incident room. There needs to be an immediate response. If I use the example of the Lancelin bus rollover where we had 30 people potentially injured, we had to provide an immediate response to that. From our perspective, to look at the bed capacities of the hospitals would be useful, and how we can interrelate to that and say we are going to send these patients to here et cetera. The last thing you want to do is overwhelm a particular institution. You want to be able to share the load across the various parts of the health sector. So bed status is one. What resources are available and what resources are not available because it is not available on that particular day. It is just more dynamic information sharing across that. Again, I will be perfectly clear, it is not just the health department, it is also St John Ambulance, and we need to do a better job with that coordination between the two agencies. It is a good relationship now. I think we can do better.

The CHAIRMAN: We have had some disasters over east. Does St John WA get involved in interstate and intercountry —

Prof. Jacobs: We occasionally send paramedics across to other disaster sites on request. Like everything else, the request has to come from that agency for additional support, rather than just people rolling up. I am sure from your findings elsewhere, one of the biggest issues that we have in disasters is the disaster tourist, where people just lob in from all around the world. They want to do all the right things but they do not come with any sort of equipment that is useable in the environment. They do not come with the appropriate training. They do not come with the appropriate PPE. They do not come with the appropriate credentialling. Some people we do not

even know who they are. That is one issue. So we will certainly send staff, and we have done in the past upon request from those agencies at that point in time. The Council of Ambulance Authorities, which represents ambulance jurisdiction in Australia and New Zealand, has an emergency management subcommittee. When a disaster occurs in another jurisdiction, that committee talks amongst each of the jurisdictions about how they can assist each other. If there is a disaster in Queensland, we will send two people across, not to be involved in the disaster but to learn from the experience that they are taking at the time. Really it is not to be a tourist but to see how they manage it and to learn from the experience there and then. So those are the sorts of relationships we are starting to build.

Ms M.M. QUIRK: This might be a question on notice as well. Obviously your personnel are attending at sites where you might have police or FESA personnel, and your personnel presumably will sometimes be required to render medical assistance to other emergency services.

Prof. Jacobs: Correct.

Ms M.M. QUIRK: Again, most of that will probably be physical but I wonder if there are incidents of cases where there are people breaking down or whatever at the site.

Prof. Jacobs: You are right, I cannot answer whether there are specific incidents. We certainly do provide medical cover for the other emergency care workers. At the recent fire, for argument's sake, north of Kelmscott at the eastern area, we will have a paramedic presence there, but we will also send out volunteer event first aid services and we will set up a first aid post at those sites to provide that sort of care. In terms of people breaking down and requiring that, I cannot let you know if that is the case.

Ms M.M. QUIRK: Do you know with the first aid training that you give other emergency services, does that include a component of giving them some basic tools in terms of some mental first aid if you like?

Prof. Jacobs: No, it does not. The basic first aid tools are given. In saying that, again, nationally through St John and to some degree with the Council of Ambulance Authorities, is the concept of building community resilience around disasters and natural disasters because again, if you take a community that is devastated by flood, fires or whatever the case may be, it is the community that is going to be the first port of call—it is going to be the neighbours and so forth. We actually have a PhD student who is an emergency physician who has looked at community resilience in high schools and what do high school children have—and this is overseas—and their resilience to disaster is poor. They do not really have a concept about how to do simple things like get water when you cannot turn the tap on and very basic skills.

Ms M.M. QUIRK: I understand you have a contract with FESA to train their personnel in terms of first aid. I understand that has expired —

Prof. Jacobs: Again, it is not under my direct directorate, so I am happy to take that on board and determine that. We are certainly happy with the training, but I am not too sure what contracts apply. We do have a contract with FESA to supply paramedics to the helicopter, but I am not too sure about the first aid management, and I can find that out for you.

The CHAIRMAN: Do you collect any information or keep an eye on your staff in terms of how they are coping after disasters? Do you have any issues with—the most severe is suicide and alcohol and other substance abuse?

Prof. Jacobs: No, I am almost positive, and again I will confirm that, that we do not keep that information on staff and how they are tracking psychologically post disasters. Again, part of that is that we have so few of them, and again with the volunteer component, but I could not answer that directly at this point.

Ms M.M. QUIRK: One of the experiences that certainly came across in both Christchurch and New Orleans was the issue of emergency service workers who were themselves victims or their families were victims. Are there any special policies for your personnel in those circumstances?

[10.30 am]

Prof. Jacobs: No, there is not. Certainly, again, if you take our country volunteers, and as you said, there will people who often go to another accident, the same people doing it. The other issue that we are acutely aware of is that they are more than likely going to go and help someone who they know, who is a resident in the town, who is one of their colleagues or the farmer down the road or whatever the case may be. The community attitude around that is actually incredibly supportive. I dare say it is often if you tried to pull people back, saying that you cannot attend because of that, then I think that people would be more frustrated and angry. I think it is not a case; I think it is providing the right support mechanism behind that.

The CHAIRMAN: Does St John give any external assistance, psychiatrist or academics, to design your processes for dealing with trauma and stress of this kind?

Prof. Jacobs: We use outside consultants, again, from our employee support programs in doing that. But no, not anything.

Ms M.M. QUIRK: I would like just a general analysis, I suppose; a little bit more detail. I think you talked about a logistics command vehicle or whatever. I would be interested to know a bit more about what other things you think you need in terms of disaster management. Maybe you could just include that in the other correspondence.

Prof. Jacobs: I would be more than happy to do that. Then I can refer that directly to our disaster management people who can actually give that. The reason I know that is the case is that we have discussed at an executive level that we need to really actually invest in our disaster management capability even more to actually make it more robust.

Ms M.M. QUIRK: And in that context, anywhere that you think they have done it well—any other states that you think have got it worked out a little better.

Mr A.P. JACOB: Going back to my earlier question, outside of the disaster scenario, do you do anything where you monitor a cumulative effect on your staff who serve for a long time and will have seen multiple incidents or isolated incidents?

Prof. Jacobs: No, we do not. We do not take multiple incidents and then correlate them against staff individually and say, "Gee whiz, you've been to a lot of tragic events." We certainly will find staff who have difficulty at times, and then we will identify that through our existing processes, but it is not a routine mechanism of saying, "Gee whiz, you've been to five traffic accidents in the last month. You need to come off and have a debrief." No, we do not do that, and I am not sure that that is the right way to go.

The CHAIRMAN: Some of the evidence we have received interstate and overseas suggest that some of the most traumatic events are the ones that involve children. Your paramedics would have to show up when there have been children involved. Is there any special circumstance or anything special that you do once you have known your staff have turned out to those events?

Prof. Jacobs: Nothing especially except what we currently do, which is that we identify those as being events. They are tragic events. One that comes to mind is the unfortunate one where the individual drowned their children some years ago. We identify that as being an event. We will automatically in those sorts of events dispatch an ambulance team leader—it was a scene in Mandurah—and/or a clinical support paramedic. Equally, we will also then ring the chaplain and say, "You might want to follow this up", and they will follow it up almost at the point of call. Our chaplain previously was Don Sonsee, who was magnificent. Our new one, Cindy Monteith, is absolutely brilliant as well. They will go to scenes. Our crews will often ring them through the

operations centre and say, “Listen, the individuals, the actual community member, the husband, wife, family member are having difficulty with it.” One that really comes to mind is suicide hangings, which is very tragic, particularly with young people involved, which is not uncommon. The family are devastated by that. Often we will send our chaplain to be able to provide some support until they can put them into an assistance program through elsewhere. So we often provide support not just to our staff but also to victims’ families.

The CHAIRMAN: Ian, thanks for coming. I will read you a closing statement so you know what happens from here on, because we do send you out some information. Again, thanks for your evidence to the committee this morning. A transcript of the hearing will be forwarded to you for 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 a particular point, could you please include a supplementary submission for the committee’s consideration when you return your corrected transcript of evidence? Again, thanks very much.

Prof. Jacobs: A pleasure; thank you very much indeed.

Hearing concluded at 10.35 am