**REPORT ON PROCEEDINGS BEFORE**

# COMMITTEE ON LAW AND SAFETY

## INQUIRY INTO VIOLENCE AGAINST EMERGENCY SERVICES PERSONNEL

**At Jubilee Room, Parliament House, Sydney on Monday, 20 February 2017**

**The Committee met at 9:10 am**

**PRESENT**

Mr G. Provest (Chair)

Mr E. Atalla
Ms J. Leong
Mr D. Tudehope

**The CHAIR:** Good morning and thank you for attending the third public hearing of the Committee on Law and Safety's inquiry into violence against emergency services personnel. My name is Geoff Provost, I am the Chair of the committee and member for the electorate of Tweed. With me today is Damien Tudehope, the member for the electorate of Epping, and Jenny Leong, the member for the electorate of Newtown. Mr Edmond Attalla, the member for the electorate of Mount Druitt, is stuck in traffic but he will be here shortly, and we have one apology. This morning the Committee will hear from representatives of the Health Services Union, NSW Ambulance and the NSW Ministry of Health. I take this opportunity to thank all witnesses for making themselves available to give evidence before the Committee today. For the benefit of those in the public gallery, the Committee has resolved to authorise the media to broadcast sound and video excerpts of the public proceedings. Copies of the guidelines governing the covering of proceedings are available.

I now declare the meeting open. I welcome our first witness, Mr Gerard Hayes, State Secretary, Health Services Union. Before we proceed, do you have any questions regarding the procedural information sent to you in relation to witnesses and the hearing process?

**Mr HAYES:** No, I do not.

**GERARD HAYES**, State Secretary, Health Services Union, sworn and examined:

**The CHAIR:** Would you like to make a brief opening statement before the commencement of questions?

**Mr HAYES:** Yes, very briefly. I appreciate the opportunity to appear before the Committee again. We were able to ventilate some concerns previously; however, there are other issues that may be of assistance to the Committee and we have the opportunity to raise those today.

**Ms JENNY LEONG:** Can you tell the Committee, in broad terms, how you feel the duress and communication systems within the NSW Ambulance Service and also those used by ambulance paramedics fare? Are you aware of any concerns or issues around them? Further, are you aware of what might be pointed to as good examples of best practice models?

**Mr HAYES:** I think they are working at capacity as best they can at the moment. It is important to note that ambulance paramedics work in a very fluid environment and that can get very volatile very quickly. It is not simple for ambulance paramedics or, indeed, for management, to be able to ensure 100 per cent compliance that people will be saved all the time. As I understand it, communication is generally good, particularly in the metropolitan area; however, there are issues within regional New South Wales in terms of communication. In the Ambulance Service the training for de-escalation and preventative issues such as if there are concerns in turning up to a matter, ambulance paramedics will generally wait until there are appropriate resources to support them. The technical issues of communication are complex, as they always are given the size of this State, and I think that is something that can be focused on a lot more. We are certainly of the view that the Ambulance Service is prepared to do that, and we are prepared to work with them. In answer to your question generally, I think the Ambulance Service is doing everything it can with what it has but it is not as cut and dry as to be able to provide full security of a paramedic in a fluid environment.

**Ms JENNY LEONG:** I appreciate that, in terms of being able to recognise that things are being done with the resources available. Are you are aware of when the last technology upgrades were made to the existing systems and have any concerns been raised by your members around that?

**Mr HAYES:** In terms of their communication of data and so forth, no huge issues have been raised by members. I think the issue generally, particularly in regional areas, is at times paramedics will go out singularly, without a second officer. That is a very big concern and it goes down to a staffing point of view at the end of the day. As to communications within the city, we do not have major issues being raised there. Certainly, that generalised ability to get communications out in the regional areas I guess is the overall problem that has been raised with us.

**Ms JENNY LEONG:** Are you aware of any problems in current procedures when NSW Ambulance communicates with the NSW Police Force in a crisis situation or if there is a need to call in extra support?

**Mr HAYES:** It has not been raised with me that that there is a major concern with that. The relationship between the police and the Ambulance Service, as I understand it, is very good. Indeed, paramedics within the Ambulance Service often speak highly of the ability of police to be able to respond and provide that protective opportunity. The only time that may fall short is in areas where that police presence does not have the ability.

**Ms JENNY LEONG:** The Committee has been told that there are serious concerns with the technology and the communication and duress protocols specifically for paramedics. I have two questions: what can be done with the existing resources, and how does it compare with resources given to other emergency service workers such as police and fire brigade officers, et cetera? Do you have any comments or views on what could be improved and how those benefits could be improved, if there were additional resources, rather than what is currently being done with existing resources?

**Mr HAYES:** Clearly when we look at the three different agencies: ambulance paramedics are approximately 3,500, they are double crewed so that brings that down to about 1,500 staff; fire services are somewhere in the vicinity of 7,500 or 8,000 staff; and police are somewhere around 19,000 staff. They are all looking after the same area but all dealing with different facets and different workloads. In some respects numbers alone are not an easy comparison, given the different workloads and different responses they have. In this day and age a lot of time needs to be spent with the Ambulance Service addressing that fluid environment and ensuring safety and security. I note that in Victoria they are looking at having cameras on paramedics. I think the last occasion I was before this Committee I made the observation that it is from an evidentiary point of

view; I do not think it is going to do a lot to proactively decrease that potential assault. Also there are a whole range of privacy issues that come to hand as well. It is something that we need to spend a lot of time with the Ambulance Service looking at. I do not think anyone has the knockout blow in terms of this at the moment but I am sure with the technological changes, and how rapid they do move, there is an opportunity to be able to work through what advancements could assist in future.

**Ms JENNY LEONG:** The database system that is used, which is referred to in the health department's submission to this inquiry, is called AmbCAD?

**Mr HAYES:** Yes.

**Ms JENNY LEONG:** There is basically an implementation process looking at how that can be used and how caution notes can be put in. Do you have any comments on the AmbCAD system and how it works?

**Mr HAYES:** We would like to speak with the service more in relation to that. Again, it goes to the point similarly with the Serious Incident Management [SIM] system in the health system generally. That system is barely used and, if people do use it, they do not see that it goes anywhere; there is no net result. So reporting is one thing but the really important thing in this is the action that comes from that reporting. That is certainly something that we would like to be dealing with the Ambulance Service in a consultative manner going forward. I just do not think we can rely consistently on systems that will report what occurred but actually do very little to be able to prevent that reoccurrence.

**Mr DAMIEN TUDEHOPE:** Are members of the Australian Paramedics Association (NSW) part of the Health Services Union as well?

**Mr HAYES:** Some maybe, not all.

**Mr DAMIEN TUDEHOPE:** Have you had the opportunity of reading the transcript of evidence that association gave to this Committee?

**Mr HAYES:** No, I have not.

**Mr DAMIEN TUDEHOPE:** They suggest that there are additional technological improvements to communications equipment that could be available. Are you aware of any technological improvements?

**Mr HAYES:** I am not. Broad consultations would be able to produce some ideas going forward in relation to that. I am not aware and I am not a technical person.

**Mr DAMIEN TUDEHOPE:** Going back, and potentially covering some other ground, if you were to make a suggestion to this Committee about its recommendations with regard to protection of emergency workers—other than identifying the problem, which we seem to know—what would it be?

**Mr HAYES:** That category breaks down into different areas. If we are talking about workers within a hospital campus or paramedics on the street, clearly the safest thing for paramedics is proactivity in terms of knowing when not to get into a situation. Sometimes those situations are volatile and they occur very quickly.

**Mr DAMIEN TUDEHOPE:** How do I deal with that?

**Mr HAYES:** From my experience, the only way to deal with that is by having the appropriate resources to ensure there is appropriate backup and appropriate crewing in the first instance. NSW Ambulance has a particular code for a paramedic in trouble, and a paramedic in trouble must know that there will be a response.

**Mr DAMIEN TUDEHOPE:** Is the code okay?

**Mr HAYES:** You call the 01 code, and you must know that you will get a response. We are trying to prevent having to call that code. We must ensure that there are two officers in a vehicle to deliver the appropriate treatment. The other important thing is that paramedics now have the ability to administer drugs that will relax a patient. Speaking from experience, it is very hard to relax a patient when you are fighting them on the ground and trying to get a line into a vein. Again, having the appropriate resources to protect not only the paramedic but also the patient is important. If there are four people to hold down the patient safely and securely so that an IV line can be inserted to administer medication it is a successful outcome. If there are two paramedics, that will not be achieved. If there is only one paramedic, that person simply has to get out of there. That resourcing for paramedics is the most important thing.

**Mr DAMIEN TUDEHOPE:** What is your perception about that at the moment?

**Mr HAYES:** It is grossly under resourced.

**Mr DAMIEN TUDEHOPE:** Are you suggesting that we should increase the number of paramedics attending from two? If so, how many should there be?

**Mr HAYES:** We need at least two paramedics on each vehicle to attend a scene. However, we also need a redundancy factor so that if support is required it can be provided. Over the Christmas period a person had to wait 40 minutes with a broken leg in the middle of the CBD because there were not enough vehicles available. In the middle of the year there will be trolley block because of the nature of the conditions in winter. Those resources—what there are—start to get distracted or are not able to be released. Of course, that puts more pressure on the system.

The service is now looking at super stations. I have serious concerns about that. You will find, for example, that one of the super stations will close down Fairfield station and move cars to Bankstown. That is all well and good, but given the traffic we see today from Blacktown to Fairfield, or further past that catchment area, it will take longer. That builds up frustration for the family of the people who are waiting. That is why I keep referring to resourcing. It is not only about paramedics getting there in a timely manner. If they do not, I can assure members that families get very angry very quickly, which makes the situation more volatile. There is full understanding of their anxieties and what they are going through.

**Mr DAMIEN TUDEHOPE:** I accept what you are saying about that. Therefore, timely attendance can reduce the potential for a difficult situation to develop.

**Mr HAYES:** Yes.

**Mr DAMIEN TUDEHOPE:** Can you turn your mind to the specific circumstance where an ambulance crew is attending a scene involving drugs or violence? Are two ambulance officers attending that scene sufficient?

**Mr HAYES:** If it is an ice-related situation, perhaps not.

**Mr DAMIEN TUDEHOPE:** But they do not know that before they arrive, do they?

**Mr HAYES:** No, they do not. That is the fluidity of the situation. It is not a matter of predicting the future with a crystal ball.

**Mr DAMIEN TUDEHOPE:** Are you suggesting that ambulance crew numbers should be increase?

**Mr HAYES:** Absolutely.

**Mr DAMIEN TUDEHOPE:** From two to what ?

**Mr HAYES:** The number of crews needs to be increased.

**Mr DAMIEN TUDEHOPE:** That is a resourcing problem. How many paramedics should be in the crew?

**Mr HAYES:** Two paramedics is appropriate generally speaking.

**Mr DAMIEN TUDEHOPE:** If they arrive at the scene and are confronted with potential violence, is that sufficient at the moment?

**Mr HAYES:** I do not think it is sufficient at the moment because paramedics are getting injured.

**Mr DAMIEN TUDEHOPE:** What is your recommendation?

**Mr HAYES:** We must first ensure that paramedics understand what to do in a violent situation and how to extract themselves. We also need to ensure that the appropriate backup—whether it be police or other paramedics—is available. The communication systems that are in place and that could be in place will go a long way to help in that situation.

**Mr DAMIEN TUDEHOPE:** Where are the deficiencies at the moment?

**Mr HAYES:** I keep coming back to the point that the deficiencies are clearly with the resourcing once the situation has developed. We cannot predict that, but once it has occurred we should do something about it. The communication in city areas is generally good. However, in regional areas you take pot luck from time to time with regard to whether the communication will be adequate and if there are appropriate resources. For example, if you are at Wellington or somewhere else like that in regional New South Wales, you might need a police response but they may be out doing other work and may be unable to respond.

I am not saying that we have all the answers, but we are prepared to work through this with NSW Ambulance to minimise these unwarranted events, whether they are alcohol- or drug-related. There are mental

health issues as well. It is a complex situation that many other areas in the health sector do not face. Most other areas of health have controlled situations to a point. Mental health units can be volatile from time to time, but overall they generally have resources and a clinical mixture necessary to be able to handle the situation. Of course, there are times when they also get out of control. Paramedics are in a situation that cannot be predicted on any given day. Much of the time things will be okay, but every now and then they will not and it is hard to plan for that to some degree.

**Mr DAMIEN TUDEHOPE:** I am hearing that in handling situations generally more resources need to be available for backup situations.

**Mr HAYES:** Yes.

**Mr DAMIEN TUDEHOPE:** However, you are not suggesting that there should be an additional crew member, other than perhaps in regional areas, which have their own difficulties because of remoteness and the like. You identified the two major factors relating to dealing with stress situations, including, first, proper education so that officers know what they have to do to de-escalate the event, and, secondly, communication with the base or some other emergency service that can assist. Is that correct?

**Mr HAYES:** Yes.

**Mr DAMIEN TUDEHOPE:** Where are the current deficiencies in training of ambulance officers?

**Mr HAYES:** I do not know and I cannot say honestly that I know whether or not there are deficiencies. Generally, NSW Ambulance training involves identifying these matters, determining how to get out of a situation, and how not to get into a situation. It is about using caution as opposed to being aggressive in response and so forth. I believe the service is doing that. However, I am suggesting that we need, and it is timely that we have, a more focused view of these issues.

**Mr DAMIEN TUDEHOPE:** By and large, what you have just articulated—without being totally across all that the service does—is that a training system is required to deal with how ambulance officers should be dealing with stress situations.

**Mr HAYES:** Yes.

**Mr DAMIEN TUDEHOPE:** Currently we are using state-of-the-art communications with other emergency services, is that right?

**Mr HAYES:** Yes.

**The CHAIR:** The member for Mount Druitt, Mr Atalla, has just joined the Committee. Would you like to ask some questions?

**Mr EDMOND ATALLA:** No.

**The CHAIR:** Well, I will ask some and take a different tack. Do your 34,000 members also include security guards employed by the health system in the hospitals?

**Mr HAYES:** To sum up, we look after everybody in Health except for nurses and senior doctors, so junior medical officers, cleaners, allied health professionals, paramedics, administrators, the lot.

**The CHAIR:** We have been focusing on paramedics and they are at risk being out in the field, as you said. What about the other workers you represent such as security guards in the hospital and I would assume that at times other people can be affected by violence or attacks on them in the hospital? Are you aware of any training or de-escalation?

**Mr HAYES:** It is concerning and I am mindful that you are speaking with Health later today. As I mentioned last time, in January of last year—not this year, last year—two people were shot at Nepean Hospital. We advocated heavily for a round table that was going to facilitate a whole range of viewpoints from police and Health. That has still not been resolved some 14 months later, which is of great distress.

**The CHAIR:** Are you still at a table talking about it?

**Mr HAYES:** The table has sort of contracted dramatically. The issues that have been put forward have not been realised. Legislative change that was required has still not been realised. Instead of what we would suggest is at least 200 security officers, a grand total of 15, which will not deal with attrition. It is disappointing and why it is disappointing is this: Last time I was before you at the end of it I showed you a photo of a security officer from Morisset. Here we are some months later and you are probably well aware a person from Morisset has lost their life and is now subject to the courts—a resident, a client, at Morisset.

Hospitals are not places where you just get injured; you can get killed and this is continuing to occur. Security at hospitals is a most important issue. We are seeing that it is at the end of the food chain. It is something that we will address if we have to. We record an incident but we are actually doing very little to prevent it. If I can just give a quick figure to you and this comes from the Institute of Safety, Compensation and Recovery Research. It indicates that paramedics are 15 to 30 times more likely to make a workers compensation claim and nurses are between 9 to 15 times more likely to make a workers compensation claim. In 2010 to 2015 assaults on public hospital campuses increased by 5.8 per cent, which effectively means that in 2010 it was 5.5 per 100,000 and it has gone up to 6.6 in 2015 per 100,000. These are the issues. Hospitals are becoming dangerous places.

**Mr DAMIEN TUDEHOPE:** Is that a document that we have?

**Mr HAYES:** I am happy to supply that to you. It is coming to the point where it is all about dollars and cents.

**The CHAIR:** There has been some movement, has there not? I know my local hospital has increased the level of security guards on duty after some incidents.

**Mr HAYES:** And after we went to the Industrial Commission under work health and safety to ensure that these things occur. There is a view of the Ministry of Health that maybe the health and security assistant models, that is, someone who is a cleaner who can do security work or an administrative person who can do security work may be a way to address this. They will address it financially, however all it will do is ensure that when a security issue occurs someone will respond. No-one proactively will ensure that security issue does not occur in the first place and then it gets to the point—you asked the question of me in the follow-up about contractors. We see time and time again where contractors are not orientated to the particular health campus.

Indeed, Liverpool has a batch of 40 contractors trained at one time. Those contractors may not ever be used so when they are called in they will not have a working knowledge of the geographical outlay of the facility let alone that understanding of the emotional and clinical aspect of the facility, which is so important. Also, as I mentioned previously, I give credit to the Ministry of Health which has instituted the TAFE course that does go some way to getting people to professionalising the security function within the health setting and we see that security function also has a clinical function which goes hand in hand with treating patients because ultimately, good, bad or indifferent, all people within the health facility will be a patient.

**The CHAIR:** Do you have any concern about the testing and review by NSW Ambulance of its duress systems following an activation? Perhaps I should expand that a bit further. If there is an incident and they are a member of the HSU, does the union meet with the member, step them through the process and offer support and guidance?

**Mr HAYES:** Yes.

**The CHAIR:** Because I can imagine it would be a fairly stressful period in their lives?

**Mr HAYES:** It is and before this Committee I would say that I am disgusted by the Professional Standards and Conduct Unit [PSCU], which is there to hang people out to dry as opposed to going through a process. One of the biggest strains our members have is going through the PSCU, which appears to us to be punitive and appears to hang out to dry as opposed to rehabilitate.

**Ms JENNY LEONG:** Can you expand that acronym for those who do not know what it is?

**Mr HAYES:** It is the professional standards unit effectively. Some of our members, without going into detail, have been effectively stood down or effectively moved from their location for anything up to six months, maybe more. One case in particular comes to mind—remedial action only. So a person has their life turned upside down. They are in a high stress job already, their life is turned upside down and at the end of a very lengthy period it is found, "Well, we'll just give you some remedial activity." The person gets moved away from their station, their credibility, their character, gets brought into question, and we find if there is a shortfall in the Ambulance Service, that is it. The Ambulance Service functions very, very well in many areas but for this punitive approach of what our members see as guilty until proven otherwise and it does not matter what occurs to the individual through the process until it gets to the end of the process.

Not many people have gone through that process who have been terminated or been dismissed but I can tell you now the level of anxiety that is brought upon them—and I share this with the Committee: we are now moving into the Industrial Commission to attack one of these matters that has recently been brought to bear in a grossly unfair way which put a senior paramedic of many years service, incredibly well qualified, to the position of questioning themselves and questioning whether they continue in the Ambulance Service after the best part of 30 years commitment to the Ambulance Service. When put through the ringer, at the end of the day, nothing to

see here; this is the first time ever. We are not going to let this go. We do not want to do this. We want to work with the Ambulance Service. The PSCU, from our perspective, is just out of control. They have very little concern for the individual.

**The CHAIR:** So, in summary, you do not think there is a proper review of various incidents?

**Mr HAYES:** Absolutely not.

**Mr DAMIEN TUDEHOPE:** Following on from the Chair's question, there is no proper review of incidents?

**Mr HAYES:** Clinical incidents?

**Mr DAMIEN TUDEHOPE:** Yes.

**Mr HAYES:** One blends into the other. In this particular case I am talking about we are trying to work out if it is a clinical review, and it does not appear to be from our perspective. Paramedics are encouraged to do root cause analysis and if they have a concern put it forward. Paramedics more and more do not want to do that because of the outcomes. No-one is perfect, people can make mistakes and if we rectify matters it is a good system. You must have confidence that it will not be a punitive approach.

**Mr DAMIEN TUDEHOPE:** There is room in the system for a review which identifies potential professional failure?

**Mr HAYES:** Of course.

**Mr DAMIEN TUDEHOPE:** Is it your position that a review of an assault circumstance involving a paramedic, is there a system for that?

**Mr HAYES:** Yes, the Ambulance Service has a system for that.

**Mr DAMIEN TUDEHOPE:** Is that satisfactory?

**Mr HAYES:** It can be and at times it is not. There are times where I have seen individuals go through an assault situation. The one I am thinking of is not a physical assault but a violent interaction in the back of the ambulance. Next thing you know it was a matter for the ambulance paramedic to justify the matter.

**Mr DAMIEN TUDEHOPE:** I understand that. If an event occurs is there an adequate system in place that at the conclusion of the event, such as an assault, is there a review mechanism for what happened such as how could we have done this better?

**Mr HAYES:** Yes, there is a review mechanism. Is it adequate? I am not convinced it is, I think it could be more robust.

**Mr DAMIEN TUDEHOPE:** Tell me.

**Mr HAYES:** It goes to the resourcing of the administration to have adequate time to juggle those matters with other interests.

**Mr DAMIEN TUDEHOPE:** What would you interpose into the system to make it more adequate?

**Mr HAYES:** I would do a full review of the PSCU and its function. I would have a clinical review program as a maintenance program where people feel they can raise issues. It has to be brought forward with confidence, that it is a proactive approach not a reactive approach. To train a paramedic costs thousands of dollars and to have a punitive approach over something that is remedial is a waste of taxpayers' money. If anything, in terms of these matters, there needs to be a full review of this program. We would like to be a part of that to get the best treatment for patients and to avoid paramedics having excessive stress placed upon them and be treated fairly and reasonably.

**Mr DAMIEN TUDEHOPE:** You are identifying that the nub of the problem with the review is the potential for disciplinary proceedings. That places undue stress on the paramedic or health service worker involved.

**Mr HAYES:** I take it further. We understand that in life there is potential for disciplinary matters for all of us, and we accept that. The bias towards that is what concerns me.

**Mr DAMIEN TUDEHOPE:** You are identifying that there is a bias in the system to have a default position that looks for a disciplinary proceeding to emerge out of the event?

**Mr HAYES:** We are presently prosecuting that before the Industrial Commission.

**Mr DAMIEN TUDEHOPE:** If you could fix anything you would concentrate on fixing that bias?

**Mr HAYES:** Absolutely. If any of my staff have a problem I would rather that they talk to me about it and we can resolve it knowing that they do not have to hide. If there is a problem now a problem can occur later on unless it is addressed. If it is addressed appropriately that is the best way forward.

**Mr DAMIEN TUDEHOPE:** This will be ventilated in the Industrial Commission?

**Mr HAYES:** Yes.

**Mr DAMIEN TUDEHOPE:** Are you able to give us the details of the case.

**Mr HAYES:** I will take advice. I am more than happy to.

**Mr DAMIEN TUDEHOPE:** I would be interested to see how that is resolved. The primary submission to the Industrial Commission is that your members are being, in a sense, victimised?

**Mr HAYES:** That is correct.

**Mr DAMIEN TUDEHOPE:** By way of the disciplinary proceedings that may stand in the way of proper outcomes.

**Mr HAYES:** I think it is fair to say not only victimised because of the process but because they are members of the union as well. I am happy to take advice and forward as much detail as I can.

**The CHAIR:** Do you think that what you have indicated is prohibiting people reporting incidents?

**Mr HAYES:** Yes.

**The CHAIR:** You believe that reported ones as opposed to the actual is different?

**Mr HAYES:** People value a critique as long as they accept it is a critique and something one can learn from and move forward. The problem is that if you put your hand up to be critiqued and suddenly you have a major problem you are unlikely to do it again. We come back to the resourcing: you have exhausted paramedics, tired management and limited ability to deal with a range of matters, so you do the best you can with what you have. I keep coming back and harping on that point, that the management and paramedics can do well with an appropriately resourced paramedic system which, going forward in this day and age, will be key to people in regional New South Wales. It makes a big difference to have intervention of a highly clinical nature on a farm 50 kilometres away from a hospital than it does to do that trip and then get to a point.

**Mr DAMIEN TUDEHOPE:** It was very helpful, thank you.

**The CHAIR:** Thank you for appearing before the Committee today. The Committee may wish to send you additional questions in writing, the replies to those questions will form part of your evidence and be made public. Would you be able to supply a written reply within five business days?

**Mr HAYES:** I will do my best. I will forward that document to you this afternoon.

(**The witness withdrew**)

**ALLAN ROSS LOUDFOOT**, Executive Director, Clinical Service, NSW Ambulance

**GEOFFREY IAN WATERHOUSE**, Senior Project Manager, Radio Telecommunications Capital Works Program, NSW Ambulance

**DAVID DUTTON**, Executive Director, Service Delivery for NSW Ambulance, sworn and examined

**The CHAIR:** I welcome the witnesses from NSW Ambulance. Thank you for appearing before the Committee today. Before we proceed, have you any questions relating to the procedural information sent to you in relation to witnesses and the hearing process?

**Mr WATERHOUSE:** No.

**Mr DUTTON:** No.

**Mr LOUDFOOT:** No. I am here primarily as chair of the occupational violence prevention strategic advisory group.

**The CHAIR:** Would you like to make a brief opening statement?

**Mr LOUDFOOT:** Yes, I will. First of all I place on record the apologies of my Chief Executive, Mr Dominic Morgan, who is attending a meeting in Melbourne which is primarily around beyondblue, which is a mental health and wellbeing summit, which is obviously associated with some of the matters we are dealing with today. I once again thank you very much indeed for the opportunity to provide the Committee with some additional information following the hearing that occurred in November.

**The CHAIR:** Do you want to say anything at this time?

**Mr DUTTON:** No, sir.

**Mr WATERHOUSE:** No.

**Mr EDMOND ATALLA:** In relation to the duress alarm system, will you provide the Committee with an indication of its adequacy? What are its shortfalls, if any?

**Mr LOUDFOOT:** It is quite a complex matter but I will try to make it as simple as possible for everyone to follow. We have a number of duress systems that paramedics can use in their environment. We have a vehicle duress system. We have also got duress initiated by buttons in the front and back of the vehicle. We have also got a portable function within the portable radio that they can actually initiate duress. They can also initiate duress by voice and that can be on the radio or it can be through satellite phone or whatever. So those are the mechanisms that we have, and it then runs on an environment which is based on three systems: the government radio network, the private radio network [PNR] system and then the mobile data terminal network that utilises commercial 3G and 4G satellite bearers. That is how they initiate it and those are the systems that they work on.

In terms of identifying the accuracy of the duress location, we undertook a significant amount of work on independent testing in regional and metro locations. We went to Dubbo, Newcastle, Wollongong and Sydney. We chose those locations because they had specific characteristics that we could try to map. One was open field, minimal, horizontal obstruction—that is the kind of regional areas—remote location, the metrocentric which has its issues around buildings and all that, and then natural terrain shadowing. On those four sites we did multiple tests around those sites. Whilst I say Newcastle, there would be potentially a dozen locations around that area that we tested it.

In open field conditions we got within five metres of the actual location. So we said, "that is where they should be." We tested the system and that came out within the five metres. Within the metro areas, and areas where there is shadowing, that was between 20 and 50 metres, so pretty close in terms of where the actual incident was. As a caveat, that is with our current installed equipment which is going through a very significant upgrade as we currently speak, and I can explain more to that if the Committee so requests. We are pretty comfortable that we do that. The second part around that shows how accurate it is. If I can recall correctly, and how much coverage there is, we did a series of tests around regional and—

**The CHAIR:** Did you run into black spots?

**Mr LOUDFOOT:** Yes, Chair, I will explain in a moment. We did 8,000 kilometres in the metro area and 56,000 kilometres of testing in regional areas to look at the pooling, and how accurate it was—

**Ms JENNY LEONG:** Have you been testing in the past two months, five years?

**Mr WATERHOUSE:** The pilot testing that we undertook has been done in the past 12 months. The pilot test was around validating the commercial bearers that are actually advertised. So we tested all four majors. We also tested four proprietary satellite vendors as well and we also validated our GPS and filing ABL systems as well. One of the other important things was also understanding black spot remediation programs that we have got in place and just validating again what we have on our own record versus what is known within the paramedics' working environment.

**Ms JENNY LEONG:** All of the testing that you have discussed so far has occurred in the past 12 months?

**Mr WATERHOUSE:** That is correct, yes.

**Mr LOUDFOOT:** Within that we do know that there are some existing black spots and as Mr Waterhouse indicated we do have a remediation program. We spent $500,000 last year and we are spending $400,000 this year. Those black spots are generally identified by the operational paramedics who go to every nook and cranny within the State. We have a process that they can record that concern to us and that goes into a register and then we remediate against that particular black spot.

**Mr EDMOND ATALLA:** I would like to ask Mr Waterhouse a question. You are an expert in the telecommunications field. We all know that telecommunications are quickly phased out. As new technology comes in old technology gets replaced. In relation to the duress system, when was the last time this was updated or upgraded? Do we currently have the latest, best technology?

**Mr WATERHOUSE:** To answer the first question, the current refresh of our rural fleet has happened in the last 12 months. That has promoted old technology into current technology. We have also been able to look at current technology by way of using Telstra priority services, which is especially there for emergency service organisations. So we get the top tier of the priority tree within the bearer. We work closely with the NSW Telco Authority, which is rolling out a statewide Critical Communications Enhancement Program [CCEP], which is a consolidation of all New South Wales Government agency radio networks. That will give us the next stepping stone for future paths of technology, which will be LTE.

**Mr EDMOND ATALLA:** You spoke about the regional ones being refreshed in the last 12 months. How old is the technology for the areas that have not been refreshed?

**Mr WATERHOUSE:** The technology that remains, which is in our metro vehicles, is currently between seven and eight years old. We are currently looking at having a refresh completed by 30 June this year. That will give us one platform of technology and interoperability between metropolitan and regional areas.

**Ms JENNY LEONG:** I may just continue on with the issue of the refresh and we will go on from there. Thank you for taking the time to appear before the Committee. My understanding of telecommunications technology is limited but in a web design context, which I understand more about, you can talk about a redesign of a web site, which means that you do all of the backend and you get the state-of-the-art database and technology behind it and you make it all look beautiful, new and fresh on the front.

**Mr WATERHOUSE:** Yes.

**Ms JENNY LEONG:** I wonder in this context, if that is my understanding of a web redesign—there could be a full, behind-the-scenes latest technology for the database and how it all talks, versus the refresh of just designing the front page again. What is the equivalent, in lay terms, of the refresh that you are talking about, which has happened so far with the technology?

**Mr WATERHOUSE:** What you have presented is a good statement. It is pretty close to what we are doing. We deem backend infrastructure as network management centres, links, routers, equipment. The presentation of what you see on a personal computer for your web design is actually the MDTs, portable radio or the mobile fixed into an ambulance vehicle. Our refresh is turnkey. It is the complete backend infrastructure—links, network management centres and also the equipment and kit that sits with the paramedic or within the vehicle itself.

**Ms JENNY LEONG:** Would you say that the refresh that has been done in regional areas is state of the art, to the point the technology allows, or are we catching up in terms of where the refresh has taken us to?

**Mr WATERHOUSE:** That is always a hard question, because technology moves so fast. When we go through a research and development [R and D] phase to implementation of a complete installation, some of that technology—it has not reached another life—has gone onto another journey. What we are putting into the

ambulance vehicles now will give them a strong, concrete foundation for the next steps. It is what we call future-proofing.

**Ms JENNY LEONG:** I am not sure whether you oversight the concerns, complaints and challenges that happen around those current duress systems. Have you seen improvements in terms of the level of concerns paramedics have raised about the functionality of the duress systems since that refresh has taken place? Rather than anecdotally, is there any evidence in terms of how much is reported about those functions versus how it has improved?

**Mr LOUDFOOT:** Earlier I informed you of all the testing regimes and the accuracy of that. That was shared with the statewide joint consultative committee—with all the industrial bodies. That is one of the mechanisms that allows this sort of feedback to come through, where any concerns are raised.

**Ms JENNY LEONG:** Have you seen improvements and a reduction in complaints in comparison? Currently we have had the refresh in the regional areas but not in the metropolitan areas. Has there been a difference in terms of the response, the protection, the reduction in incidents because of the improvement to that communication technology?

**Mr LOUDFOOT:** I would need to take that question on notice because I am not really aware of the fine detail within that. I can comment that any concerns that come in get investigated to determine the cause, because we want factual evidence rather than anecdotal evidence that comes across.

**Ms JENNY LEONG:** Earlier you talked about the different mechanisms and different functionalities that exist. You mentioned the mobile or portable elements. Does every paramedic have on them a portable radio or device, or are there some instances where they would not have those available and there would just be one portable device per vehicle?

**Mr LOUDFOOT:** I do not have that information in front of me. We have purchased a significant number of hand portable devices. Mr Waterhouse would know the detail and the number purchased.

**Mr WATERHOUSE:** We are doing a terminal refresh over the next two financial years, including the current financial year. We are looking at replacing up to about 6,000 terminals in the workforce.

**Ms JENNY LEONG:** I guess what I am looking at is whether the current amount of portable terminals or devices allow every paramedic to have a duress system on them. Is that need currently met or is there a need for more?

**Mr LOUDFOOT:** I will need to take the question on notice. From my understanding every vehicle has a hand portable. If an individual was by themselves they would have that hand portable. Every crew would have the ability to have that duress functionality.

**Mr EDMOND ATALLA:** Is it your intention that every paramedic should have a portable?

**Mr WATERHOUSE:** That is the intention.

**Mr LOUDFOOT:** I am fairly comfortable that we have, but I would like to confirm that.

**Ms JENNY LEONG:** It would be good to have some detail around that.

**Mr LOUDFOOT:** Yes.

**Ms JENNY LEONG:** To give you the context, one of the things that we have been looking at in the Committee is the incidents that occur where there may be violence to a paramedic who is not necessarily in the confines of the vehicles or when something does not go to plan. If that is the case if only one individual has a duress button and the other does not, that can raise serious concerns. So it would be good to get detail around whether the policy is that every paramedic should have one of these, and also whether that need is currently able to be met.

I want to ask you briefly about the communication systems between ambulance and the police. Are there areas, in your opinion, that could be improved? Are those technical improvements or improvements that are non-technical and much more about human interaction, policy and guideline improvements that are needed? I would be keen to get your thoughts on both those areas.

**Mr LOUDFOOT:** Some of it is around policy and procedure, and some of it is around technology. For example, if there is an incident that requires urgent police presence by the paramedics, that would come through the control centre. There are two reasons for that. The first is that everything is then able to be tracked, logged and recorded. The second is that we have an Inter-CAD emergency message system with the police. We can send a request directly into the police system. They would dispatch and respond back through that system.

**Ms JENNY LEONG:** Do you think that that current system is working adequately to provide protection to paramedics on the ground?

**Mr LOUDFOOT:** That works extremely well; yes. That is used fairly extensively—not just for duress but for passing work between the different organisations. It is for police, fire and ambulance.

**Mr EDMOND ATALLA:** Currently there is the duress system in the vehicle and there is a portable radio.

**Mr LOUDFOOT:** Yes.

**Mr EDMOND ATALLA:** Now there is technology where people can wear duress pendants separate from a radio that identifies their location, et cetera. Are there any plans to move to this technology?

**Mr LOUDFOOT:** There are. In the future, as we move from today into the next few years, we certainly mean to have the introduction of a personal duress alarm. Certainly the technology is potentially there to allow us to do that but, again, I think there is a systematic approach to ensure that we have an extremely robust system, which is the core business, and then we can work through what the implications would be of having all our front-line clinicians having that potential duress. Because, again, the current system allows a check and balance so if there is a duress activated the control staff can actually validate whether it is a genuine duress—sometimes it is pressed in error. We can very easily have someone press something and it sets off a duress, but you have got to be able to go back and validate whether it was genuine. It is something that we will be considering.

**Mr DAMIEN TUDEHOPE:** Just as an aside, I have a duress alarm in my office and there is no system for saying it is a false alarm; the police just come.

**Ms JENNY LEONG:** It concerns me that any duress system would have a verification system first. We get them to come even if we accidentally bump it with our knees.

**Mr DAMIEN TUDEHOPE:** Are you aware of a critical incident that has escalated because of a failure of communications?

**Mr LOUDFOOT:** No.

**Mr DAMIEN TUDEHOPE:** We are having this discussion about duress alarms and whether paramedics are sufficiently covered to ensure that there is a response to a distress situation but you are not aware of any incident where there has been a failure to respond?

**Mr LOUDFOOT:** Not to my knowledge, no.

**Mr DAMIEN TUDEHOPE:** Where there has been a critical incident and potentially an ambulance officer has been the subject of an incident of violence, what is the process for reviewing that incident?

**Mr LOUDFOOT:** If there was that type of incident, it would be recorded in our Serious Incident Management System [SIMS]. That is then reviewed by the managers and assigned a risk score. It is then appropriately addressed depending upon what score it is given. My colleague here, Mr Dutton, and the service delivery staff are the ones who generally investigate those matters. Depending upon the severity, briefs are provided to the Ministry of Health and the matter is addressed accordingly.

**Mr DAMIEN TUDEHOPE:** At a stab, how many reviews have been held?

**Mr LOUDFOOT:** Reported to police—I have not got the figures with me but it was reported last time at 140 or something I think.

**Mr DAMIEN TUDEHOPE:** Incidents?

**Mr LOUDFOOT:** Where prosecutions were undertaken and briefs provided. I will take the question on notice. We do have a fairly comprehensive breakdown of all the various types of assaults and location of assaults and action taken.

**Mr DAMIEN TUDEHOPE:** If you were going to make any recommendations to reduce that number of assaults or incidents, what would you be suggesting?

**Mr LOUDFOOT:** As you are probably aware, I am the chair of the Occupational Violence Prevention Strategic Advisory Group. That report has just been presented to the chief executive and the executive leadership team, and endorsed by that group.

**Mr DAMIEN TUDEHOPE:** Can the Committee have a copy of that report?

**Mr LOUDFOOT:** If you request it, you certainly can. The report contains 29 recommendations. The intention of the service is to move now into the implementation phase. We will be having an expression of interest for a project manager to then undertake the main recommendations within the actual report.

**Mr DAMIEN TUDEHOPE:** Rather than you give us the individual recommendations that you have made, they are all contained in that report?

**Mr LOUDFOOT:** They are contained but I can give the Committee some broad headings for its information. Things around the use of technology and some of the areas we have been talking around there—for example, what about body cameras? What about individual duress alarms? All that needs to be explored. There are areas around training—we think there are some significant benefits in that prevention area. The policy and practice area needs to be addressed. There are a number of other groupings, including things around specification of station security. There is also the area around communication—for example, how do we communicate with the public? What are the benefits of doing that? Those are the main themes that come out of that actual report.

**Ms JENNY LEONG:** Can I ask a question on the time line of the production of that report and the sharing with the committee that you undertake? Is that an ongoing committee? Was it set-up for a certain time? What was the reason and the trigger for that report to happen now? What is the time frame for how long it has taken to establish this report and also when you will see the recommendations implemented or actioned?

**Mr LOUDFOOT:** Early last year it was identified by the chief executive that there had been a significant amount of work done in the past and there was the potential to do some further prevention work in the future. That we needed an overall strategic overview of the organisation and how it was going to potentially reinforce occupational violence prevention within the organisation. That committee was created in April of last year and we brought together a very comprehensive group of individuals, obviously involving operational people as they are the end users, so to speak. We also had Health involved in terms of the office of the chief psychiatrist and all the industrial bodies. We did a significant amount of background research, looking at all the territories and jurisdictions within Australia to look at what all the ambulance services were doing in this particular field. We went into New Zealand and the United Kingdom and did some comparative analysis. It was then November that the report was finished and it was with the executive to have some careful consideration. That has been signed off and issued to all the staff. Also we have a beacon from the chief executive indicating the next step, which is to move into a transition to implementation based on this actual report.

**Mr DAMIEN TUDEHOPE:** That report would be invaluable to this Committee.

**Mr LOUDFOOT:** Yes.

**Mr DAMIEN TUDEHOPE:** It has been put to the Committee that one of the potential difficulties with the reporting of incidents is the manner in which the Professional Standards Unit gets involved to potentially involve your officers in disciplinary proceedings. What is your answer to the allegation that there are officers who are reluctant to deal with issues because of the stress that arises from having to deal with the Professional Standards Unit?

**Mr LOUDFOOT:** My view would be that professional standards would not routinely get involved in a complaint matter. The issue is highlighted in this report in terms of the ease of individuals being able to document concerns. We could provide an analysis based only on the evidence provided. There is some contention as to whether it is under reported and whether the paramedics almost accept some form of occupational violence as part of their day-to-day business. Again, we have recognised that in the report.

**The CHAIR:** I put it to you that I am a paramedic and I suffer a violent incident. Can you step me through what I do from the time I am assaulted?

**Mr LOUDFOOT:** Yes. It obviously depends on the severity of the violence involved because there are obviously different levels. There can be verbal assault and physical assault. The nature of the assault will determine the type of action taken. However, if you are assaulted you must first ensure that you are safe and that you can continue to provide the care that you need to provide. There is a clear understanding.

**The CHAIR:** Who makes that call? If Mr Tudehope and I are paramedics at a scene and I cop one in the nose, do we have a discussion about whether I am fit enough to continue?

**Mr LOUDFOOT:** First, you and your colleague would ensure that you were safe from any further assault. You may decide to retreat quickly from the scene and request police backup. That falls into the system we have.

**Ms JENNY LEONG:** Can you talk us through that? The member for Epping and the member for Tweed have just retreated to the vehicle.

**Mr LOUDFOOT:** Hypothetically speaking.

**Ms JENNY LEONG:** I feel sorry for whoever needs care. At that point they assess whether they need backup. What does that mean? Do they ring 000 on their mobile?

**Mr LOUDFOOT:** If they are in the vehicle they can press the duress button. They would restrain the individual to ensure they contain the situation. If it were so violent that they had to exit the vehicle, they would have the portable radio. They would press the duress button and the control centre would go through the process of notifying the serious injury management system and the police would attend.

**The CHAIR:** Then what happens? The police have taken away the offender, I have a bleeding nose, and the member for Epping is not being very sympathetic.

**Mr EDMOND ATALLA:** You would call an ambulance.

**Mr LOUDFOOT:** No, the duty manager would be notified and would then take over the welfare side of the incident. Depending on the severity of the injury, and if you had unfortunately incurred a physical injury, the manager would determine whether medical treatment was required. We would also have to determine whether you were suffering some form of emotional stress as a result of the incident. The duty manager would take you through that process and ensure that the support systems were in place to look after you both physically and mentally. A report would be put into the system electronically.

**Ms JENNY LEONG:** Who would do that report?

**Mr LOUDFOOT:** The staff member would do that, but the manager can do it on their behalf.

**Ms JENNY LEONG:** So the individual who has been injured is responsible for making the report?

**Mr LOUDFOOT:** Yes. However, the manager can do it if the staff member is seriously affected by the incident. They would be stood down to allow that to occur.

**Ms JENNY LEONG:** How often are those incidents reported by the individual? Do they have time in their work schedule to be able to do that, or is that an additional workload?

**Mr LOUDFOOT:** They are given the time to do that; they would be stood down from operational duties to allow that to be done. Again, the report contains a breakdown of the numbers of reported incidents.

**Ms JENNY LEONG:** Do you think under reporting is a problem?

**Mr LOUDFOOT:** I think it is a potential problem, but we really do not know. My instinct as a former paramedic is that serious incidents are reported. However, I do not know how much tolerance is built into the paramedic workforce with regard to lower-level incidents.

**The CHAIR:** The Committee has heard evidence that the NSW Ambulance process for flagging the addresses of violent patients is long and drawn out and that it may not be effective in preventing violence. Do you have any comments to make about that, or could any improvements be made to make it more effective?

**Mr LOUDFOOT:** Flagging relates to a residence rather than to a potentially violent individual. Should the individual change their place of residence, unfortunately the flag would potentially apply to an innocent individual. We have to take a reasonably cautious approach to imposing flags.

**The CHAIR:** How do I get a flag? Must I commit two or more assaults? Is there a benchmark?

**Mr LOUDFOOT:** There are various reasons for applying a flag. Sometimes the flag is applied for a very good reason. The system notifies staff of pre-existing medical conditions and individuals in our palliative care programs. That is the positive aspect of the process. The slightly less positive aspect relates to potential violence. That occurs when paramedics have experienced first-hand, potential or actual violence. That is put in the system and reviewed after a period of time.

**The CHAIR:** Is the process long and drawn out?

**Ms JENNY LEONG:** How do you do the flagging?

**Mr LOUDFOOT:** I am fairly certain that is not very long and drawn out. I will take that question on notice. I think it is relatively simple in terms of providing an address.

**The CHAIR:** Who makes that decision? Is it the local station manager, or is it passed down the line? Who can push the button and determine that an address is flagged?

**Mr LOUDFOOT:** I will take that question on notice. I am not sure who would authorise it. However, a backend technical person puts it into the computer-aided despatch system.

**The CHAIR:** There has been a rollout out in the NSW Police Force in terms of dealing with people with mental illness. Is there a similar process in NSW Ambulance for officers dealing with people with mental health issues?

**Mr LOUDFOOT:** We have undertaken an extensive training program for staff dealing with people with mental health issues. We have also run a pilot scheme in the Hunter area looking at an alternative and additional training. There was an identified increase in incidents in that area. We have trialled that, and it is something that can be considered for the service.

**The CHAIR:** The NSW Police Force worked with the Schizophrenia Association of New South Wales to develop its policy. I assume that NSW Ambulance would be working in partnership with the key stakeholders.

**Mr LOUDFOOT:** Yes. We work with the mental health and drug and alcohol agencies to deal with the issue. We also have full-time managers who look at mental health issues and training. Clearly, a significant number of our patients have some form of mental illness. It is a key area. From my perspective, training is a major prevention tool. Again, the report states that that should be explored in terms of the content and the appropriateness of the training.

**Ms JENNY LEONG:** I want to clarify the reporting of an incident. In a situation where a paramedic is rostered on for a shift, how much of the time of the shift are they not on active duty where they would be able to undertake things like the reporting of incidents or the review of policies around prevention or other things?

**Mr LOUDFOOT:** I will pass that to Mr Dutton to comment.

**Ms JENNY LEONG:** To put it in context, the use of the phrase "stood down to be able to make a report", in my understanding of that colloquial language when you are stood down, tends to be a form of punishment, when you are stood down from active duty. Even in that sort of language and acceptance, to be stood down to have to make a report of an incident would make me concerned that there is not the space and time to do that as part of regular duties and I just wonder what space there is within a paramedic's rostered on shift to engage with that reporting, even if it was not a critical incident?

**Mr LOUDFOOT:** I will pass over to Mr Dutton to give some comment on that. The "stand down" is my phrase. There is no disciplinary connotation associated with that at all. Again, within the potential for future prevention, there is a new reporting management system currently being developed by Health and that is going to potentially allow us to access and use that system from remote devices so potentially we could do it through mobile phones, tablets or whatever, so again that would greatly assist staff to have ease of access into that system and it is really important that we make it user friendly so that they will be encouraged to potentially use the system.

**Ms JENNY LEONG:** It will be great to hear that.

**Mr DUTTON:** As to your question in relation to examples post an incident happening in the field, clearly the front-line manager has a key role to play here in being alerted to that incident. Depending upon the physical location they may well attend the scene or if, for example, the incident transpired in the ambulance vehicle on the way to the hospital they may meet the crew at the hospital. They would be expected to make contact with the crew and to ascertain that all the safety issues referenced earlier have been attended to.

If we were in the unfortunate circumstance where there was physical injury, that treatment was provided to the officers concerned and then all of the follow-up reporting that is required. In my experience the supervisor would effectively take that crew offline for a period of time and that would generally be proportionate to the severity of the assault. If we were talking at the end of this spectrum of a verbal assault it might be that that crew has a period of time at the hospital to complete their report, gather their thoughts before returning to active duty. In a more serious example where we had physical injury I am certainly aware of circumstances where crews have been taken offline for hours or potentially the remainder of the balance of the shift.

It really is a discussion between the front-line paramedics and their supervisor that assesses the individual circumstances that they are presented with to determine the course of action. Any assault that is reported in the system receives automatic front-line management follow-up within a 24-hour period, so that may be then a shift of duty that their supervisor would make contact with them—just check in and see how they were going. If they were proceeding to rostered days off, that would normally be effected by a phone call. Again, severity of incident really determines the management action that occurs there.

The other thing, referring back to the Professional Standards Unit and some of the evidence you have heard there, any assault that is reported to police is given what they call a computerised operational policing system [COPS] reference number, which is the NSW Police system for tracking incidents. Then our Professional Standards Unit would be available to assist that officer as that instance moved forward. For example, that might be some assistance in preparing a statement that might go before the court or again at the serious end of the spectrum it might be assisting the officer to prepare to give evidence at a court hearing for an assault.

**Ms JENNY LEONG:** Assuming the purpose of reporting an incident is then for systems to be improved, protocols to be adjusted, et cetera, what feedback is given to the individuals who make that report so that they know what broader changes or actions have been taken, if any, as a result of their report?

**Mr DUTTON:** The case officer assigned by the Professional Standards Unit is responsible for keeping the officer involved as that progresses. That might be email or phone contact just to advise them.

**Ms JENNY LEONG:** That is if there is a police report?

**Mr DUTTON:** That is correct.

**Ms JENNY LEONG:** What I am talking about is something that is internal; what happens within NSW Ambulance rather than a police matter?

**Mr DUTTON:** Certainly. The front-line manager would be the main point of contact for the staff member to know what is happening. The front-line manager would also have a good appreciation for patterns and trends within their local area of responsibility. We have certainly seen examples where front-line managers have links to existing programs or used, for example, senior paramedics to mentor more junior clinicians in the way that they approach patients, the tone of voice, the non-verbal body language, those sorts of things, in a very low level but front-line attempt to reduce incidence of violence in the first place.

**Ms JENNY LEONG:** But is there a specific requirement with the reporting system: I put in a report. I say I got punched in the nose. This happened and then it goes into a system. At some point do I get a formal response back about what action has been taken, what systems have been reviewed and how things have been improved or do I just put the report in and that is the end?

**Mr LOUDFOOT:** Yes, you put the report in and that is roughly the end. However, with the new system you will know who is managing that actual incident and you will be able to track it through the system and for more serious incidents we would initiate a root-cause analysis, which is an extremely formal process where recommendations come out and those recommendations have to be actioned and registered. That is the way of us being able to manage those incidents.

**The CHAIR:** Thank you for appearing before the Committee today. The Committee may wish to send you additional questions in writing. The replies to those questions will form part of your evidence and be made public. Would you be happy to provide a written reply within five business days to any further questions?

**Mr LOUDFOOT:** Yes.

**(The witnesses withdrew)**

**(Short adjournment)**

**KAREN CRAWSHAW**, Deputy Secretary, Governance, Workforce and Corporate, NSW Ministry of Health, sworn and examined

**ANNIE OWENS**, Director Workplace Relations, NSW Ministry of Health, affirmed and examined

**The CHAIR:** I welcome witnesses from the NSW Ministry of Health and thank them for appearing before the Committee today. Before we proceed do you have any questions regarding the procedural information sent to you in relation to witnesses and the hearing process?

**Ms CRAWSHAW:** No.

**The CHAIR:** I assume that you have met our Committee members. Do you wish to make a brief opening statement?

**Ms CRAWSHAW:** I would, just to give a bit of context to our appearance today. First of all, I want to say that the safety and well-being of our staff is equally as important to us as the safety of our patients. We cannot expect our doctors, nurses, allied health and other health workers to provide world-class patient care if the environment they work in is not as safe as it could be. To achieve this we need to make sure that everyone understands their work, health and safety responsibilities so that safety is everyone's business.

NSW Health's flagship policy for work, health and safety is the work, health and safety better practice procedures. This sets out duties and responsibilities of all staff to contribute to a safe and healthy work environment. From this flagship policy we have a range of specific policies that deal with managing the hazards and risks that are unique to our workplace and to our different clinical settings and client groups. These policies include: how we manage patients with behavioural disturbances and how, why and when we restrain patients, both mechanical and chemical restraint.

In relation to preventing and managing violence in the workplace we have a zero tolerance to violence policy. That outlines what local health districts, specialty health networks, ambulance and other organisations of NSW Health need to do to identify, assess and eliminate or control violence-related risks. It also covers how to respond when violence occurs and requirements such as ensuring our staff receive training to develop the skills to respond appropriately when violence occurs. NSW Health also has its security manual "Protecting people and property", which is a comprehensive document that sets out the standards for all aspects of security risk management in our health workplaces.

Together these two key documents set out practical strategies for ensuring our workplaces are secure and our staff are supported when faced with violent situations. Both these policy documents focus on having strategies in place to prevent or minimise the likelihood of violence occurring as a priority. When violence does occur there are standards for supporting staff and reviewing practices to continuously improve. These documents establish the framework from which we set the 12-point plan, which I understand is of particular interest to the Committee today.

The background of the plan was a round table on hospital security in February 2016 with key stakeholders including expert clinicians, representatives from local health districts, ambulance and health industrial associations. This followed growing concern about the increased prevalence of methamphetamines, such as ice, in the community and increasing violence. In particular, a trigger event was the shooting that occurred at Nepean Hospital in January 2016 when a patient managed to obtain the weapon of a police officer who was attending the emergency department. That resulted in the shooting of a police officer and one of the security staff. We came up with a 12-point action plan endorsed by Government that our health unions have signed up to as well.

The key elements of the plan include: providing multidisciplinary training to staff who work in emergency departments to better manage workplace aggression, improving our workplace safety culture, developing strategies to professionalise our security workforce, providing training to security staff to give them the skills for working in the Health environment, employing an additional 30 security staff at hospitals across the State, developing patient management and treatment pathways for patients presenting to emergency departments under the influence of psycho-stimulants, broadening the scope of the memorandum of understanding between NSW Health and NSW Police Force beyond mental health to improve handover and responsive procedures of aggressive and behaviourally disturbed persons more generally, providing legal protections to security staff where health professionals require assistance in order to render lawful medical treatment or care of patient, and clarifying the circumstances in which security staff are lawfully able to remove individuals from hospital premises, and improving NSW Health's incident management reporting system.

We have made significant progress over the past 12 months to implement the plan and I am happy to take questions about specific aspects of the plan, however, a few highlights include: $2.5 million was received as part of the 2016-17 NSW Budget to recruit 30 additional security staff across the State, and all of these staff, a combination of security and our health and security assistants, are now in place and working within hospital security teams; $600,000 was allocated to roll out a three-day TAFE training program for our security workforce to build their skills and capabilities for the challenges of working specifically in the health environment—a very different environment to that of a security bouncer at a hotel or a club—this includes communication skills, knowing how to effectively de-escalate situations, and ensuring the security staff have a solid understanding of what their role entails; and $1.5 million was also provided to support a work health and safety training culture and training of staff. A new one-day equivalent course designed specifically to meet the needs of staff working in our emergency departments is soon to be rolled out across the State with train the trainer underway and a range of online training modules and resources being developed. Training modules for managers have also been developed to build their understanding of their work health and safety responsibilities.

In addition, following an external security audit of 20 emergency departments and a self-assessment of all other 24/7 emergency departments in the State we have identified a priority package of some $11 million in remedial security works to address issues identified through the security audit and self-assessments. These works include: improving perimeter protection, particularly in smaller facilities in rural and remote areas by providing remote locking capacity on the main public access entry doors where this is not already available—we will be doing about 130 facilities; and CCTV to monitor access of persons coming to the hospital after hours. Other works include: improving access controls between public and staff-only areas, separate paediatric and adult treatment areas and ensuring there are no places of concealment.

One of the recommendations from the audit which we supported is that all staff in emergency departments wear mobile fit-for-purpose duress alarms. Around $5 million has also been identified for this purpose and we are currently in the process of procuring these alarms. It is not that there were not alarms before, it is just we are upgrading and improving the kinds of alarms we have got. We have good discussions with the police about the memorandum of understanding and they have agreed to expand its scope beyond mental health. Recently I met with Corrective Services and will be working with them on a similar memorandum of understanding for when they bring prisoner patients into our hospitals as well. Again Corrective Services does attend with firearms so again there are issues that we need to work through with them.

We have achieved a lot, we have got a lot more to do. The 12-point plan has provided a good framework for NSW Health to drive change and better embed a stronger work health and safety culture and ensure everybody understands their responsibilities, takes measures to reduce violence in the workplace where they can and looks out for not only themselves but also each other. It is an important part. We want to send our staff home to their families in the same way and condition that they come to us at the beginning of their working shift. It is very important for us.

**The CHAIR:** Ms Owens, do you have an opening statement?

**Ms OWENS:** No.

**Mr DAMIEN TUDEHOPE:** In relation to the components of the 12-point plan, are there any issues which require legislation to give force and effect to the delivery of it, including potentially the legal framework relating to security officers and the way that they are looked at?

**Ms CRAWSHAW:** There is, as I mentioned, some legislative change proposed in the 12-point plan. If I go through what the protections are at the moment. We have quite an old inclosed lands Act but it, nonetheless, has those powers that enable us to essentially remove trespassers from the land, so people who conduct themselves in a way such that they need to be removed. What has not been clear under that is ensuring that security staff with the requisite skills can, and are clear about their ability to, remove people from premises where they are conducting themselves in a way that presents a risk. Our primary position is to have police do it. Our security staff are not a private police force; they are security staff and they work under the guidance of our clinical staff. They are not there to substitute for police. So wherever possible we seek a police response if it is somebody who is misconducting themselves—I am not talking about patients here, I am talking about others. There is very little in the way of violent incidents arising from other than patients. I think it is 97 per cent of our physical aggression incidents in our hospitals arise from patients, not from others. When there are others it often hits the headlines or creates quite a bit of a storm from a public point of view but generally the violence is attributable to the clinical setting and to dealing with patients. In terms of that we have recently amended the Health Services Act in cooperation with the relevant portfolio.

**Mr DAMIEN TUDEHOPE:** Attorney-General.

**Ms CRAWSHAW:** Yes. For example, when we are rendering medical treatment to a person who may be intoxicated with psycho-stimulants, alcohol, or may be in a way where they cannot actually respond and consent to treatment, the Guardianship Act permits of emergency medical treatment. Previously security staff have been concerned; for example, they were not clear about their responsibilities in helping to restrain patients.

The legislation now makes it clear that if we have staff acting under the direction of a health professional to render that sort of emergency medical treatment they are covered. They are not held liable, providing, obviously, they do things under the direction of a clinical response. That mirrors legislation that has been in place for a number of years in the Mental Health Act, which provides a similar level of cover for those acting under the auspices and direction of clinical staff, for example in relation to involuntary mental health treatment. So we have now covered both the mental health situation and the non-mental health situation.

In addition, there is also a provision—I think it is in the Crimes (Sentencing) Act—that provides, as an aggravating factor in determining sentence, where a person has assaulted a health worker. We have written to the Attorney General to confirm that our security staff are regarded as health workers. We think they are but we want to be clear.

**The CHAIR:** That is a very relevant point. We did look at that closely.

**Ms CRAWSHAW:** We have that in hand.

**The CHAIR:** When did you write to the Attorney General?

**Ms CRAWSHAW:** It would have been not long after the 12-point plan was underway. Again, we think that those people are health workers but we want to be clear that even non-clinical staff are regarded as health workers for that purposes. Obviously an aggravating factor in sentencing is after the event.

**Mr EDMOND ATALLA:** Did you get a response?

**Ms CRAWSHAW:** I think we have had a response.

**Ms OWENS:** It is still a work in progress.

**Ms CRAWSHAW:** I will come back to you on that but I think we have not yet had a final clarification of that.

**Mr DAMIEN TUDEHOPE:** That was a very extensive answer and—

**Ms CRAWSHAW:** Do I think there is any more legislation to be done? No.

**Mr DAMIEN TUDEHOPE:** Except potentially an amendment—

**Ms CRAWSHAW:** Yes, to clarify that if we need to.

**Mr DAMIEN TUDEHOPE:** —to ensure that security officers are covered.

**Ms CRAWSHAW:** Correct.

**Mr DAMIEN TUDEHOPE:** One of the issues which has been raised with this Committee is the perception that health workers take violence as being part of the job, especially in emergency departments. How do we implement an education system that says that every incident of violence should be reported so that we can, perhaps, move away from the situation where, potentially, health workers just accept that this is part of their lot in life and just treat it by getting on with it?

**Ms CRAWSHAW:** There is no question there is that effect of becoming inured to a low level of violence. I do not think that anybody ever accepts significant violent incidents, where people are seriously injured. Let us look at the context. I know that you are looking at emergency services personnel so it is relevant to our emergency departments. We have an incident reporting system. It is an old, clunky system and we are replacing it. I think I heard the tail end of our ambulance colleagues explaining that the new system in this case will provide much better feedback loops. We are in the throes of implementing that. That is one thing.

One thing is to let staff know that when they report they will get feedback. I think that encourages a greater level of rigour around reporting. As I mentioned in my opening statement, we have a zero-tolerance-to-violence policy that has been in place for quite a significant time. That is very clear about the obligations on our local health districts and speciality networks to encourage and ensure that reporting occurs. That has been part of NSW Health culture for quite a significant time.

With respect to violence in the workplace, we can do a manual exercise of pulling out the data from the old, clunky system. It is a manual exercise; it is not a push-button system like the new system. We have done that exercise and looked at the breakdown of violent incidents and where they occur. Day to day, staff put up

with verbal aggression. I do not know whether it is a symptom of our society, but like staff in any service industry, our staff put up with a level of verbal aggression. Just to be clear, about 40 per cent of incidents involving physical aggression over the last three or four years are in mental health areas—you can understand that—and 40 per cent are in our general wards, not in emergency departments. About 10 per cent of those incidents are in emergency departments and about 10 per cent occur elsewhere—other settings such as community settings or public areas of the hospital. So, if you put it in perspective, a lot of these incidents happen on the wards, not in the emergency departments.

With respect to serious incidents—a notifiable incident to SafeWork NSW, where there has been a need for overnight attendance or attendance at a hospital for an injury—we have had about 13 notifiable incidents in the last four years across NSW Health. Of those 13, I think six have occurred in the last four years in emergency departments, involving various categories of staff. I think there were three nurses, two security staff and one doctor.

Again, putting things in perspective, we do not have a lot of serious physical incidents but the risk is there and the repercussions can be profound. So we have to be very vigilant. The 12-point plan has been, over the last year, a good lever to refresh the need for staff to be more vigilant about their own personal safety. I have walked around hospital wards and I have sometimes seen boxes of brand-new duress alarms sitting there, not being worn. So we have to get beyond a laissez-faire approach to personal safety and ensure that our staff are vigilant. That starts with leadership at the clinical unit level. If you have a good, strong clinical leader who is aware and vigilant and encourages the staff in the unit to be vigilant about their personal safety that becomes the way they do business on that ward or in that unit.

There is no one silver bullet. It is a multifactorial exercise. We have had violence prevention training for a long time. It is extremely excellent violence prevention training but it is for four days.

**Mr EDMOND ATALLA:** Do they get paid to go to that training?

**Ms CRAWSHAW:** Yes, it occurs when they are on duty. It is very well attended by the mental health staff, but it is perhaps not as practical as it could be—I am referring to your terms of reference—for emergency departments. It is quite hard to get staff released from emergency departments for four continuous days. So we have picked the eyes out of the training and looked at the main issues, de-escalation techniques and other tools that are really important and appropriate for the emergency department setting, and we have turned that into a one-day-equivalent course that can be done in chunks of a couple of hours. That makes it a lot more flexible. It is important that we have staff inductions. We make it very clear in our inductions and we go through some level of workplace health and safety and violence prevention awareness—I think is probably better rather than full training at that point. Again, one of the areas where we do think we have not captured hearts and minds as well as we could is in the induction of the junior medical staff. There on a ward, where you are a nurse who comes to that ward every day, there is an opportunity to really understand how that ward works and to get into the groove around how they deal with their safety issues on the ward. With junior medical staff you have got people rotating—interns rotating during different terms, our registrar population rotating through different terms—so it is a lot more of an environment where you do not necessarily have them there in any one place to inculcate and reinforce.

So we have got to look at cleverer ways of dealing with our junior medical staff. One of the things we are looking at doing now is a video that has a little bit more impact than perhaps being talked to in an induction where they are being overwhelmed with lots of information. We will follow that video perhaps with a little laminated card that gives them the key things they need to remember. Just to raise again their need to be vigilant as well.

**Ms JENNY LEONG:** What training do young doctors finding themselves in hospital settings—

**Ms CRAWSHAW:** They get training at induction.

**Ms JENNY LEONG:** How long is the induction? How long would you spend in the induction teaching them, for example, de-escalation techniques; how to deal with violent incidents in the workplace; how to report those incidents; and how to be aware of how to protect themselves and their co-workers?

**Ms CRAWSHAW:** They have access to the four-day training but a lot of them were not accessing it. That is why the one-day training that we have designed for the emergency department will also be very useful for them. That will be about eight hours that will provide them with a range of tools to help with de-escalating and vigilance with personal safety.

**Ms JENNY LEONG:** So currently young doctors who are working now—

**Ms CRAWSHAW:** They do work health and safety training.

**Ms JENNY LEONG:** What kind of training will they have had before they find themselves in that environment?

**Ms CRAWSHAW:** They will have gone through mandatory workplace health and safety training at the beginning of their start with NSW Health, but it would be a broad affair. It would not just be looking at violence and personal safety; it would be looking at hazard reduction around manual handling—manual handling is by far our biggest level of injury. So a range of workplace health and safety obligations. Annie, do you want to add to that?

**Ms OWENS:** One day of the four days, one-day equivalent, is around personal safety. That is the de-escalation—

**Ms JENNY LEONG:** How many young doctors have done that four-day course? I do not know what the numbers are. I appreciate that you are saying that there are these systems and these processes, but the Committee is also hearing that people feel as if there is not an expectation that people are trained. It is one thing to say that the course is available but it is another thing to ensure that everybody does it or is actually trained.

**Ms CRAWSHAW:** There is mandatory training. There is mandatory training around workplace health and safety when you become an employee of NSW Health that they would have done. I think my point was that there is a lot of mandatory training. There is a range of mandatory training in a range of areas, from child protection, workplace health and safety, so a number of issues. What we have thought is: we do not necessarily think that the message is coming through as clearly as it could because of the amount of information they have to absorb at that induction. That is why we are looking at what we can do to target that particular cohort of employees in particular. We agree with you that there is probably more need to have an impact with them than we are currently having.

**Ms OWENS:** One of the practical things about the proposal for taking that ED-specific training of one day and being able to break it into two-hour blocks, is that it is much more likely that all the populations will be able to access it. Further, when you have that population who have done that training in an ED it is easy to build that into the range of day-to-day events they are involved with. So they can practise together, they have all got the common knowledge of it. Instead of it just becoming whether or not they have done that training, it becomes something that is part of their everyday work in that environment.

**Mr DAMIEN TUDEHOPE:** Returning to the issue of the almost desensitisation of the workplace, if we just accept this, part of the other problem is the ease with which reporting is able to be done. The last thing a health worker wants to do is to have to take an hour aside to write up a report. How easy do we make it for health workers to provide reports so that you have an accurate picture of what is actually going on in emergency departments?

**Ms CRAWSHAW:** As I mentioned in my opening statement, we have got a new and improved incident management system coming along. The current system is more than 10 years old. At the time it was pioneering—pioneering because before that time never had we had systematic reporting of incidents, clinical or workplace health and safety, et cetera—particularly clinical. It was a pioneering system but it was a system of its time. It is very clunky and it did not give that level of feedback and ease of reporting, and fine reporting—being able to really mine the data in that system without it being a major manual exercise for a lot of it. At the moment, I do not think it is an hour—that would be an exaggeration—to fill in an incident report. It is more than not just filling the incident report in, but actually feeling that management has responded, and that is where, perhaps in some places, and again it is patchy—we are a big system and some places do it extremely well but there are places that do not have that level of feedback—and it is certainly not an automated feedback in the system. This new system will provide a level of automated feedback. That means it will really put the onus on managers to make sure that they are feeding back. At the moment there is nothing there that jogs a manager to feedback to staff—some managers do, some managers don't.

**Mr DAMIEN TUDEHOPE:** The figures appear to indicate that of the violent incidents that occur to health workers in hospitals, only about 10 per cent are in the emergency departments?

**Ms CRAWSHAW:** Yes.

**Mr DAMIEN TUDEHOPE:** Are you able to say how many of those incidents are drug related?

**Ms CRAWSHAW:** We have got some figures.

**Mr DAMIEN TUDEHOPE:** You have identified the increased use of ice as a problem.

**Ms CRAWSHAW:** We did. We cannot tell you how many are alcohol related. Anecdotally if you talked to our emergency staff they would still say the preponderance of intoxication that presents problems for

them remains alcohol related. I did have some figures, just bear with me. We have had this work done by the epidemiology department. Just to put it into perspective, we had 2,733,853 presentations in 2015-16 and of those, 81,355 were mental health presentations. There was a clarity of diagnosis that this was a mental health presentation. Sometimes, as you would appreciate, when people present at emergency departments their particular presentation does not always pick up that they maybe suffering from a mental illness or it is picked up later on down the track rather than at the ED presentation itself. Mental health presentations represent about 3 per cent, and drug-related presentations are 2,566. In those cases we have identified a presentation involving opioid, cannabis, cocaine, amphetamine, or benzodiazepine use. Again, that is 2,566 of 2,733,853, which is about 0.1 per cent. However, there is no question that people may not necessarily always get picked up in terms of drug intoxication. Where it is clear, it is in the order of about 2,500.

Our epidemiologists examined how things looked in 2009 and in 2016. Our drug-related presentations were 419 in 2009, and in 2016 of approximately 5,000 it is believed that 4,500 were drug-related or there was some level of intoxication involving drugs. Sometimes people present with a broken arm—that is, it is not a drug presentation but a physical injury—but the clinician manages to elicit that they have been under the influence of drugs. That is a twelve-fold increase; we have gone from 419 to 4,500 presentations in seven years. That may account for the perception that even though it is still not an enormous prevalence it is still a big increase. That does create the perception that our emergency departments have an ice epidemic on their hands because there has been a significant increase.

**Ms JENNY LEONG:** Has there been an increase in the number of emergency department presentations overall?

**Ms CRAWSHAW:** I cannot tell you what it was in 2009.

**Ms JENNY LEONG:** You have given the Committee raw numbers representing the increase from 2009 until 2012, but we do not have raw figures for the number of presentations.

**Ms CRAWSHAW:** No. As a nurse and doctor cohort in emergency departments, I was seeing 419 across the State. I am now seeing 4,500 across the State. That is a significant increase.

**Ms JENNY LEONG:** I am not saying that it is not. However, in terms of that—

**Ms CRAWSHAW:** As a proportion—

**Ms JENNY LEONG:** —being a proportional increase in respect of how many you are seeing. One of the things that has been raised is the increased stress in emergency departments, waiting times and other factors which can increase the workload for staff which can add to the escalation in this aggression and violence.

**Ms CRAWSHAW:** It can.

**Ms JENNY LEONG:** It would be useful if the Committee could get that figure.

**Ms CRAWSHAW:** I am happy to provide it. We have had a significant increase. We might be able to get it before end of this hearing. However, members should bear in mind that there is not the same level of staffing in 2016 as there was in 2009. There has been a major increase in staffing levels and a huge amount of work has been done in respect of different models of care in emergency departments. There is also backup for rural and regional emergency departments with telehealth. In addition, there has been some physical expansion of many emergency departments and many have been reconfigured or completely rebuilt. We cannot simply look at the presentations in 2009 and 2016 because a great deal of work has been done in that area.

**Mr DAMIEN TUDEHOPE:** We heard from a representative of the Health Services Union earlier today, who expressed some disappointment with the roundtable process. The union thinks that it has stalled. Is the round table ongoing and is further consultation being undertaken about the delivery of security services or preventing violence in health institutions?

**Ms CRAWSHAW:** That is an incredibly unfair characterisation of the process. I have taken the Committee through the 12-point action plan and our response to the security audit. We also have an $11 million capital works program under way as we speak. Preventing violence in our hospitals is not all about more security staff. We have been focusing on improving the professionalisation of our security staff. I refer to the security personnel as "staff". They are not guards; I do not even refer to them as "officers". They are members of our staff and are part of a multidisciplinary response. They are not the only response; on the contrary, they must work under the direction of the clinical staff. I have already mentioned the extra 30 security-related staff that we have included in the system.

Ms Owens is coordinating a professionalisation task force with the Health Services Union to deal with this issue. We have developed a policy and are ready to issue it dealing with authorising appropriate security

staff to be able to eject troublesome people from our hospitals on those rare occasions when they must be ejected. As I said, we have also responded to the Health Service Union's concerns about protecting staff under the Guardianship Act, which mirrors the Mental Health Act. We have increased the number of security staff, and we have conducted a three-day training module over and above the class 1 security licence training for health-specific environments. We are putting every security staff member or security staff-related member through that course.

**Ms OWENS:** By the end of last year, about 300 staff had completed that training, and by the end of this year they all will have completed it.

**Ms CRAWSHAW:** To say that it has stalled is a very unfair characterisation and I reject it.

**Ms JENNY LEONG:** I recall that the Health Services Union representative said that the round table had "contracted" rather than "stalled".

**Mr DAMIEN TUDEHOPE:** I think it was the same.

**Ms JENNY LEONG:** I believe that the concerns were raised in the interests of everyone working with goodwill in advancing the 12-point plan. The union may have said that the round table had contracted in terms of input rather than criticised it as being stalled. In the interests of wanting your area to work well with the union to advance the cause of protecting those health service workers—

**Ms CRAWSHAW:** We always work well together.

**Ms JENNY LEONG:** We do not want to cause tension.

**Ms CRAWSHAW:** It will not cause tension, but I will not accept that we are stalling. To be clear, I meet three or four times a year with the unions to update them on how we are going with the plan. I do not recall Mr Hayes being at the last meeting, but the Health Services Union is an attendee, along with the Australian Salaried Medical Officers' Federation of NSW, the Australian Medical Association, the Nurses and Midwives Association, and Unions NSW if my recollection is correct.

**Ms JENNY LEONG:** Thank you for your opening statement.

**Ms CRAWSHAW:** I can answer you—the 2008-09 annual report figures for emergency department [ED] attendances were 2,416,774, so even if we do it proportionally it has still gone up.

**Mr DAMIEN TUDEHOPE:** It is still about 12 per cent.

**Ms JENNY LEONG:** So there has been a focus on different types of technology and assistance reporting in relation to prevention because obviously the preference is to prevent these incidents occurring as opposed to dealing with any changes after they have occurred. In terms of emergency department staff, how much time would they have on a shift to engage in reporting of minor incidents, read up on changes in policy, protocols and practice? What time would they have on the shift that would not be front line doing their job in the emergency department? Where is the space that people report those low-level incidents? Where is the space for them to review changes in procedures or protocol, as you point out, and where is the time for them to open the box of duress buttons and distribute them? How much time do they have when they are not doing that front-line service to be able to engage in those preventative strategies?

**Ms CRAWSHAW:** If you are on an incredibly busy shift—but there are peaks and troughs and obviously when you are going through a trough you take the opportunity to do some of the other jobs, like in any job. With any job it is not dissimilar. There are mandatory training obligations and the nurse unit manager, for example, for nursing staff has to make sure that time is scheduled to enable those staff—for example, everybody has to go through the resuscitation training I think annually. They have to make that time to do it and they release the staff member to do it because they have to do it.

Similarly we have now designed a one-day equivalent multidisciplinary course in two-hour chunks where all the staff in an ED can practise together—security staff, doctors and nurses. We expect that to occur and we will be going out and making sure it has. With our security audit where we did the 20 security EDs and we did self-assessments on the others, one of the areas where we were very disappointed with the result was the level of compliance with the required training. That is one of the reasons we have designed this course with online resources and online components, as well as the face-to-face part of work that is factored into the staffing.

You are not expected to be in two places at once. I know the Nurses and Midwives Association might say nurses sometimes have to be in two places at once but nurse unit managers are required to think about what mandatory requirements are coming up for training and make time accordingly and staff accordingly for when

that happens. So I cannot say to you there is dedicated time on every shift. It does not work like that. Like any other job it is looking at staffing to a level that makes sure there is available time to complete the mandatory training and then when there is additional training required, for example, when they are upskilling in a particular area or when regional staff have to come to Sydney to do something, then they will backfill.

**Ms JENNY LEONG:** That takes care of the training element. What has become clear, as the Chair said at the start, is that there seems to be a level of acceptable aggression or violence or verbal abuse that happens that medical staff and staff in hospitals see as part of their job.

**Ms CRAWSHAW:** Yes.

**Ms JENNY LEONG:** We have also heard, on the other hand, that potentially there is a slightly cumbersome reporting process but that is on the improve, which is very good to hear.

**Ms CRAWSHAW:** It will become more automated for them. There will be drop-down menus that will make it easier to do things.

**Ms JENNY LEONG:** It will ensure that training happens on a systematic basis?

**Ms CRAWSHAW:** Yes.

**Ms JENNY LEONG:** But if you are rostered on a shift that happens to be a busy shift and a couple of incidents occur that do not mean you are taken out or have a physical injury but they are aggressive or threatening incidents that you would probably want reported so that you could then review practices and procedures, what time or space is there during a shift for those incidents to be reported?

**Ms CRAWSHAW:** I reiterate, implied in the staffing that you build in is a responsibility to fill in the required records. For example, it is the same as filling in a patient record. People do not see it as, "Well, if we get around to filling in the patient record we will." You fill in a patient record. It is part of the job. When you put staff on, you put them on on the understanding that there is a level of record-keeping in that role and you staff accordingly.

**Ms JENNY LEONG:** Do you think that there is currently an issue with under reporting of those more minor incidents in hospitals?

**Ms CRAWSHAW:** Okay. I think our physical aggression reporting where there is actual physical contact with staff is quite good. I think reporting that a patient swore at me is probably not particularly good and then it is a question of judgement as well for that individual staff member. You have to remember we have coming into our hospitals the most vulnerable people—people at their worst. They are in extremis often; whether they are psychotic or intoxicated or they are just extremely stressed and manifesting their stress in an angry and aggressive way. That is a picture every day of the week and our professional staff understand that.

I am not saying that they have to put up with inappropriate conduct but they also understand that in this industry you have to deal with people often at the lowest ebb in their life and it is part of what brought them to that profession and part of why they seek to help and lift those people. We have got to give our staff the tools in terms of resilience and de-escalation to make sure that if they have been sworn at, they know how to respond, bring it down, make it clear to that person it is unacceptable and ensure it does not happen again. I am not sure beavering away and filling in a report every time a patient was unpleasant would necessarily be a productive use of time.

**Ms JENNY LEONG:** To be fair, I am not talking about incidents where a patient is unpleasant; I am talking about what could be serious levels of threat or verbal abuse and one of the concerns I have had throughout this inquiry has been the fact that we seem to somehow put physical abuse on a higher level of seriousness than verbal or threatening abuse when in fact the levels of anxiety and serious personal impact that that kind of threatening behaviour can have on someone's ability to conduct their work arguably sometimes has more of a long-term impact. We have heard evidence in this inquiry as a result of those kinds of concerns. How would you see we could improve the level of reporting of those verbal and threatening incidents, obviously taking on board that a medical professional is going to have an understanding of what is a normal presentation due to the condition of the individual versus what is unacceptable behaviour for any individual to be subjected to in the workplace—not to say they will not continue their job but to allow procedures to be improved?

**Ms CRAWSHAW:** I would say that if you are talking serious threats, not rudeness and sometimes offensive language but really serious threats, they do get reported and we take it seriously and if it is an ongoing threat we will assist in taking out apprehended violence orders [AVOs], for example, if there was a real level of ongoing threat to a person.

**Ms JENNY LEONG:** Do you think improvements could be made in terms of the current procedures and policies to improve the reporting of those verbal abuse instances?

**Ms CRAWSHAW:** I think we make it very clear in our zero tolerance to violence that it includes verbal threats and intimidation.

**Ms JENNY LEONG:** Do you think there could be any improvements to how things are done such that there will be improved reporting?

**Ms CRAWSHAW:** It is in our current reporting but it will be clearer through drop-down menus in our new system that that is one classification or category of behaviour that is to be reported. The drop-down menu will include verbal intimidation and threats.

**Ms OWENS:** Can I add that I think your question goes to the environment in which people feel it is an appropriate activity to make the report. A lot of the work is about shifting that culture in a number of different ways to say your safety is as important as clinical safety. Some of the responsibilities you refer to are managerial responsibilities. Who is responsible for everyone wearing their duress alarm? Management is. When EDs are well staffed in terms of the management function the manager makes sure, firstly, that they are wearing the device. It sends the message that it is important, that it matters as much as anything else you are doing. It is part of changing the landscape so it is easier to make the report and people are more likely to do it. Some of these things take longer than others, but you have to shift the culture to say it is important.

**Ms JENNY LEONG:** I have one specific question as to whether you have thoughts on how it is handled. You mentioned apprehended violence orders [AVOs]. That was raised by a witness late last year. Do you have any thoughts on how it can be handled? It is particularly an issue in remote or regional areas where there is an emergency department. If there has been an AVO situation or an incident in that emergency department where a staff member has been subjected to an attack of some kind, verbal or physical, but that individual lives in the area and needs access to emergency services, do you have any thoughts or guidance for the Committee in relation to how we might handle that situation?

**Ms CRAWSHAW:** It is a very tough one.

**Ms JENNY LEONG:** Indeed, which is why I am asking you.

**Ms CRAWSHAW:** I came in on the tail end of discussions around file flagging in ambulance and we have file flagging. If you go to our zero tolerance policy—and it is worth a read by the secretariat on what we do have there—file flagging is such a device. Clinical staff can initiate it. There is more opportunity to do it. It gets back to your point about the extent to which our staff suck it up rather than saying, "Hold on a minute I am not going to suck this up." They are more tending to suck it up in a regional area where they know the person and they live in that community.

Certainly there are those options around flagging a file of a patient so that when you are dealing with them you can look at whether there is an opportunity to have another staff member available. It is again very difficult, and it would happen rarely, but you could not say that the possibility would not exist where somebody who has been a perpetrator of violence in the past in an ED, arrives at the perimeter, at a locked front door—locked now after our capital works program—and the staff member who perhaps in the past has been subjected to their violence is the one on duty in that small ED.

At the moment because of the changes we are making they will be able to look at CCTV. They will know who is there and they will be able to determine whether to open the door and let them in or not. That is an important extra piece of security we can give staff. If it is somebody where it is a situation where an AVO is out on that person or they have previous history with the person and are fearful they would be able to contact police or other assistance before they decided to open that door and let them in. Some of the physical safeguards and improvements are going to help. I agree with you. You can make improvements and you have to be thoughtful how you make those improvements in rural places.

**Mr EDMOND ATALLA:** I would like to follow on about the culture of reporting. I understand from previous evidence there is a culture of minor incidents not being reported due to time constraints of medical staff. There is a culture that they might be seen as wimps if they could not handle someone pushing them aside or verbally abusing them, assaulting them or intimidating them. That is why there is a lack of minor reporting, as previously indicated. I understand that you are upgrading the systems to make it easier for reporting. We heard evidence that the Nurses and Midwives' Association has developed an app to report incidents to the union rather than management. How will that work? The staff have limited time and now they have two reporting systems, one to the union and one to management. Why did the association need to develop its own app for reporting?

**Ms CRAWSHAW:** I do not know. Obviously the primary reporting is for staff. Not all staff are members of the Nurses and Midwives' Association, although they have a large membership. The reporting requirements are for us. The fact that the Nurses and Midwives' Association has provided an app to their members is a matter for them. Presumably they have done it in circumstances where they have no management accountability to respond to the incident. I assume that it is an opportunity to take it up with us. When there are incidents they are concerned about they do take it up with us. I am not overwhelmed with incidents from the Nurses and Midwives' Association but when they do take them up we respond if they have concerns. Anyone is entitled to do an app on anything. Staff have an obligation to report to us, not the Nurses and Midwives' Association.

**Mr EDMOND ATALLA:** I am concerned they have chosen this course of action because of the cumbersome reporting system.

**Ms CRAWSHAW:** We are a big system. One of the challenges we face in rolling out big information technology [IT] systems, which are IT systems we try and roll out, is the scalability of systems. When you have 140,000 employees and 200-odd facilities getting software that is readably scalable is a challenge. A lot of health systems are smaller and they put them in at a local level. We seek to have scale so we can report to the Ministry from the ground up and be able to look at things on a statewide basis as well as a local basis. That means that our IT systems often have those challenges of scalability. We have been successful in delivering IT systems at scale and we are intent on successfully delivering this system.

**Mr EDMOND ATALLA:** Is there a time frame?

**Ms CRAWSHAW:** We hope by the end of this year.

**Ms OWENS:** There is a pilot in March.

**Ms CRAWSHAW:** I think it is April.

**Mr EDMOND ATALLA:** Will all staff get training?

**Ms CRAWSHAW:** Of course. Just as with our other IT systems, there is always built in to the implementation plan training in the use of the system. It will be a more intuitive system so there will be much more help in drop-down boxes, less filling in manually descriptions of what the incident was about, you will be able to choose something and click on it. We are looking to improve things with that.

**Ms OWENS:** The other thing it will do is that all reporting will be on that system. One of the things that was identified in the audit was that sometimes security staff were not reporting on to the clinical system but had their own system. And that is an artefact of the separation of the different roles that we are doing a lot of work to bring together. The new system will ensure it is comprehensive of all incidents.

**Ms CRAWSHAW:** The current system does actually enable the reporting of all incidents. As Annie said, I think that is more a symptom of a mindset of security somehow being separate from the clinical staff rather than that multidisciplinary approach that we are really pushing.

**Mr EDMOND ATALLA:** Will you encourage management to have reporting as a priority?

**Ms CRAWSHAW:** Yes. One of the things when we put in the 12-point plan, and I felt that we needed to really lift a culture and get over any laissez-faire approach to personal safety—we have an organisation called the Health, Education and Training Institute [HETI] which is where we do a lot of our statewide training resources for the system. They are the ones that were charged with developing up the one-day equivalent course, in chunks of two hours, for emergency departments for violence managing aggression. We have a number of management courses, as you would appreciate, and training through that all the way through from front-line managers, nurse unit managers—we call it Take the Lead program—all the way to courses around training for senior leadership roles.

I asked, and they are and have been built into various management training, a beefed-up component around really pressing the workplace health and safety responsibilities, including managing aggression. I have to say they were there before but really beefing it up and reminding managers that they are actually officers under the workplace health and safety legislation and they have statutory responsibilities.

**Mr EDMOND ATALLA:** When you capture all the reporting are they put in annual reports or where do they go?

**Ms CRAWSHAW:** This is in the new world?

**Mr EDMOND ATALLA:** Yes, when your systems are up and running.

**Ms CRAWSHAW:** When our systems are up and running—as Annie said, it is a system that deals both with clinical incidents and workplace health and safety responsibility. So there are reporting obligations to SafeWork NSW. This will assist us with those reporting obligations to SafeWork NSW. There is a whole framework around clinical incident reporting. You will recall that under the Health Administration Act reportable incidents are privileged. The Clinical Excellence Commission is charged with being the custodian of that data, analysing that data and looking at how we can improve and, where appropriate, provide reports on trends et cetera in relation to particular safety issues that come out of the clinical data. It will provide resources for a range of reporting.

**Mr EDMOND ATALLA:** Will the quarterly Health report that is issued that shows waiting times in hospitals and so forth incorporate the number of incidents at particular hospitals?

**Ms CRAWSHAW:** I do not know whether it will incorporate the number of incidents in hospitals.

**Mr EDMOND ATALLA:** So we can see a trend or which area—

**Ms CRAWSHAW:** They do, if you go online and look at the website of the Clinical Excellence Commission there are a huge number of reports. I think they do six-monthly reports around some of that trend information but individual incidents themselves, clinical incidents, are privileged. You cannot have access to individual detail—that is all privileged under the Health Administration Act. WorkCover do public reporting as well.

**Ms OWENS:** We have requirements to report to WorkCover.

**Mr EDMOND ATALLA:** I understand those types of incidents to report to WorkCover but I am talking about once your new system is up and running, given minor incidents of verbal abuse, minor physical injury that will get captured. Will members of Parliament be able to look and see how the hospital is performing? Are these issues addressed? Will they be on a decline?

**Ms CRAWSHAW:** I do not think it will be a publicly available reporting system. It will provide data that will enable public reports of various kinds, just like any other of our data—we have an enormous amount of data—but it is not individuals being able to go through any of our data and just pull out—

**Mr DAMIEN TUDEHOPE:** There is a comparison with the education system. We know, for example, the number of assaults on teachers.

**Mr EDMOND ATALLA:** That is what I am leading to.

**Ms CRAWSHAW:** I did take you through the number of physical assaults and gave that data.

**Mr EDMOND ATALLA:** Is that public information?

**Ms CRAWSHAW:** I have made it public now.

**Mr EDMOND ATALLA:** Is it in a report that we can read?

**Ms CRAWSHAW:** The NSW Bureau of Crime Statistics and Research [BOCSAR] does reports by hospital and local government area of assaults and crime, do they not?

**Ms OWENS:** Yes, they do and that includes public and private hospitals. But the main purpose of the data is to inform, say at hospital level, the risk assessments that are done at the hospital to inform post-incident management, to improve the systems, to understand what the particular risks are at those hospitals and to use them in-house as a dataset to inform our practice rather than as a public record.

**Mr EDMOND ATALLA:** That is a matter for the Committee to consider at a later point. I refer to security staff whom you have labelled as "staff" and not as "officers".

**Ms CRAWSHAW:** Yes, I like to call them staff because I like to see them as part of the multidisciplinary team.

**Mr EDMOND ATALLA:** Are they on the payroll or are they contractors?

**Ms CRAWSHAW:** No, most of them are on the payroll.

**Mr EDMOND ATALLA:** The majority of security staff are—

**Ms CRAWSHAW:** The vast majority are on the payroll either as their role as a security staff member or we also have a classification called Health and Security Assistant [HASA] which is an industrial classification that enables an individual to have a security response but also to do other soft services work—perhaps cleaning or whatever.

**Mr EDMOND ATALLA:** Do those on the payroll have a security licence?

**Ms CRAWSHAW:** Yes, a class 1A. Anybody who performs a security function in our hospitals has to have a class 1A security licence. What I emphasised in my opening statement was that we have now, as part of the 12-point plan, commissioned TAFE to do a three-day health-specific security training course which is over and above the training to get a class 1A licence. We are putting all of our security staff, including our HASAs through that.

**Mr EDMOND ATALLA:** You can take this question on notice but do you have the number of security staff in the Health system?

**Ms CRAWSHAW:** We do.

**Mr EDMOND ATALLA:** I need a breakdown of percentage or number of contractors versus—

**Ms CRAWSHAW:** It will be very hard to provide contractors—staff are on the payroll so we can give you the payroll figures—but their engagement is done through fee-for-service. It would be very hard to provide you with contractors—

**Mr EDMOND ATALLA:** In terms of number of contractors—

**Ms CRAWSHAW:** In terms of numbers of contractors. But again our estimate—and we have done an estimate I think at the end of 2015 or the beginning of 2016 when we looked at the round table—it was less than 3 per cent, was it not?

**Ms OWENS:** The use of contractors can be up to 10 per cent. Our security staff is, at any one time, in general, around 1,100 full-time equivalent, of which roughly half are our health and security assistants and half are security staff.

**Mr EDMOND ATALLA:** Can you tell me the difference.

**Ms OWENS:** Yes. Both of them have a 1A licence, so they are both enabled to respond to security incidents. The health and security assistants may work much of their time as a cleaner or on another task in our back-of-house services. They have the licence so they are paid more than a normal cleaner, and they respond to incidents.

**Ms CRAWSHAW:** And they are trained to do that.

**Ms OWENS:** Security staff do only security work. That is part of what we are talking about in the professionalisation group about how that all works and how it will work in to the future. But they both have a 1A licence.

**Mr EDMOND ATALLA:** We have heard prior evidence that the security staff employed or engaged at the hospital are not necessarily specialised in dealing with health issues, because they come from a general security background. If that is not the case, and the staff are actually hospital staff, why are they not specialised? Why are they not given the training?

**Ms CRAWSHAW:** That is what we are doing. That three-day course that we have commissioned TAFE to do—that we are putting all of our security and HASAs through—is for that very issue. We decided we wanted to make sure that those who routinely work with us have the relevant training in a health environment.

**Mr EDMOND ATALLA:** When did this come in?

**Ms CRAWSHAW:** We kicked that off just before the 12-point plan, but it was incorporated into the 12-point plan. So we have been going for about a year and a bit.

**Mr EDMOND ATALLA:** So it is recent.

**Ms CRAWSHAW:** As Annie said earlier in evidence, by the end of this financial year?

**Ms OWENS:** By the end of this calendar year all of the current staff will have done that.

**Mr EDMOND ATALLA:** Security staff, yes.

**Ms OWENS:** We also have a group, at the moment, who are being formed that way, which is even better. That means that when they come in—they are going to be employed as HASAs or security staff—they will be doing all of their training with us, including to get the 1A licence.

**Mr EDMOND ATALLA:** That is great to hear. I will move on to the issue of CCTV cameras and monitoring. Prior evidence indicated that the use of CCTV is only relevant after the incident and not before. Are

there any intentions by NSW Health to use CCTV coverage as a preventative measure rather than as a reactive measure after the incident?

**Ms CRAWSHAW:** We do use it for prevention, as well. Rather than going through all of the policy, if you go to the Zero Tolerance Response to Violence policy—in particular our security manual—it gives you quite a deal of information around use of CCTV and when and how to use it. There are three areas where we use CCTV. We sometimes use CCTV in a real-time feed—constant monitoring—where it is assessed that the risk requires it. I have mentioned the perimeter issue. One of the biggest issues for us is in making sure perimeter security is there. I have talked about how you can remotely lock the front door. You can work out whether to let somebody in or out after hours in a small ED. Part of that can be through perimeter CCTVs, so that, for example, if somebody wants to get in you can look up and see who it is.

Then there is the use that you have alluded to, where it is up there for its deterrent effect rather than being utilised on a live basis. One of the things that I have said is that it stands to reason that we need the capacity, on all our CCTV, if necessary—even if you are not constantly monitoring it—to have a feed, so that if we did need to go and look at it we would have a feed. I am not, in any way, suggesting that it would be a good use of resources to have banks of CCTV and banks of security staff monitoring. It would not be.

The best device response is to have good duress alarms that the staff have on them and can let off as soon as there is an incident. That is the best response. So, yes, we put CCTV in, in these different ways, as the need arises, but duress alarms are the primary emergency response.

**Mr EDMOND ATALLA:** And you are going to make sure that they are rolled out?

**Ms CRAWSHAW:** CCTV is already out there.

**Mr EDMOND ATALLA:** No, I am talking about the duress alarms.

**Ms CRAWSHAW:** As part of that $11 million upgrade we are upgrading some CCTV. I am going to make sure of that CCTV feed. You should not just take the video and look at it after the event. Even if I am not looking at it all the time if there is an incident I should be able to go and look at it.

**Mr EDMOND ATALLA:** I understand. In the 12-point plan you have identified 20 hospitals that are going for the security audit. How were those 20 hospitals selected?

**Ms CRAWSHAW:** In consultation with the unions. We identified 20 hospitals where we thought there were physical incidents. There is a whole raft of risk factors. You look at the number of physical aggression incidents. We did a bit of a manual dive into the data that we have talked about. We looked at the crime rates in an area. The unions had an opportunity to say that there had been representation from membership around this.

The 20 hospitals were put together through a combination of risk assessment using our available data and what the unions felt should be included. As I said, the other 24/7 EDs—I think there are about 150 all up—were self-assessed. So we had a good self-assessment. The same sorts of criteria that our audit team looked at were then sent out, and the districts were asked to do that in respect of their 24/7 EDs.

**The CHAIR:** I must admit that as Chairman of this Committee I am impressed with the steps that you have taken with such a large and diverse workforce. I understand that a number of your programs are being implemented over time. When do you think you will be in a position—particularly with those 20 primary hospitals that you have done specific audits on—to be able to come back to us and say that what you are doing is working? When will you be able to say, "We have seen a fall-off in assaults of emergency workers," or "We need further strengthening here or there." When do you think you will be in a position to say that you are actually winning?

**Ms CRAWSHAW:** I think I have given the unions an implementation plan, and I am happy to leave a copy of the implementation plan—of the recommendations of the security audit—with you. All of the districts—including those who self-assessed—have local implementation plans that they have sent to us. In some cases we have not been happy with the local implementation plans and we have worked with the districts to get them up to scratch. So, every one of these places has a local implementation plan. There is also the broader implementation plan around the common issues. We used the security audit not just to deal with the 20 hospitals. It was a random sample, really, of the broader issues.

**The CHAIR:** Yes, I understand.

**Ms CRAWSHAW:** I will leave you with an implementation plan that you can look at. We are going to redo it. I think we will probably go back and do that in 2018-19. By that stage it gives them the opportunity to have done the physical design changes and to get the duress alarms in place—for example, as I have said, we are

making a $5 million investment in improved duress alarms but you need the back-to-base work. Now you would appreciate in rural and regional New South Wales you have not got wall-to-wall technicians available. Because of the work we are doing we have to queue it a bit to enable the technical staff in those areas to keep up with demand. I am sure we will be going back in 2018-19, certainly it will be time then to evaluate and make sure that there is good progress. I am certainly happy to leave you with a copy of the implementation plan..

**The CHAIR:** Thank you for appearing before the Committee today. The Committee may wish to send you some additional questions in writing, the replies to those questions will form part of your evidence and will be made public. Would you be happy to provide a written reply within five business days to any further questions?

**Ms CRAWSHAW:** Certainly.

**Ms JENNY LEONG:** I seek the indulgence of the Committee to pass on my absolute thanks, which I have not done publicly before, to the staff at Royal Prince Alfred Hospital. They were highly impressive. Unfortunately, my daughter had to go into the High Dependency Unit and I could not speak more highly of the people who provided that service.

**Ms CRAWSHAW:** Thank you very much.

**Ms JENNY LEONG:** Would you please pass that back in a positive way. They were the most impressive people I have ever interacted with.

**Ms CRAWSHAW:** It is wonderful to get good feedback. Terrific. I really appreciate it.

**(The witnesses withdrew)**

**(The Committee adjourned at 12:11)**