REPORT ON PROCEEDINGS BEFORE

LEGISLATIVE ASSEMBLY COMMITTEE ON LAW AND SAFETY

PHYSICAL HEALTH OF POLICE AND EMERGENCY SERVICES WORKERS IN NSW

At Macquarie Room, Parliament House, Sydney, on Monday 10 May 2021

The Committee met at 12:50

PRESENT

Mrs Wendy Tuckerman (Chair)

Ms Steph Cooke
Ms Tamara Smith
Mr Mark Taylor (Deputy Chair)

PRESENT VIA VIDEOCONFERENCE

Mr Edmond Atalla

The CHAIR: Before I commence, I acknowledge the Gadigal people, who are the traditional custodians of this land, and I also pay my respects to Elders of the Eora nation past, present and emerging and extend that respect to other Aboriginal and Torres Strait Islander people who are present. Today is the hearing of the Legislative Assembly Committee on Law and Safety inquiry into the physical health of police and emergency service workers in New South Wales. We have witnesses taking part via videoconference and also attending in person at Parliament House. The hearing is being broadcast to the public on the Parliament's website. I thank everyone who is appearing before the Committee today.

STEVE FRASER, Member, Health Services Union, and Paramedic, NSW Ambulance, affirmed and examined

TESS OXLEY, Member, Health Services Union, and Paramedic, NSW Ambulance, affirmed and examined

The CHAIR: Thank you for attending. Would either of you like to make a short opening statement before we begin the questions?

Mr FRASER: Yes, please. I will make a statement on behalf of the paramedics in the Health Services Union. The work of a paramedic is, by its nature, physically demanding and we have a 20 per cent rate of employees who have accepted workers compensation claims. That is one in five employees who are paramedics who have injured themselves on the job. That is 10 times higher than the average rate across the workforce. Over half of these are physical injuries and there is a serious failure to prioritise the health and safety of our paramedics. In first aid—those of you who have done first-aid courses—the priorities are DRABC; danger being the first one. The system does not allow paramedics to protect themselves from physical danger.

Constant understaffing results in paramedics being responded single and having to work single, in a job that is created and modelled for two people. The gym equipment that is supplied and provided gathers cobwebs as paramedics miss their meal breaks and work 14- and 15-hour shifts. Equipment to improve ergonomic safety, such as mechanical CPR devices and fully functioning lifting devices, are not prioritised in budget and fiscal planning. We still use lifting devices called carry sheets that I learnt how to use 40 years ago when I started as a paramedic, and we use them today—manual lifting that injures paramedics' shoulders and backs. When paramedics are injured, the opportunity to redeploy and alternate duties while they recover or as they change careers is almost non-existent in rural areas. COVID, if anything, has shown us that this does not have to be and working remotely is becoming more the norm than the exception. Chronic underfunding and a wages policy that labels physical wellbeing as productivity employment-related costs leave paramedics feeling more like disposable items than the professionals we are. Thank you.

The CHAIR: Ms Oxley, would you like to make an opening statement?

Ms OXLEY: No, thank you. Mr Fraser spoke for us.

Ms STEPH COOKE: When is a single paramedic deployed? You have just mentioned some of the issues in your opening remarks. What are the unique risks presented when that occurs?

Mr FRASER: We have what we call solo operators, such as extended care paramedics [ECPs] and motorcycle paramedics, who are trained and deployed on special occasions under very strict and controlled guidelines, and even they are caught out from time to time. But when we talk about single paramedics being deployed, it is when their partner has been unable to turn up for work due to sickness or illness or when there is a shortage on the roster due to another injury or workers compensation claim and it has not been filled properly, whether that be through overtime or adjustable rostering—basically, when someone turns up for work and for whatever reason their rostered partner is not there. Sometimes that is planned; sometimes that is unplanned.

Then when they are called out is the case of there being no-one else left to go. They will be at the station, the call will come in and there is a case of someone who has fallen, to give you a less severe example. Someone has fallen—"We will just send the single paramedic." That is okay because it is just someone who has fallen. They get to the house and they gain entry and there is an elderly person and he has slipped in the bathroom and is lying face down with a head injury between the toilet and the bath, and as a single paramedic you are not going to stand there and do nothing and wait until backup arrives. You are going to do something to get that person at least out of that position. They are the things where injuries are happening.

The worst case scenario is where there is a cardiac arrest. Someone's heart has stopped beating and a single paramedic is sitting on station waiting to be teamed up with a non-existent partner at this point and they are responded to the cardiac arrest. You have got to go, so you go and get there and have to start single-person CPR and it might be, especially in rural areas, 45 or 50 minutes. I think our case study in the submission shows someone that actually had their career ended by having to do that repetitive strain CPR for 45 to 50 minutes without backup because there is no-one arriving. The paramedic cannot protect themselves from that because they get there, they are sent there, they respond there. You cannot stand there and do nothing, so you have to get involved. You cannot just say, "This one is not for me." So they get involved and they get injured. Those are the type of circumstances where a single responder may well go. Even something as innocuous as someone who has slipped in the bathroom can be a devastating result for the paramedic.

Ms STEPH COOKE: Is that an example of what you said in your opening statement, that "the system does not allow paramedics to protect themselves"? Is that one example of the system that you are referring to?

Mr FRASER: Absolutely. Because, by the nature of what they do, paramedics are there and they put themselves in harm's way constantly as part of the job. This is a situation where a paramedic, through no choice of their own, is thrust into a situation where they are there and they are single. The system says we are to do a dynamic risk assessment and make sure that it is safe to conduct ourselves and safe to do that sort of business. But if you are there on your own, there is someone lying in a pool of blood face down and they are jammed in behind the shower screen or the toilet and you have to get them out of that situation by bending forward, we are not going to stand back and do nothing. That is not why we are in this job. So we put ourselves further into harm's way and end up being injured. The system puts us there, with no consideration other than to tick the box to say, "Oh, well, we have responded a resource on that job", and we have no choice but to act when we are there.

The CHAIR: I ask a supplementary question. So, basically, Mr Fraser, you are telling us that when rosters are developed there are usually partners that operate an ambulance or you work in pairs, but if someone calls in sick or something happens sometimes you have to then operate as a single paramedic?

Mr FRASER: That is correct.

The CHAIR: So it is not something that is deliberately rostered as a single paramedic? Unless there are special occasions on motorbikes or—

Mr FRASER: Yes, the only intention of those is what we call solo operators, to give that distinction. Where we get frustrated is when there is a long-term absence, whether it be sick leave or maternity leave or workers compensation, and it goes over the period of the roster and that absence is not filled because there is not any staff to fill it.

The CHAIR: Okay, so that is a whole different scenario as well. Just in regard to relief that happens as a result of someone pulling out of a shift for that day or the next day, is there a pool of paramedics that can relieve in that situation?

Mr FRASER: I might defer to Tess Oxley who has worked in deployment there and she can give you some more in-depth information.

Ms OXLEY: When planning on backfilling known vacancies on rosters we do try to use part-time staff and casual staff. However, their availability is dependent not just on what they have got going on in their private lives but also how many hours they have already worked during the work. They are limited as to how many hours they can work. After that we move to looking to see whether staff can be moved within their sector, before we go to overtime, which also then means that a single officer may be single for over an hour with different shift lengths and also travel time. That will be accepted before we are even able to look at putting an overtime staff member on, who could have started at the same station at the same time as that officer. Therefore, you usually end up with potentially two to three hours at both ends of the shift where you have a single paramedic and that is the high-risk time of when they are being sent out.

The CHAIR: You talked about the limits of hours that part-time or casual staff are available. What are those limits?

Ms OXLEY: Casuals are allowed to work three shifts a week. Anything over that they are then considered working a full-time roster, so they are only allowed to do the three shifts a week.

The CHAIR: Is a shift 12 hours?

Ms OXLEY: A 12-hour shift, yes. Part-timers are generally limited to whatever their contracted hours are. If they are only contracted to 12, we can ask them if they would like to do additional hours up to 38 hours in the week. However, they are not obliged to do anything more than what their contracted hours are.

The CHAIR: Okay, thank you.

Mr MARK TAYLOR: Mr Fraser, you mentioned a couple of scenarios which are common, like if you arrive on the scene and need to remove someone from danger or do some immediate action which involves lifting and moving, thus causing injuries. Are there any mechanical aids or items available out there to assist those single officers, or is your argument that really you need two people and that is the end of the story?

Mr FRASER: It is generally that, in terms of moving people, even with mechanical aids we tend to need two people to put them on, especially when you have to move from tight areas. But with two people there is that exception. When I referred to CPR or extended CPR when you are on your own, then there certainly is a mechanical aid or a multitude of mechanical aids—what they call mechanical CPR devices—that can be fitted by a single person and basically it does the CPR for that person. It can go for six hours until the battery runs out. Those devices are available. They are slowly creeping onto ambulances now, but we would like to see one on every ambulance. If you see again our scenario was a CPR-induced injury. You are only supposed to do two

minutes at a time of CPR—it is recommended by the Australian Resuscitation Council—and that is for the benefit of the patient not just for the benefit of the performer. But these machines will make that, if you like, career-saving in those circumstances. As far as moving people, it is still really a two-person job.

Mr MARK TAYLOR: So there are no training gaps in relation to those movements or those procedures? Is there an improvement for training necessary in assisting those scenarios?

Mr FRASER: Not to my knowledge. This is my fortieth year as a paramedic and I still have not figured out a way where you can move someone safely if they are, for want of a better term, a dead weight. Someone who is unconscious is very, very difficult to move on your own.

Mr MARK TAYLOR: I note in your organisation's submission on page 2 there is reference to the actual serious injury rate going down over the past five years.

Mr FRASER: Yes. We put that to the fact that there is a younger workforce. We put it down to the fact that people are being a bit more aware, and to the fact that we as a union have been fighting incredibly hard to stop single response, especially in regional areas. We have put mandates forward to make sure there is dual response. We are in a constant battle to minimise single responders and we think that has got a lot to do with it.

Mr MARK TAYLOR: So you think the reason that medical retirements as a percentage of injured workers has gone from about 5 per cent to 2 per cent is because of the lowering of the deployment of single units?

Mr FRASER: That is one of the factors. I think the other factor is there is a bit more awareness of self-protection. Paramedics are becoming more educated in the fact that they should be looking after themselves in these situations and not trying to be "a hero" and doing it on their own, and being a bit more self-aware.

Mr MARK TAYLOR: Like using different techniques, et cetera, or waiting for assistance?

Mr FRASER: Yes and sometimes learning to say, "No, I'm not going." That is becoming more common. But then you get the patient safety issue at the other end of that, so we worry about that as well.

Mr MARK TAYLOR: That is the same then with your medical retirements per thousand employees which has gone down from 10 to three as well over that time. So that is a decrease as well, is it not?

Mr FRASER: Yes and I could not give you a causation of that other than it seems to go hand in hand.

Mr MARK TAYLOR: Just to clarify, it appears as though the majority of the injuries, the physical injuries, are caused by "body stressing". So it is not being assaulted or turning up at a violent situation or something. It is a movement or carrying or lifting—body stressing. Are there other types of injuries in that body-stressing category that you are talking about?

Mr FRASER: That is pretty much it. The movement—shoulders, backs, knees and those type of injuries from having to lift, carry or move without being able to prepare properly. When you are taught to lift you are taught to keep your back straight, bend your knees, do all that. Well, sometimes you are pulling someone out from underneath a train, sometimes you are leaning forward to get to someone who is stuck behind a door and you cannot open the door, so it is not always possible. So, yes, it is that type of stress injury.

Ms TAMARA SMITH: I am really shocked. We recently had an inquiry into assaults on police and officers on shifts not being replaced was a big deal. Are you saying that, day to day, even for maternity leave, long-term sick leave and workers comp, officers are not replaced, or that it is hard to replace them?

Mr FRASER: I will go to Ms Oxley on that one.

Ms OXLEY: It can be hard to replace them, but also officers are not replaced above our 2010 staffing levels. Particularly in metro it takes a number of absences before staff start being replaced with those additional resources that we have. Instead we rely on staff movements, which leaves single officers quite a lot for extended periods of time.

Ms TAMARA SMITH: In regard to global staffing, in a regional area like mine there are not above-establishment officers to draw on?

Ms OXLEY: Very rarely.

Ms TAMARA SMITH: Can you comment on transport? In my area my ambos have told me that, for example, if one ambulance is doing a run up to the Gold Coast to transport someone, then you would not want to have a heart attack in Alstonville because there are very limited numbers of ambulance officers on duty.

Mr FRASER: Absolutely. Ambulance operates under what they term minimum operating levels. Minimum means exactly that. They were set in 2010—11 years ago. In the North Coast at the rural stations,

minimum means one, and one ambulance, a crew of two. We finally got to the point where we make sure that we have got a crew of two. But, as you rightly point out, when they head off to the Gold Coast, as we do often now—with the professionalism of paramedics we often make transport decisions that bypass local hospitals to get the patient to the hospital or the facility that has the correct response to them. In trauma, for example, we will bypass and go to the Gold Coast and that leaves places like Alstonville empty for hours at a time.

Ms TAMARA SMITH: It is something I do not talk to the community about because it is terrifying. It is a terrifying statistic and I am very glad that that is coming out in this inquiry. I have one more question. The carry sheets that you talked about—what are the carry sheets, sorry?

Mr FRASER: The carry sheet now is a plastic sheet that joins together in the middle and you slide it under the patient with a strap that runs out and joins the two halves. In my day—I am sad to admit—they were four wooden handles down each side about this long and the paramedics literally lifted. Now the handles are aluminium so we have come a long way. You actually lift with your body twisted and carry someone down the stairs. So you walk with your body twisted. You manoeuvre the person, who can be 100 to 120 kilos—four paramedics at best. Sometimes there are two of us, each holding one handle each carrying someone downstairs. It was a great piece of gear in 1980 because we had nothing else, but there are things like hover mats now. There are stair trackers. There are other means to do it but they are expensive so we do not have them.

Ms TAMARA SMITH: Thank you. I note all of your recommendations and support all of them.

Mr EDMOND ATALLA: Thank you very much for your submission and for all the work that the NSW Ambulance does. The statistics that you mentioned are astonishing. Twenty per cent of your workforce are on workers compensation. That is an astonishing figure; it is 10 times higher than the average industry spend. In your opinion, how can you bring down that figure? What do you think needs to be done to bring down that figure?

Mr FRASER: As we addressed in our submission, we think that the first step is to make sure that there are at least two paramedics on a job that can work together to move someone. There is also the fact that every time we do a job we are carrying in 24 kilos of equipment in terms of monitors, kits, oxygen equipment, oxygen cylinders to every job we are doing. We can rationalise that but I believe that is an internal issue that we can take care of. The other thing is ergonomic equipment that is modern and technical—instead of carrying someone down the stairs, investing in things like stair trackers that actually use friction and tracks to be able to roll people downstairs.

These things are all on the market, they are all available but they are very costly. The investment in that is not there. As I said in my earlier statement, that makes us as paramedics feel like disposable items. The nature of the work we do is difficult. It is a very dynamic environment. We cannot always plan for the way we address an issue. Sometimes we have to move fast and that means we have to put ourselves at risk. Having enough resources there, both in human resources and in proper equipment, would give us the chance to do that. It would just narrow that injury field, if you like, and give us a chance to do it without getting injured.

Mr EDMOND ATALLA: When a person is on workers comp, at what stage can that position be backfilled?

Ms OXLEY: The position can be backfilled when the rostered numbers for a sector fall below the 2010 operating levels.

Mr EDMOND ATALLA: How are they backfilled—with casuals?

Ms OXLEY: Yes, we have the part-time option—the part-time staff—casuals, and if there is anyone that owes shifts from shifts swaps. Only as an absolute last resort will an overtime staff member be placed onto that shift.

Mr EDMOND ATALLA: You have indicated some of your staff work 15-hour shifts. Is that permissible under the work and safety guidelines?

Ms OXLEY: Because of the nature of our work—if we get a late job or if there are delays—it is an unavoidable extension of shift overtime. However, we are finding that it is starting to become more routine now and that they are not the high-acuity urgent jobs that are pushing us into these extensions of shifts. It is becoming lower-acuity jobs but the high backlog due to Ambulances' inability to be able to resource enough crews to attend the calls that are coming in.

Mr EDMOND ATALLA: Do you believe Ambulance paramedics working 15-hour shifts are working in a safe environment for themselves?

Ms OXLEY: I think—luckily for patients we are trained—that we will always be safe towards our patients, but it is towards ourselves where things start to lack. It is where you start to lift without quite thinking

about if you are ready, where you make a quicker extrication plan to try to leave earlier, and where you are driving home fatigued. These are all the places that the risks come in. Fortunately for our patients we still operate at a high level of care for them.

Mr EDMOND ATALLA: You have indicated how you backfill workers comp paramedics. So where does the understaffing occur and why, if you are able to backfill?

Ms OXLEY: There are two things. One is that the 2010 levels are understaffed for what we require to be able to go out to the public these days. As Mr Fraser said, it is 11 years old. The numbers and the population changes have dramatically increased. The other thing is that as staff are becoming more fatigued and working these longer hours, it is becoming a struggle to be able to find the staff available to cover even overtime shifts. As you said, we have done 14- or 15-hour shifts; the last thing you want to do on a day off is come in for another 15 hours.

Mr EDMOND ATALLA: You are saying the benchmark that you use, 2010, is outdated and needs to be revised?

Ms OXLEY: Grossly outdated, yes.

Mr EDMOND ATALLA: Why has it not been revised?

Ms OXLEY: Funding.

Mr FRASER: That is a question we cannot answer. We have asked continuously. I believe we have got representatives in the NSW Industrial Relations Commission today asking for those to be revised. We can only assume they have not been revised because it means they would have to fund more staff to be on every day. That is our assumption as a union. We continually ask for it to be revised. With 2010, if you know and you are aware, in New South Wales and particularly metropolitan areas of New South Wales we have got very few extra ambulance stations and very few extra resources with the growth we have had. Even though we talk about the 750 new paramedics, the requirement to put paramedics on the road still predates that to 2010. Of those 750 extra paramedics, if 500 do not turn up on a particular day, they only still have to replace back what was there in 2010.

Ms TAMARA SMITH: The citizenry of New South Wales has increased by one million people since 2010.

Mr FRASER: And we are still working—so the ambulance service still says we only have to fill to the 2010 numbers.

Ms STEPH COOKE: One final question from me: Would better or different use of the patient transport service assist paramedics in what they do, particularly in rural and regional areas of New South Wales?

Mr FRASER: Absolutely, particularly in regional New South Wales—not necessarily for what we are talking about in terms of physical injury in that issue of emergency response, but certainly in that area of maybe having more paramedics available for the emergency response. Instead of having them tied up on low-acuity, non-urgent cases, those paramedics would be available to dual respond to that. To us in the Health Services Union, the patient transport service or the non-emergency service is a critical part of giving care and making paramedics available. Having said that, we have to be aware that they are also under physical stress. They are taking people home. There might be two of them, but they are the ones who have to take them back up the stairs and take them down long windy pathways and get them from the stretcher to their bed at home. Even though it is low acuity and they have got a little bit more time to be able to be aware, they have got physical stresses as well.

Ms STEPH COOKE: But presumably it would also assist in the fatigue management that you referred to earlier, in terms of 15-hour shifts et cetera, if patient transport was doing those low-acuity jobs?

Mr FRASER: If they were doing them 24 hours a day, yes. It is the after hours when there is the changeover and, as Ms Oxley pointed out before, at that end of shift you have done 12 hours and then two minutes before knock off there is a job that comes in. Because patient transport is finished—they do their day shift—if they became a 24-hour-type service, or at least midnight to midnight, it would make a huge difference.

Ms TAMARA SMITH: I ask one very quick question. The police in my area are really struggling with how much they are being asked to transport patients who are having acute mental health issues to hospital. Are you finding that as well in regional areas, that instead of acute mental health teams you are doing that?

Mr FRASER: Absolutely. As the health arm of the emergency services, the police tend to call us as well to help where we can. Sometimes they cannot get us because we are tied up doing other things. But, absolutely, mental health is resource heavy. Because once we do the mental health assessment and decide that

person needs a mental health facility, then, especially in regional areas, we go to a mental health facility and not the local hospital. Then we go with the two-hour, three-hour transfer out of town—there is no-one in town.

Ms TAMARA SMITH: You could almost say that in regional areas there is a higher need for numbers in terms of the tyranny of distance. It would be interesting to see what the numbers correlate to. It would be interesting to know what the 2010 numbers were mapped around.

Mr FRASER: That is it. Mental health issues have grown and they are resource heavy because they are a speciality. Then we have got the other issue that in 2010 the situation with what we call "bed block" or "ramping" was not the same as it is now with the heavier load right across Health. We have got ambulances that are in bed block or standing in corridors waiting, caring for the patient while they are waiting for a bed. That puts further drain on the resources that are trying to cope with the number of cases that come—

Ms TAMARA SMITH: Because you are responsible until they are admitted, is that right? Until they are in that bed—

Mr FRASER: That is correct. We care for the patient until there is a handover or a transition of care and we take care of that patient in the corridor, sometimes for hours, while they are trying to sort a bed.

The CHAIR: Just a couple of other questions; I know we are running a little bit late but I think this is important. You stated that the injuries for worker's claims are higher in this jurisdiction. How does it compare with other jurisdictions, and why do you think they are lower in other jurisdictions?

Mr FRASER: In our submission you will see that the national average of New South Wales is higher than the other paramedics. It is 13 per 1,000, whereas ours is 94.6 per 1,000, or 95 per 1,000. That is for paramedics—between New South Wales and, say, Western Australia. We are one of the busiest ambulance services. We are a highly populated State. We are busy. We are still operating under 2010 numbers for a 2021 population. I think that has got a lot to do with it. As far as the greater workforce, as I said in my statement at the beginning, we are a dynamic—it is inherently risky, what we do, because you cannot plan for it; because things change in an instant and you have to adapt to that; and because sometimes seconds mean lives. We often hurry and perhaps put ourselves at risk in that hurrying. The other side we spoke about was assaults. We are walking into the areas the police are and our members are also subject to assaults—and it is regular for paramedics as well. While we talk about those lifting injuries, we cannot forget that they are also getting punched, kicked and spat on at the same time.

The CHAIR: I ask a final question: When it comes to the physical health and fitness of paramedics, how is that monitored across their working lifetime?

Mr FRASER: It is not. You do a physical test, which has developed over time. But when I joined the ambulance service I was 19—I would have passed any physical test—and now the ambulance service has made me the man that I am today. Some people would say that is a physical wreck, but I am still kicking—I am still going. But in seriousness, no, it is not. It is really up to the paramedic to make sure they are fit, well and healthy, and as long as you turn up for work and you get in that seat you are pretty much right to go.

The CHAIR: Thank you so much for your attendance today and for the evidence you have provided. We may send you some further questions in writing and your replies will form part of your evidence and be made public. Would you be happy to provide a written reply to any further questions should they arise?

Ms OXLEY: Yes.

Mr FRASER: Yes.

The CHAIR: Thank you for your attendance, it is really appreciated, and thank you for your service.

(The witnesses withdrew.)

ANGUS SKINNER, Research Manager, Police Association of New South Wales, before the Committee via videoconference, affirmed and examined

KATE LINKLATER, Research Officer, Police Association of New South Wales, affirmed and examined

The CHAIR: Thank you, ladies and gentlemen, and I welcome the next panel of witnesses from the Police Association of New South Wales. Before we start, do you have any questions about the hearing process?

Dr LINKLATER: No, thank you.

The CHAIR: Would either of you like to make an opening statement before we begin the questions?

Mr SKINNER: Yes, we would like to make a statement. We thank you for the opportunity to take part in this inquiry. For the bulk of our opening statement I will hand over to my colleague Dr Kate Linklater. Dr Linklater joined the NSW Police Force in 1999, serving in roles across general duties, detectives and also research-based roles. She is now on a secondment at the Police Association. Dr Linklater's PhD research focused on perceptions and experience of difference and diversity in the NSW Police Force and therefore we have selected her as our representative for this Committee. I will hand over to Dr Linklater.

Dr LINKLATER: Thanks, Mr Skinner. Before I start I would like to acknowledge the Gadigal people, who are the traditional custodians of the land on which we meet today. I also pay my respects to the Elders past and present of the Eora nation. Thank you for giving the Police Association the opportunity to participate in this inquiry. Our members will be directly affected by its findings. The Police Association strongly supports strategies that are designed to improve the overall health and wellbeing of our members. This includes strategies that will assist them in maintaining their physical fitness. It is certainly the case that having officers in good physical health will be of benefit to those individual officers, the NSW Police Force and the general community. Good physical health is known to contribute to a reduction in the risk of injury, to improvements in mental health and to improvements in performance for some—but not all—policing tasks. It is our belief that encouraging officers to maintain their physical and mental health will also result in a reduction in time off work due to injury, reducing the costs of injury management and workers compensation.

Having said this, the Police Association does not and will not support imposing mandatory physical standards on our members. Doing this is likely to have negative and detrimental effects on the policing workforce as a whole. In a society where it is widely acknowledged that we need greater diversity in our Police Force, mandatory fitness standards will only serve to exclude people that may have valuable skill sets such as communication, problem solving, decision making and moral reasoning. This exclusion will relate to but is certainly not limited to women, older people and people with disabilities. We cannot endorse that. We acknowledge that there are some job roles in policing where fitness is important and standards are necessary. Those standards are already in place and we hold the position that they should always be directly relevant to the job tasks required for that role. Outside of those roles, there are other strategies that will assist in gaining the benefits of physical fitness for our police. The NSW Police Force already has some positive programs in place and we suggest that those can be built upon further.

Maintaining physical fitness takes time. When there is an expectation to maintain fitness outside of work hours, more pressure is placed on our members, especially those with childcare or other commitments. Our members should be given time on duty to maintain their fitness. This will also serve to build and maintain an overall culture of fitness in the organisation. If this is not possible, at the very least officers should be paid for the time required to maintain their fitness outside of work hours. Any fitness programs provided should be guided by best practice and include options for the officer to choose what is best for them. This allows officers to have some autonomy over their own physical health, which will also have mental health benefits. It is our hope that the recommendations put forward by this inquiry will look at physical fitness through a holistic lens, encouraging our members to improve their overall health in a supportive rather than punitive environment. Again, thank you for giving the Police Association the opportunity to speak to this inquiry. We strongly believe that an improvement in police physical fitness will benefit our members and the community as a whole.

The CHAIR: Your submission notes that New South Wales police officers are being injured more frequently and taking longer to return to work, although you note that this includes physical as well as psychological injuries. What are the trends in the rate of physical injuries?

Dr LINKLATER: Mr Skinner, you might be better to answer that one.

Mr SKINNER: The trends since roughly 2016 have been an increasing rate of instances of physical injury—mainly in body-stressing categories, I believe, off the top of my head. That data is publicly available so it can be confirmed that the rate of physical injuries is increasing. The major drivers from a cost sense fall more

in the psychological injury category, which is obviously not within the terms of reference of this inquiry. But that is not to say that reduction of physical injuries is therefore not important just because it is not the major cost driver. Any strategies that reduced physical injury would result in an experience of health benefit to injured officers. Regarding the return to work for physical injuries, those rates are, again, far more successful than return to work from psychological injuries. In the view of the association, we would see further improvement to return to work from physical injuries if there was more flexibility in designing roles for officers who are recovering at work or who have reached maximum medical improvement and greater input to return to work outcomes from structures within the Police Force, whose performance perks and performance metrics relate to return to work and injury outcomes—for example, the deployment unit.

Ms STEPH COOKE: This is a question for either of you. Among the existing programs within the Police Force, what targeted programs are there in relation to physical injury prevention? Can they be improved in any way, in your opinion?

Mr SKINNER: You would see that both our submission and the submission of the Police Force have referenced programs such as the RECON banner. Within that is reconditioning, restart and reconnect. That method of delivering services and treatment to police officers started out as an injury recovery mechanism and it still very much has that component. Given the success of that program, it did evolve into having preventative components within its service delivery, which again are successful according to—the Police Force references preliminary findings of an evaluation. In addition to that, the submissions reference Your Health First and some nutritional programs as well as the placement of physical training instructor [PTI] personnel within each command. The Police Force has certainly done a good job of coverage of the types of programs that a workplace might institute with an objective of increasing or improving physical health and physical fitness and translating that into desirable outcomes.

Where improvement could definitely be identified, though—regardless of those programs being seen as effective and well designed, that obviously has not translated into trend improvements at a scheme level. So evaluation of those programs at a program level rather than a high-level policy review would be able to identify how those programs could deliver better outcomes that translate into an experience at a trend level, so reducing injuries or achieving health outcomes that are desirable and that are set as a measure of success. We are seeing plenty of reviews at a policy level stating coverage of preventative, targeted and rehabilitative or physical health cover, mental cover, but there is a gap in evaluation at a program level. Yes, you have a program covering something that is necessary for an overall effective wellbeing strategy, but an evaluation at a program level of whether it is delivering outcomes that are needed to translate the trend experience is probably not as extensive as it could be.

Dr LINKLATER: I would also add to that and say with all those programs, it is helpful to have those based on the evidence in front of us. So if there are particular types of physical injury that officers are prone to, then any of those physical fitness programs or anything like that need to be geared towards what those injuries are. We cannot separate psychological health from physical health; they are intrinsically linked, we know that. There is a lot of psychological injury within the Police Force, so we need to think about what the evidence is that will help police get better or to not get those injuries in the first place.

Ms TAMARA SMITH: Were you on the other inquiry?

Dr LINKLATER: Yes.

Ms TAMARA SMITH: I thought you were familiar and I was not losing it. When you were saying that, I was thinking that in the context of the inquiry into assaults on police, you would have to say that they are looking at systems things that impact on the physical and mental health of officers. I think that has come through in your submission. I am hearing that the association does not want to set a mandatory physical fitness level and that modern policing does not require that. Is there a requirement for ongoing physicals for officers at all anymore?

Dr LINKLATER: Only in particular job roles.

Ms TAMARA SMITH: Such as diving and—

Dr LINKLATER: Diving or the tactical operations, that kind of thing.

Ms TAMARA SMITH: But it is not the case for ordinary policing.

Dr LINKLATER: No.

Ms TAMARA SMITH: Could you say a little bit more about what the association would like to see? What would it look like to have officers able to have a workout while they are on shift? Maybe that is the wrong way to put it given the awful situation of officers not being replaced. The recommendations of this Committee

were around staffing in particular and it is unacceptable that officers are not replaced for maternity leave and long-term sick leave and all that. What would be the model that you might look at in terms of how an officer would be able to maintain their fitness on duty and be resourced to do that? What might that look like? Have you thought about that?

Dr LINKLATER: I think it would be different for every command. It would not be a blanket strategy because obviously if they are at a police area command [PAC] where officers are working general duties, they still have to meet first response.

Ms TAMARA SMITH: Yes.

Dr LINKLATER: But we also have a significant amount of the workforce that does not work in first response, so it is possible for them to go to the gym or do some kind of physical fitness on duty. To say that we have a blanket solution to everything is probably not true, and it would need a lot more work to think about rostering and being a little bit imaginative in how we do that. Like I said in my opening statement, maybe for some commands that is not possible but I would suggest that for a lot it is.

Ms TAMARA SMITH: If the commands are given that brief and it is legitimate—is it considered in police culture that it is legitimate now?

Dr LINKLATER: Physical fitness?

Ms TAMARA SMITH: Yes, or for officers to train while they are on duty if they can.

Dr LINKLATER: I think it depends on where they are based.

Mr EDMOND ATALLA: In relation to officers that are on workers comp, do you have some statistics? What percentage of the workforce are on workers comp?

Mr SKINNER: As in a live claim, are off work or are—

Mr EDMOND ATALLA: Due to workplace injuries. For example, the evidence from NSW Ambulance said 20 per cent of their workforce are on workers comp. I want to get a figure from the police perspective.

Mr SKINNER: I suppose there are a number of ways—on workers comp could mean currently on claim but that does not necessarily mean they are not at work. Also, does that mean at any point in time on one day how many are off work and on claim versus across a year and how many claims and how many spend time off work? It might be something that I have to take on notice to answer accurately, but that information is certainly available depending on exactly how you would like that expressed—whether it is at a point in time, how many are on claim, how many are off work.

Mr EDMOND ATALLA: Basically, I want to get a feel for the understaffing levels—people who are off duty due to workplace injuries and not backfilled, which leads to the understaffing of police officers. What percentage of positions are vacant as a result of workplace injuries?

Mr SKINNER: Okay, I can provide that on notice. Off the top of my head, I know that generally commands have a headcount versus authorised strength sitting at roughly 90 per cent, but that obviously does not entirely encompass your question. Then it would be further influenced by short-term sick leave and short-term injury, but I will take that on notice and get back to you with an exact answer on the absences due to workplace injury.

Mr EDMOND ATALLA: Thank you very much. Do you have any information on the average length of service of a police officer in New South Wales? What is the average length of service?

Mr SKINNER: That is something you would have to ask the NSW Police Force for. I would imagine we would have that available. The categories of length of service used to be reported on at a point in time but again, is that length of service from start of career to when they end or current length of service for officers who are still in the Police Force?

Mr EDMOND ATALLA: Generally you would have a figure to say the average length of a police officer on service could be X number of years based on the average employment length of each officer who is currently serving.

Mr SKINNER: Okay, that is not something I have to hand right now. It is something that the Police Force would be able to answer and I can endeavour to see what information we have on that from our end as well.

Mr EDMOND ATALLA: I will ask the Committee staff to take note of that question to be followed up. I have heard some of my colleagues talk about physical training on the job and so forth. How do you measure the physical fitness of police officers? Do you measure the fitness of police officers on a regular basis?

Dr LINKLATER: Currently, when an officer is recruited, they are required to meet a particular standard. That is listed in the NSW Police Force submission. But as they go throughout their career, unless they go into particular job roles that have particular standards, there is no requirement for them to be tested.

Mr EDMOND ATALLA: So there is no requirement, other than those specific jobs that you have indicated, for any police officer to be assessed for physical fitness?

Dr LINKLATER: That is right.

Mr SKINNER: There is a process in certain circumstances for officers to be referred for an assessment based on fitness for duty assessments. But that is only when it relates to the potential that there is an unfitness for duty. It is not systematically applied across the workforce. There is no requirement applying to all police officers that would mean that they participate in a fitness test or a health check periodically through their career. There is a voluntary one, which is the Your Health Check referred to in both our submission and the Police Force submission, but no requirement that the whole of the workforce do so.

Mr EDMOND ATALLA: Would a regular police fitness test be something that the association would support?

Dr LINKLATER: No, it is not. There is a couple of reasons for that. We believe that a mandatory fitness standard places undue stress on officers in terms of time outside of the workplace. It is likely to exclude those officers who are not naturally able to do those particular physical tasks. For instance, if we have women, older people or people with disabilities, if we have mandatory fitness standards placed on them, we are actually creating more exclusion instead of inclusion within our workplaces.

The CHAIR: Could you see any benefit at all of having physical medical checks during an officer's lifetime? It does not have to be mandatory.

Dr LINKLATER: Those things are in place. Do you mean mandatory?

The CHAIR: Voluntary.

Dr LINKLATER: They are in place at the moment.

The CHAIR: Not so much a requirement, but just a general wellbeing check-up.

Dr LINKLATER: My understanding is that the NSW Police Force has those things in place. Officers can go and get their health checked.

The CHAIR: On a voluntary basis though?

Dr LINKLATER: Yes.

The CHAIR: Do you know the take-up on that?

Dr LINKLATER: I do not know that.

Mr SKINNER: Again, the Police Force submission contains reference to the total number of officers that have participated in a program called Your Health Check. That is a program where nurses attend work locations around the Police Force and offer a basic health check service for those who choose to participate. The NSW Police Force submission has an overall figure—the total number of officers that have participated. From memory, I believe it was in a period of roughly five years that there had been 11,000 health checks of roughly 7,000 to 8,000 individuals. So obviously some have participated on more than one occasion. That would indicate that there is at least a fairly significant cohort that are choosing to participate in that health check. We think that that health check is a beneficial program. Again, whether it has translated into improved health for officers or reduced injury or time off work measures is something that, according to information presented to us, has not been formally evaluated. We do believe the program is beneficial. Officers like it. Obviously a large cohort choose to participate in it. But there could be further evaluation that might assist in improvements to that rollout.

Dr LINKLATER: The NSW Police Force submission says that since 2014 they have completed 11,070 assessments on 7,720 individual police.

Mr MARK TAYLOR: You conduct mandatory physical testing for some of the specialist roles. What is the rationale behind that?

Dr LINKLATER: My understanding is that that physical testing is more linked in with the job tasks that they have to do. So for police divers, they have to do particular physical assessments that are linked in with the physical occupation that they have. It is the same with tactical operations and that kind of thing. To impose a

mandatory fitness standard on someone who has a desk job or something like that seems a bit counterintuitive to me.

Mr MARK TAYLOR: It would have to be in line with the scope of their role. Obviously, someone doing a desk job may have to carry a box or something. That might be the limit of the physical interaction. But someone in general duties would have a different scope as well, and someone in a specialist role would have a different scope again. Are you saying that you would not support point-blank mandatory testing for someone in a general duties role?

Dr LINKLATER: I would say that if that was something that the Committee was looking at, I would strongly suggest that it was very much evidence based on the role that that officer was actually doing and that it was very much about a preventive measure.

Mr MARK TAYLOR: So as part of an overall package. I would not suggest that you fail the fitness test and you are out. Obviously it would be part of some form of package that you undergo a test to identify some possible areas of improvement to assist you in doing your role. That could be combined into an overall package, whether it is training on duty, whether it is diet or nutrition or something along those lines. Would the association see something along that package? I just note that in your submission there seems to be a point-blank line in the sand, "No, we are not having it."

Dr LINKLATER: I have an issue with having a mandatory fitness standard where we might have someone who is my stature up against a six-foot-five guy who is obviously going to be able to do strength-based training better than what I can naturally. So from a diversity perspective, I feel that we need to be very careful about how we impose standards and how we say, "Right, you need to be able to jump over a six-foot high fence." That is fine if you are six foot five, but it is not okay for someone like me who has to train really hard to do that. So when we have got people who potentially have childcare issues at home or childcare commitments at home where they do not have the time to do the same fitness as someone who is a 19-year-old single person, are we actually creating more problems than we are solving? That is my issue.

Mr MARK TAYLOR: When you say you are coming from recruiting you undergo a physical test—I am unsure whether there is differences in those tests or whether they are the same test. But certainly, within a couple of months you are out doing your tasks. You may be doing those same kinds of tasks in 10 years' time as you were doing after six months' time. One would assume that you do need some form of standard because there is a reason why they are there in the first six months. How come they are not there in the last 10 years? I do not understand the line in the sand. Are you saying that you would consider some form of package around preventative or assistance or progression?

Dr LINKLATER: Perhaps the line in the sand is not—

Mr SKINNER: If there was a proposal put to us that had fully formed those concepts where there might be an assessment and then does not result in any adverse actions depending on the outcome of that assessment, and it therefore meant there is advice on the areas of improvement and you now have the facilities and time on work to address those areas, it is something we would consider. But, yes, I think what we have referred to is we would not abide by a standard whereby there is a test and if you fail it is your own responsibility to make physical fitness standards imposed by a workplace and then no provision for support, advice and time to meet that standard or to rectify deficiencies when you are assessed in that standard. That is something we would not consider. But if something that did involve advice and on-duty training was proposed, we would obviously consider that. It is not something I could answer conclusively now without seeing how it would operate.

Mr MARK TAYLOR: It would be similar to a number of other employment programs that you would have in any organisation, for example, if you were lacking academically or legally. You would be given assistance to come up to the required standard in the tasks that you need to perform the job. At the end of the day, I suppose we are talking about not only your own personal safety but those of your colleagues and those of the community, aren't you, if you reach the appropriate standard, whatever that appropriate standard is?

Dr LINKLATER: Perhaps another thing that we might think about as well is, if we are going to raise fitness standards or if we are going to put standards in place, we also need to take into account what are the key things that a police officer needs and physical fitness is one of many things that a police officer needs. It is not to say that that is not an important thing. It is one of the many important things that they need, like communication skills, decision-making, strategic thinking, those kinds of things. If we place too much priority on one of those things we potentially are losing out in other areas. That is probably something also to think about. I guess the mandatory fitness standards—the line in the sand, yes, it sounds quite solid but, like Mr Skinner said, if we are looking at preventive evidence-based things, we can look at that.

Ms TAMARA SMITH: I wanted to echo the evidence that you gave in the assaults on police inquiry. Most physical injuries that police sustain are related heavily to assaults. I guess the question is: Does physical fitness in any way prevent those assaults? What we did see in that inquiry was a range of other skill sets that are required. This inquiry is about physical health. Do you see any relationship between physical health and prevention of assaults?

Mr SKINNER: It is true to say that there is a large cohort of physical injuries that occur in the context of things like arrests or use-of-force incidents or assaults on police officers, and there is evidence in the research literature that physical fitness can reduce some instances of those physical injuries in those types of contexts. I think what we would say is that should not form such a strong conclusion that means that imposing a physical fitness standard, presumably one that would be above what some members of the Police Force currently are because otherwise it does not reflect the change—the proposal that there be a physical fitness standard is assuming that that standard would be above what some people are, because otherwise why would you do it? That assumption that that increased fitness will address the problems that are identified cannot be universally assumed. It will prevent some injuries that occur in arrest incidents but it also potentially skews the skill set of the workforce if you are providing increased requirements to increase fitness or increased recruitment weighting on physical fitness. It does not necessarily lead to a loss of other skills but it certainly could if it is ill-considered.

Therefore, just as you could avoid injury in your context of assault police by increasing the physical fitness of police officers, you could also avoid injury by emphasising those other skill sets that might avoid use of force in the first place. An assumption that physical fitness will cure those injuries should not be taken to a degree where other skill sets do not receive the priority they deserve. The reason why we might be coming across as sort of hard line in the sand opposed to that standard is that it is that sort of assumption which creates a big difficulty in returning officers to work, which is a major priority for all of New South Wales—every workforce in New South Wales—including the NSW Police Force very much so. An assumption that every police officer needs to be able to perform the following list of tasks and those tasks require a certain physical fitness standard, that is a big barrier to returning injured officers to work. There is a lot of injured officers who could perform a large range of the tasks that an officer may be required to do. They should not be prevented from returning to work just because there is a short number on that list that would be more challenging with their injury restrictions.

It is from that perspective and that motivation that we are trying to encourage flexibility to how you use the skill set of a workforce to address the work demands or the risk incidents they might encounter rather than the assumption that physical fitness is the only mechanism by which they could do so. That is why we would support anything that increases physical fitness but not in a way that punishes officers who for whatever reason have difficulty meeting it or skews the skill set of the workforce that would otherwise be present if there was not an increased emphasis on physical fitness.

Ms TAMARA SMITH: Like a return to suitable duties. There is a nexus between this sort of idealised image of a police officer being a superhuman with way above average physical strength and stamina and all of those things, and then over the life of an officer. You are saying that there is a range of duties in modern policing that support both ends of what you just described.

Mr SKINNER: Yes.

Ms TAMARA SMITH: Does the culture accept suitable duties? Does the culture accept a range of skill sets once you are well into your career?

Dr LINKLATER: I would suggest that the way that competency generally—and not just in relation to physical fitness—within the organisation is based on everyone being the same. That encouragement of different skill sets—speaking a second language or something like that is not seen as extra competency, it is just seen as something else. Everyone still has to meet those exact same standards, and having something like a second language does not go towards you being seen as just as competent as everyone else. That is what came out of my research.

Ms TAMARA SMITH: Thank you. Very interesting.

The CHAIR: Thank you very much for providing your evidence today. There may be an opportunity that some further questions may be asked in writing. Your replies will form part of your evidence and may be made public. Would you be happy to provide written reply to any further questions?

Dr LINKLATER: Yes.

Mr SKINNER: We would.

The CHAIR: Thank you so much for your time; we very much appreciate it.

(The witnesses withdrew.)

BORIS FEDORIC, National President, Australian Society of Rehabilitation Counsellors, before the Committee via videoconference, affirmed and examined

BERNADINE EUERS, Chief Executive Officer, Australian Society of Rehabilitation Counsellors, before the Committee via videoconference, affirmed and examined

The CHAIR: I welcome the next panel of witnesses from the Australian Society of Rehabilitation Counsellors. Would either of you like to make a short opening statement before we begin the questions?

Ms EUERS: Yes, please. I might start. Firstly, I would like to thank the New South Wales Legislative Assembly Committee on Law and Safety for undertaking an inquiry into the physical health of police and emergency services workers in New South Wales and for inviting the Australian Society of Rehabilitation Counsellors to appear before the Committee today after receiving our submission. The purpose of my opening statement is to reiterate a few points about the Australian Society of Rehabilitation Counsellors, and I will use the acronym ASORC. We are the peak professional body representing the profession of rehabilitation counselling. I also highlight the unique knowledge and skills required of a rehabilitation counsellor and ASORC full member.

ASORC represents and advocates for rehabilitation counsellors throughout Australia and has been doing so since it was established in 1976. ASORC's mission is to promote the profession of rehabilitation counselling and continually develop and advance the professional capability of our members. Our rehabilitation counsellors work within a counselling and case management framework, applying a holistic approach across the biological, psychological and social domains when considering the health of an individual. In addition, rehabilitation counsellors possess advanced skills in personal counselling, vocational assessment, vocational training, job placement, case management, injury prevention and management, service coordination, and independent living planning.

In order to practice as a rehabilitation counsellor in Australia, a tertiary qualification is a mandatory requirement, and ASORC full members hold tertiary qualifications typically obtained at a postgraduate level in rehabilitation counselling and an undergraduate degree generally in psychology or behavioural science. They also must demonstrate competency in the five clusters of the ASORC competencies, which are aligned to the domains of knowledge, skills and behaviour. They must sign mandatory declarations around ethical conduct and adherence to the ASORC code of ethics and ASORC constitution, and maintain their professional knowledge of the skills by completing a minimum of 20 hours of continuing professional development [CPD] annually. These four aspects ensure that ASORC full members have a deep understanding of the impact of disability, health conditions and disadvantage on a person's life, especially the importance of work and education in attaining inclusion and fostering independence and self-esteem. Consequently, rehabilitation counsellors are highly qualified to provide services that are often not in the repertoire of other allied health professionals.

In summary, the professional standards of ASORC reflect the skills, knowledge and behaviours deemed to be integral to the performance of rehabilitation counselling services in the diverse Australian settings in which rehabilitation is now provided. ASORC strongly believes that rehabilitation counsellors are required for the complexity of work related to police and emergency service workers. I will now turn to the ASORC National President, Dr Boris Fedoric, a practitioner and expert in the field.

Dr FEDORIC: Thank you, Ms Euers, and thank you, everyone, for the invitation for ASORC to put forward our submission. Just in a practical sense, continuing what Ms Euers said, as rehabilitation counsellors we primarily see people when they have some sort of an injury or incapacity for work or their everyday living. We are regularly used by government organisations such as Comcare, the Department of Veterans' Affairs [DVA] and other State regulatory bodies in compensation settings; therefore, we know what issues do lead to workers compensation or injuries in general. From the physical health perspective, there is a large body of evidence to show that physical health—and we have heard it before as well—and mental wellbeing are closely linked, which really in turn plays a significant part in health in general and then the social effects downstream.

We call that in our practice the biopsychosocial effect and, as rehabilitation counsellors, we provide therapeutic interventions by using counselling skills in the context of the physical, psychological and social health and, in addition, in the context of work, careers, life and leisure. Therefore, we are uniquely positioned to have a preview of one's entire life domain in the context of our practice, not just the physical or psychological injury in isolation. We also coordinate services and bring all of these stakeholders together and, therefore, our skills are broad but, at the same time, specifically geared towards individuals' health and participation in activities, where that be work, community or life in general. The biggest problem is that we are called a little bit too late once the injury has already occurred, and then you go through the whole workers compensation side of things. Our

members and rehabilitation counsellors have been involved in prevention and early intervention. This is where we saw a far better outcome for people in their health in general.

However, we are not accessible via Medicare nor have the Australian Health Practitioner Regulation Agency [AHPRA] endorsement and we are only seen in a compensation setting. We strongly believe that if one of the recommendations could be the consideration of the use of rehabilitation counselling in providing services for first responders on Medicare and have the APHRA board endorsement, that we will be readily used by GPs and other allied health providers to work closely in the system in navigating the medical rehabilitation or wellness in general towards the specific work task and focus on prevention. And at the end we know that the frontline workers and people in general will go to their doctors or allied health providers but not necessarily work closely with their employer on their health concerns, and this would have a huge benefit not only on the frontline workers but also on the organisation. Thank you very much.

The CHAIR: Thank you, Dr Fedoric. Questions?

Ms TAMARA SMITH: Thank you so much, Ms Euers and Dr Fedoric. I was just thinking about your last comment, Dr Fedoric, that your allied health professionals are highly qualified. What I have seen missing in the past in other work that I have done is that when an injured worker is returning to work the employer is kind of their person, which in many ways represents the boss; and then there is the insurer, and they have got their return-to-work officer, which very much is about the insurer and the money; and then you have got the injured worker. Apart from the union, I can see a lot of benefit in your role in terms of if it was something that you could go to your GP and you could access through Medicare a practitioner who is your person, in a sense, who is assisting you. I guess that is just really a comment. But I was fascinated by the points that you had about poor workplace culture and, in particular, poor systems to assist with return to work, and lack of suitable alternate duties.

I am not sure if you heard the Police Association submission before you, but this idea of suitable duties in the context of policing, in the context of ambulance, is tricky. I suppose with DVA, similar but different—I guess longer periods of not being on active duty. But do you have anything to say about what is your evidence to say that you should get back to work as soon as possible, for example? Could you comment on that?

Dr FEDORIC: I think just going a step back—and certainly we heard the previous speakers as well and I think our comments kind of resonate with them too. In identifying suitable duties, yes, there is always a complexity. I think I made a comment earlier that if we are accessed by other means rather than the compensation and insurance setting, that would certainly provide that further independence, or at least perceived independence, in a whole context, because quite often we see that you have been engaged by the insurer or something like that and then straightaway the injured worker takes sides, whereas that is not the case when you are independent; it is just how the legislation schemes are set up. Definitely in designing suitable duties there are complexities, whether it is physical complexities, biosocial complexities. Navigating that really comes down to the education of all the parties.

One of the primary roles that we do in our practice is essentially mediate—mediate the outcomes and negotiate the best possible suitable duties based on that particular individual. As I said before in my opening statement, we do collaboratively work with all the stakeholders, being treatment providers, physiotherapists, psychologists, GPs, and we bring them all together and we explore all the physical, psychological and social issues and then determine altogether, being that inclusive with the first responder, whether it is suitable to return to work. Then, when that is the case, we will work with the employer to try and carve out those suitable duties. And certainly what we said before—I think there is a bit of a confusion around what is normal and what is functional.

You can still have the functional capacity and go to work and do your job, but not necessarily have, for example, a normal range of movement or normal Depression Anxiety Stress Scale [DASS] scores or so forth. So it is important to have that dialogue and have a person-centred approach when returning somebody to work.

Ms TAMARA SMITH: Frontline workers in emergency situations, what we are hearing—certainly what we heard this morning with the Ambulance—is that paramedics are responding to life-or-death situations, so I would have thought that it was quite limited, what "functional" might look like in their setting. But I hear you.

Dr FEDORIC: Just a comment that was made by the Ambulance speakers today—I think a comment was made, and I wrote it down: "It makes us Ambulance workers as a disposable item", and I think that is a very clear comment of biopsychosocial issues that our practitioners will be faced with continuously. That resonates. If somebody is not happy to return to work then why would you? And that is where you have that downstream effect where if you are not returning to work as quickly as possible, just because the environment is not really suitable, then that leads to resourcing issues and so forth.

Ms TAMARA SMITH: Thank you.

Mr MARK TAYLOR: I do not know if either of you are able to answer this question but do you have any experience or data or knowledge about comparing New South Wales police or emergency services compared to other jurisdictions or do you know of some jurisdictions which you consider are doing, say, a good job?

Dr FEDORIC: No. That is certainly something that we can take away and ask our members, because we are a national organisation and we have members all across Australia. We can certainly come back to you with something like that. No, I do not know any data off the top of my head.

Mr MARK TAYLOR: Thank you.

The CHAIR: If there are no further questions, thank you so much for appearing before us today. We may send you some further questions in writing. Your replies will form part of your evidence and may be made public. Would you be happy to provide written replies to any further questions that we may have?

Ms EUERS: Absolutely.

Dr FEDORIC: Absolutely.

The CHAIR: Thank you so much for your time. It is very much appreciated.

(The witnesses withdrew.)

(Short adjournment)

NICOLE JESS, President, Public Service Association of NSW, before the Committee via videoconference, affirmed and examined

CLAIRE PULLEN, Women's Officer, Public Service Association of NSW, before the Committee via videoconference, affirmed and examined

The CHAIR: We will recommence the hearing. I welcome the next panel of witnesses. Before we start, do either of you have any questions about the hearing process? No. Would either of you like to make a short opening statement before we begin the questions?

Ms JESS: Yes, I have a short statement. I would just like to thank the Committee for the invitation to appear before you today. I am the President of the Public Service Association of NSW [PSA] and I have been a serving correctional officer for the past 33 years. It is my privilege to be both a representative of over 39,000 workers in the New South Wales public sector and a public servant on the frontline in some of the most difficult and sometimes dangerous workplaces in New South Wales. Our union represents workers in a number of emergency services agencies including NSW Police Force, Fire and Rescue NSW, Corrective Services NSW, Juvenile Justice NSW, NSW State Emergency Service, NSW National Parks and Wildlife Service, Roads and Maritime Services, NSW Rural Fire Service [RFS] and Forestry Corporation of NSW. We are in uniforms. Sometimes we respond with lights and sirens and sometimes we carry weapons as part of our work. We work in fires, floods, hostage situations and in settings where assault is a risk we take by going to work. You have lockdowns at work; we prepare and execute plans for life-threatening situations.

We work to protect the public, deliver services and keep people safe. Our members have a long and proud tradition of improving the lives of the people of New South Wales through delivering a diverse range of services spread over almost 5,000 worksites around the State, with close to half of our members based in regional areas. We are proud of the work we do. In case the Committee is unaware, I am not considered a frontline emergency services worker by the Government, nor are the special constables who keep Parliament House safe, who are also our members. This distinction matters. Some years ago the Government designated some work as frontline for the purposes of workers compensation and partial exemption for budget cuts. I fall on the wrong side of that divide and my conditions of work are less for it. Some of our members at the RFS may be considered frontline and others not. Some of our members are considered frontline for firefighting purposes in terms of workers compensation but only after a court case establishes that. They are still subject to budget cuts that other agencies are not.

Emergency service workers like me, like my members, are often required to perform their work in inherently risky circumstances. Under these circumstances, employers can and should do more to mitigate the risks of these roles. Monitoring fitness standards may have a place to play in this if employers do it with a focus on our health and safety and the safety of the public in mind. If an employer seeks to impose a physical fitness standard on emergency service workers it should demonstrate the necessity as a tool for increasing the safety of the work being performed. Agencies should be properly funded to research, consult on, implement and measure any fitness standards aimed at facilitating the safe workplace of emergency services work. A wide range of roles within the New South Wales public service perform duties within high-risk environments. As a union, we say all workers should be treated equally with respect to their rights to a healthy and safe workplace and dignified treatment if they are injured.

My role is different to my firefighting members in the RFS, NSW National Parks and Wildlife Service and Forestry Corporation of NSW, and different again to frontline workers in Juvenile Justice NSW. What we all have in common is this: we deserve to be supported by our employer to deliver the best possible service and kept safe. As the Committee will see from our submission, we have made a number of recommendations on how to do that. As a summary, these are the principles we say should underpin any fitness standard. The standard should be negotiated with workers and our union because we know best what the job we do every day requires. Mental health must be included and cannot be separated when considering our health and wellbeing, and to do so further stigmatises workers who need and deserve help. There should be a reason related to work performance to have a standard. Standards should aim to reduce injury in the workplace, which assists both workers and employers. Individual workers should be taken into account when standards are given effect and adjustments made.

The goal of any standard should be to ensure work is performed safely. Employers should assist workers to meet the standard where a standard is imposed by them. Government should fund data collection and study to make sure standards are helping improve work performance and demonstrate that. We do not have an in-principle objection to fitness standards. What we do not want to see is employers refusing to mitigate and manage risks in our workplaces and then disposing of us if we are found to be unfit. Whether or not we are injured as a result of an employer's risky approach will mean little if we are medically retired because of it, after being measured against a standard that may not be relevant to our work. We understand that standards of fitness may serve to keep us and

the people of New South Wales safe. What we want to see and hope we can assist the Committee with is ensuring that all workers are involved in setting standards that they can meet, that we are supported to meet them and that standards are there for no other reason than to keep us and citizens safe. Thank you.

The CHAIR: Thank you, Ms Jess. Ms Pullen?

Ms PULLEN: I do not have any opening remarks. I am here to assist the Committee with any questions you might have.

Ms TAMARA SMITH: It is interesting because the Police Association of NSW was very cautious about any discussion around ongoing physical standards. I note in your submission that you have done something similar. I have looked at the Government's submission and I am just wondering where that has come from. It is not something that I, for example, have naturally leapt to with this inquiry, thinking that we should set physical standards. Have I missed something? Is there something in the Zeitgeist about that?

Ms PULLEN: Ms Jess, do you have data on that one?

Ms JESS: Just from Corrective Services NSW's point of view, I would say that the fitness standard is raising its head a bit in regard to especially workers compensation. All of a sudden a standard is produced but that standard may not be something that is put before the membership on a yearly basis. We have a certain standard as far as firearms, batons and the equipment that we use. But as soon as someone is injured in the workplace, then all of a sudden your standard for our membership comes into play. What we are concerned about is whether this is something that the Government is looking at to do on a yearly basis to say, "This is the standard." Because someone may have a decrease in their physical ability, but the knowledge and the expertise that they have in the workplace—say, for example, for Corrective Services the ability to communicate with inmates and de-escalate inmates—are far greater tools than the physical ability to run 500 metres to stop someone in a jail doing something. It is a balancing act that we see.

Ms TAMARA SMITH: It is interesting because that also did come out from the Police Association around the diversity of modern policing. Once an injury does happen, a return to work—the standard or level of fitness that is expected is different to perhaps the diversity of the workplace. Thank you for clarifying that. You were talking about the artificial—you say:

> One of the most important reforms the government could embrace to reduce the risk of injury and illness to emergency services workers is lift the artificial staffing cap as it applies in emergency services workplaces.

Can you talk a little more about that please?

Ms PULLEN: I am happy to jump in on that one. Just to clarify for the members of the Committee what I mean when I am talking about that, there is a Treasury circular. It is TC 13/03, Budget Controls - Labour Expense Cap [inaudible]. It followed on from a budget announcement prior to that that set out who was considered frontline workers and in that it is teachers in schools, sworn police officers and nurses in hospitals. They are the only group of frontline workers not subject to labour expense cap. My experience working for both this union and another emergency services union is that, every time someone is injured at work or there is a health and safety issue raised that goes to the ability of these individual workers to perform their duties and what often this looks like for the workplace, the answer is there is no money to fix it.

I know that the police have a lot of really good things to say about, in particular, some of the rehab programs they have put in place, but they cost a lot of money. There is no other agency in that emergency services space that is given access to those resources to do that individualised return to work and fast rehab to get people back into those roles that may not be the role they were in pre-injury but is a role somewhere else. In terms of my perspective, my view is that if you are putting constraints on by capping the money available to agencies, it reduces their capacity to deal with those workers and redeploy them. They might have a great deal of skill left to offer and there are other things that they can do, but there is no money to do it.

Ms TAMARA SMITH: Is that because of the classification? Is that what you are saying? Under the—

The CHAIR: Excuse me, Ms Smith. Ms Pullen, can I ask you to turn your video off because we are having trouble actually—you are a bit muffled. The transcripts are not picking up exactly what you are saying and it just may help. That is all. Thank you.

Ms TAMARA SMITH: You mentioned a Treasury circular that defines frontline workers. Are you saying that many of your members who are in emergency services are not considered frontline workers for the purposes of that rehab money?

Ms PULLEN: What I can say is that [inaudible] 2012-13 budget, the labour expense cap was introduced by the Government. There was a Treasury circular that came out that listed the workers that would not be subject

to the labour expense cap. That was teachers in schools, sworn police officers and nurses in hospitals. You were testing me as to which Premier it was. It may have been Baird. It may have been O'Farrell who was the Premier at the time. But all the media framing of it was, "Frontline workers will have no cuts." But when you go to the Treasury circular, it really clearly defines that there is only those three groups of workers that are not subject to the cap. I have [inaudible] where a head of an agency or a head of a department says, "We can't do it because of the labour expense cap." Very clearly, what we are told is that there is money. Ms Jess has probably had some experience with this as well that she can speak to.

Ms TAMARA SMITH: If you can give an example that would be great.

Ms JESS: I would have to take it on notice but there is clear—the police get a lot more as far as their return to work under workers compensation. There are a lot more programs that they have available to them. It is sort of a mentality like in a football field that, if someone is injured, you do the treatment straightaway. For Corrective Services we can take six to eight weeks before our insurer actually approves MRI scans and stuff like that, which can delay and exacerbate the injury with that time off of work waiting. We are actually touching base with the police to see how they do things and how we can improve things and put that towards Corrective Services. But I definitely think, even with Juvenile Justice and with the other agencies, that it is about money and that we just do not get the money put into looking after the employees as much as what police, the firies or the nurses do.

Mr MARK TAYLOR: So are you saying just in that last statement—would there be efficiencies gained if injury management was dealt with right across all emergency services by one type of body or group rather than having it separated into each department?

Ms JESS: One of the points that we put in there is mental health. If there was more money put into—and I do not have the stats with me at the moment but I can say I have been the chairperson for the last four years and the increase in mental health just for Corrective Services employees is on the increase—I would say probably close to about 30 per cent to 40 per cent where they are actually never going back to work. So you are losing that skill basis and that expertise. There is the cost that that has on the department in putting them in a job elsewhere. If there were programs in place to be able to deal with mental health in the first instance and to help us—I do not believe that our employee assistance programs [EAPs] are sufficient enough. When you do a specialised job like Corrective Services, even the RFS or Juvenile Justice, you want to speak to someone who is going to have a bit of an understanding about what your role is.

When you have to sit down after a death in custody or after a serious incident, you do not want to have to sit there and part of the process is explaining what your job is. That actually exacerbates your mental health. It increases your anxiety levels and so forth. You want to go in there and you want to speak to someone that can actually assist or knows and we can deal with the problem straightaway. The psychologists get supervision. Prison officers do not. Prison officers see deaths in custody. We see people self-harm. We actually have to care for people who have disabilities because we cannot get their carers in. I have been in the process where I have had to shower inmates. I have had to feed inmates and all of that. This takes a toll. Then we have had to use force because inmates are self-harming. I have had colostomy bags thrown at me—everything over the 33 years. I could tell stories. But I do not want to go into an EAPs Benestar provider and have to sit there and first of all explain what my role is—you know, blah blah blah. I want to go in there and actually talk about what is happening and have that person understand my role.

Mr EDMOND ATALLA: I picked up a couple of things from your submission. The differentiation between your members and the Police Association members is that your members are not frontline police officers. Is that what you are saying?

Ms JESS: An example—again I refer back to being a correctional officer. I am not classed as a frontline emergency service worker but I do all the roles of the fire brigade. If there is a fire in the jail I have to put the fire out. The fire brigade cannot come in until we have actually rendered it safe. The police—if there is a stabbing or anything else, we are the people who respond first of all. We have to do the crime scene, we have to bag evidence and so forth. If, say, for example, someone is self-harming then I am the nurse. I am also their carer. I am everything rolled into one—but I am not recognised as that.

Mr EDMOND ATALLA: So crime scene officers are PSA members?

Ms JESS: No, what I am saying is I do all the stuff of the fire brigade, the police, the nurses and the paramedics. I do all of that but I am not recognised for anything. I am not classed as "frontline"; they are.

Mr EDMOND ATALLA: Yes, but I am just specifically mentioning crime scene officers, who are virtually in police uniform yet they are PSA members. Is that correct?

Ms JESS: No, they are not. No, I think they are part of the Police Association of NSW. They are police officers. We may have some; I will have to take that on notice.

Mr EDMOND ATALLA: My understanding is they are part of the PSA, and my next question was going to be whether that is leading to your members being assaulted for being mistaken—because I know there was a debate and a discussion some time ago about the uniform of crime scene officers being similar to police officers and there was a discussion about trying to change the uniform of the crime scene officers, but I understand that was too costly to undertake. What I am leading to is whether crime scene officers are assaulted mistakenly for being police officers.

Ms JESS: I would have to take that on notice.

Mr EDMOND ATALLA: You have mentioned all of the stuff that you do to support all of these agencies. Do you develop programs that can maintain the physical health of your members and prevent injury?

Ms JESS: We do not have any—

Mr EDMOND ATALLA: Programs you undertake on a regular basis with your members.

Ms JESS: We do not have any programs as far as physical fitness. It is up to the individual to maintain their physical fitness. If they are injured in the workplace then they will go through physiotherapy, but that is all through the workers comp process and approved by QBE. But at the moment we have no physical—once you join it is up to yourself to keep a level of fitness. As far as mental health goes, Corrective Services NSW has just started a program called Stand T.A.L.R, which is about the individual looking and sort of doing self-checks. There are RAW Mind Coach programs and also monitoring your fellow colleagues in the workplace to see if there are any changes in their mental health. We have got that program, we have got Benestar and also, in conjunction with PSA and Corrective Services—DCJ, we co-facilitate what we call a welfare officer. She takes calls from anyone who may be having any mental health problems, going through bullying and harassment, dealing with anyone—just their mental health wellbeing.

Mr EDMOND ATALLA: Okay. But you do not carry out any preventative programs?

Ms JESS: No, not at all.

Mr EDMOND ATALLA: That is fine. In relation to volunteers working for, say, some of the associations that you have mentioned, like the Rural Fire Service and State Emergency Service, do you represent those volunteers as well?

Ms JESS: No, we do not.

Mr EDMOND ATALLA: How is the volunteers' wellbeing and safety—is that something that is falling through the cracks? How is that being—

Ms JESS: We do not represent them, so I would say that they probably would be falling through the cracks as far as—and I do not know whether they have got a standard of fitness that they must maintain. I have no idea, sorry.

The CHAIR: To become a corrections officer, do you have to meet any physical requirements?

Ms JESS: Yes, you do. Those requirements have changed over the 33 years that I have been employed. The standard has changed. But as you go on in your career there is no other test to see if you still maintain that standard.

The CHAIR: There is no monitoring over the lifetime of your career?

Ms JESS: No. The only monitoring is on the equipment: firearms, batons.

The CHAIR: I understand. Under what circumstances would your association support a mandatory ongoing physical fitness standard?

Ms JESS: Sorry, can you repeat that?

The CHAIR: In what circumstances would you support a mandatory ongoing physical fitness standard?

Ms JESS: I would say I would probably have to take that on notice. But we would want to see—we are okay, probably, with having a physical standard, but as with some of the points in our submission we would want to make sure that the department is also supporting us to be able to maintain that physical standard. Are there gyms on complexes? Do you get time to be able to maintain that standard? Are you assisted if you cannot, not just retired or moved to some other area of the department? There are a lot of variables in saying that we support it.

Ms PULLEN: If I can just jump in—I am sorry to be so rude—there would need to be, from our perspective, some demonstration that the standard has a relationship to the work. As I said, I have worked for another emergency services union. When a fitness standard was brought in there it ended up having to be revised at least once that I am aware of because it was introduced as a culling tool, not as something that related to the actual work that people perform every day. Our members would want to be clear that there is a relationship between the standards you are being held to and the actual job you are required to do.

Ms JESS: That would also go for managers as well. If Correctives Services have managers in the workplace as well there cannot just be a standard for one set of people and then another, because they are response personnel as well. The standard needs to be maintained along all levels within a correctional centre—or within juvenile justice.

The CHAIR: Understood. Are there any other questions?

Ms TAMARA SMITH: I just wanted to pick up, as an ex-teacher, what you were saying about employee assistance programs, which I understand. Obviously a classroom is very different—I have worked in prisons as well, but it is a very different context. I am just trying to understand how a psychologist—if you are saying that if you have just seen a death in custody or experienced that, wouldn't every psychologist be equipped to support someone in that kind of acute trauma of a worker witnessing that? I am just trying to understand. There were certainly things that I saw over my time as a teacher that were traumatic. To me, calling someone on the phone is never ideal, but you could then see a local psychologist. I am just trying to understand what your needs are around that.

Ms JESS: I will give you an example. If you look over in New Zealand—I have been over there—they actually have a psychologist for the staff in one of their centres where they have had a lot of assaults on staff. They have a psychologist—I think it is five days a week—for staff to actually go and speak to. When you look at the amount mental health is costing Corrective Services—and probably other agencies as well—the cost of paying someone in a centre is probably a lot less than the cost of the amount of staff on mental health and not staying in the job.

Ms TAMARA SMITH: And they could do amazing preventative resilience training and kind of become like a coach.

Ms JESS: Exactly, yes. They could hold seminars within the centre on the training days that we have—just as you said, resilience training. For Corrective Services, you would not put it in every single jail because we have what we call camp centres, which is minimum, that have very few issues happening. But in our centres that have significant incidences, that would go a long way in reducing mental health fatigue within our officers.

Ms TAMARA SMITH: Thank you, I really like that.

The CHAIR: Unfortunately we have run out of time, but I thank you for the evidence that you have provided today. If there are further questions that we would like to put to you in writing, are you happy to answer those questions?

Ms JESS: Yes.

The CHAIR: They will form part of your evidence and be made public.

Ms JESS: Yes, thank you.

The CHAIR: Thank you for your time—very much appreciated.

(The witnesses withdrew.)

DOMINIC MORGAN, Chief Executive, NSW Ambulance, sworn and examined

LEANNE McCUSKER, Assistant Commissioner, Corporate Services, NSW Police Force, sworn and examined

The CHAIR: I welcome the next panel of witnesses from NSW Ambulance and the NSW Police Force. Before we proceed, do you have any questions about the hearing process?

Assistant Commissioner McCUSKER: No.

The CHAIR: You are quite used to it by now.

Assistant Commissioner McCUSKER: Yes, thank you.

The CHAIR: Would either of you like to make a short opening statement before we begin the questions?

Assistant Commissioner McCUSKER: Yes, thank you very much. Good afternoon, Chair and Committee members, and thank you for the opportunity to address this Committee in relation to the physical health of police and emergency service workers of New South Wales. There are few professions that are more demanding than policing and every day the men and women who proudly serve the NSW Police Force help those in our communities, no matter how difficult the situation. This commitment to serve others comes with its own challenges, and I recognise the job we are expected to do can have an impact on our health and wellbeing. I have been a police officer for over 33 years and I understand the challenges faced by my colleagues on the front line whilst protecting the community. With that thought I would like to take this opportunity to reinforce that the health and safety of every New South Wales police officer is paramount and significant work has been undertaken by the NSW Police Force over recent years to ensure the physical health and wellbeing of all police officers, including spending $16.6 million over four years to continue preventative health and wellbeing initiatives as part of the workplace improvement program.

There are a number of broad and complex issues before this Committee and I will broadly touch on those, the first being how the physical health of police and emergency services impacts the performance of their duties. Policing is a safety-critical occupation and a sufficient level of physical capability is necessary to safely and effectively perform police work. The inability to perform physical aspects of police work may endanger the safety of officers and the general public, and I will briefly touch on a number of initiatives and strategies that have been implemented to continue to support the physical health capability of New South Wales police officers. In December 2019 the NSW Police Force reintroduced the requirement for probationary constables to successfully complete the physical capacity test at the end of their first 12 months, that being prior to confirmation as a constable. To date we have had just under 1,700 probationary constables through their first 12 months during that time and not one person has failed this test.

The rationale behind this initiative was to enhance the physical health of New South Wales police officers, providing support and ensuring we set them up for success in the first 12 months of their policing career—and when faced with the challenges of shift work and varying sleep patterns and eating patterns to ensure that we created and established healthy habits. The Fitness Passport initiative provides police officers and their families access to a wide range of gyms and swimming pools across New South Wales for a discounted rate. That is available at over 500 gyms and swimming pools. The practicalities of this are that all officers can use a variety of gyms that are either close to their work, close to their home or may even be when they are travelling around the State with work as well. They can still have access to gyms. We currently have over 5,116 memberships, with 60 per cent of those being family memberships. It is a good support and initiative that not only the police officers but their families are participating in this program.

The RECON program is one of the initiatives under the NSW Police Force workforce improvement program that I previously spoke about. It provides specialist rehabilitative and preventative health programs for all New South Wales police officers. It is specialist physios as well as strength and conditioning coaches. We have three clinics, two in our metropolitan area and one up in Newcastle, where officers have access to this treatment. To date we have put 1,600 employees through this program with excellent results, with 80 per cent of those officers returning to pre-injury duties. An aspect of the RECON program that is not captured by the data is the increased knowledge that the police officer gains. They feel valued by the NSW Police Force as well, which is certainly spoken about often.

There is a very large number of wellbeing support services. I have brought along our *Command Wellbeing Manual* that I can leave here. That captures all our wonderful support services: health checks, the Eat Smart program and the physical training instructors that we have across the organisation as well. I am proud to say that document does not just sit on a shelf; I do see it used around police stations as well. In terms of the physical entry requirement, I note that what is required of our officers pre-recruitment and down at the academy has been put

forward to the Committee. I will not go into specific details of that unless later on there are some additional questions. What I will mention is the substantial work that is currently being conducted down at the police academy to enhance the health and fitness of policing students and to create healthy lifestyle habits as they are first introduced into their career. A number of those fitness activities are built around ensuring that they are over and above what is required for the fitness standard. What is also being incorporated into the training down at the academy is education activities regarding nutrition, sleep, mindfulness, positive psychology and financial literacy. A longitudinal study is being looked at to see how we can capture that data as well.

In terms of impacts to the workplace management, we do see an increase of claims and we are looking at how we can increase the deployability of our police officers following an injury and how we can best manage that, and a steering committee to manage officers who have been injured has been implemented to look at the various options. Additionally, New South Wales Police has developed a mental wellbeing strategy around the key principles of the life cycle of a police officer. The four pillars are prevention, awareness, recovery and transition to ensure we look after the wellbeing and health of an officer from recruitment through to retirement. Thank you for your time this afternoon. I reiterate, the aim of the NSW Police Force is to continue to support all police officers and maintain or improve our overall health in order to better protect New South Wales.

The CHAIR: Dr Morgan, would you like to make an opening statement?

Dr MORGAN: There will be remarkable similarities, I have to say. I think we have been copying each other's homework. I would like to thank the Committee for considering the submission made by NSW Ambulance and for the opportunity to attend here today. I would like to provide you with further information regarding strategies being undertaken by NSW Ambulance to improve the physical health of our paramedics. In 2016 NSW Ambulance made a commitment to improve the mental health and wellbeing of our staff, which includes physical health. The New South Wales Government invested in the concept and committed $30 million over a period of five years in the wellbeing investment program. That time period has been extended by a further year, owing to the interference of COVID-19, and an amount of $5 million recurrent thereafter.

You have seen from our submission that for the past five years we have developed and employed a suite of programs. Those programs individually focus on a particular issue, like safety or mindfulness, but recent studies have shown that it is the interaction of all the individual pieces of wellbeing that creates the greatest benefit. Good physical health, for example, has the added benefit of a positive impact on mental health. For this reason we have taken a holistic approach to employee wellbeing. In 2018 we established a dedicated staff health unit that focuses on not only staff mental health but also physical health. The physical side is coordinated by our physical health coach and additionally employs two dedicated sports physiologists. It also oversees our wellbeing program, part of which are our wellbeing workshops, which have run since 2018 except during the main COVID restrictions. They are examples of successful strategies. This was one of the first programs developed, as the name implies, to improve the wellbeing of staff. The workshop is divided into three components: well at work, safe at work and protected at work. Each component focuses on a different part of an employee's work life but together they aim to produce a mentally and physically-well employee with the skills to protect themselves from injury caused by workplace hazards or occupational violence.

I am pleased to advise that even with the COVID-19 restrictions of 2020 we are well on the way to every staff member attending. Attendances to date are 3,678 staff, and since the lifting of COVID restrictions the workshops have just restarted. I anticipate all staff will have attended by the end of next year. For new staff, the wellbeing workshop content is now incorporated into induction training. Our health and fitness programs have seen good uptake. Since July 2020, 234 health coaching sessions have been delivered. These sessions are focused on nutrition, weight and exercise, and assist staff to implement positive change following the wellbeing workshops. Our injury prevention specialists, who assist staff to reduce their injury risk and develop strategies to manage long-term health, have conducted 383 sessions since mid-last year.

Since 2018 we have also appointed eight geographically-based safety partners, specifically located with the paramedic workforce. Medic Fit, which is a rollout of low-impact gymnasium equipment, is now completed at 233 sites across New South Wales, with 1,400 staff now fully inducted into the program. The Medic Fit program involves the construction of a mini gym in workplaces and the installation of equipment. All stations requesting the Medic Fit program have been provided with it. Our recently upgraded fleet of intensive care ambulances have seen changes to the fit-out to ensure a greater ergonomic arrangement in the front cabin and a newly designed fit-out in the rear with installed cabinetry to give paramedics a safe, ergonomic and efficient area in which to provide patient care.

Unfortunately, even with training and support, accidents do occur and staff, on occasion, do suffer injuries at work. However, I am pleased to advise that our workers compensation claims for physical injuries continue to decrease over time, and I have some updated data for you today. Since 2010-11, with a peak of 900

physical injury claims, our most recent data shows we are down to 550. Again, drawing upon the connection between physical and mental health, we recognise that getting staff back into the workplace after an injury is vitally important. Much work has been undertaken to ensure we can provide meaningful and equitable alternate duties for those staff regardless of whether they are located in metropolitan Sydney or a regional area. Negotiations have been undertaken with local health districts and other government agencies so the staff are not just restricted to roles within NSW Ambulance. Currently suitable alternate duties are not able to be found for around 17 per cent of staff seeking to return to the workplace.

Whilst there is always much more work to do, I believe our holistic approach is seeing better outcomes for our workforce than in the past and a number of further investments in new equipment to assist in hazardous manual tasks inherent to the role of paramedics are planned for the coming financial year. I would be happy to address any questions the panel has in relation to our programs and the physical health of our employees.

Mr EDMOND ATALLA: This question is to Assistant Commissioner McCusker. Does the NSW Police Force monitor the wellbeing of police officers during the officer's lifetime? Or do you only become aware of an issue when a workers compensation claim is submitted?

Assistant Commissioner McCUSKER: No, not at all. In terms of monitoring an officer's welfare, that is certainly something that is done on a day-to-day basis first and foremost by the commander of that police station. We have a number of processes in place to do that. If I can take it right back to probationary constables, they are allocated buddies in that very first instance who have supervisors that are under that direct chain. First and foremost, for probationary constables, the education officer has regular meetings with those individuals. Not only is their work performance monitored and discussed but their welfare as well as to how they are doing. Additional to that, we have what we call our trauma incident database. That captures what we will call those more high-end jobs that police officers will attend to. That is reviewed monthly by the commander to see if there are any significant concerns. It may be the case that if officers are seen to have gone to quite a number of significant events, some preventative strategies will be put in place.

But over and above that, as officers do attend traumatic and significant incidents, we will have psychologists attend the police station immediately to provide that support. We will have chaplains attend the station immediately to provide that support. There is ongoing support in regard to an employee assistance program. Peer support officers are in every command and most commands will have roughly five of those. So it is their peers, whom they may be comfortable to speak to, and not necessarily the commander. In answer to the question, I am very confident that significant processes and support are in place from day one for a police officer and it is not just when they become subject to a workers comp claim.

Mr EDMOND ATALLA: We heard evidence earlier from the paramedics, who indicated that 20 per cent of their workforce is on workers comp. Do you have a figure for what percentage of police officers are on workers comp?

Assistant Commissioner McCUSKER: What percentage are currently on workers comp?

Mr EDMOND ATALLA: Of the workforce.

Assistant Commissioner McCUSKER: No, I would have to take that question on notice at the moment.

Mr EDMOND ATALLA: If you can, please. That would be very helpful. Can you tell us what the average length of service of a police officer in New South Wales is as of your last stats?

Assistant Commissioner McCUSKER: Yes. The average length of service of a police officer sits around about 14 years' service.

Mr EDMOND ATALLA: Do you believe that is increasing or decreasing over time?

Assistant Commissioner McCUSKER: It is not increasing at a significant rate at this point in time. On average, that has been consistent for a period of time.

Mr EDMOND ATALLA: What period of time are we talking about? In the last decade? Two decades?

Assistant Commissioner McCUSKER: I would say the last decade.

Mr EDMOND ATALLA: So you are saying it has been consistent over the last decade?

Assistant Commissioner McCUSKER: Yes. I can get that further detail on notice. But I do know that average years of service is around about 14 years.

Mr EDMOND ATALLA: In relation to workers comp claims, do you think there has been an escalation as a result of physical injuries sustained by police officers?

Assistant Commissioner McCUSKER: Not an escalation of physical claims.

Mr EDMOND ATALLA: Say, over the last five years has there been an escalation?

Assistant Commissioner McCUSKER: We have seen more of an increase in psychological claims.

Mr EDMOND ATALLA: That was my next question. What percentage of the workers comp claims are attributed to mental health issues?

Assistant Commissioner McCUSKER: The workers comp claim percentage is still at its highest for physical claims. The difference being the psychological claims are for a longer period. So the officer may be off work for a longer period of time or it may result in a medical retirement that then goes into claims for weekly benefits. So the cost driver is predominantly in the cost of weekly benefits.

Mr EDMOND ATALLA: I am just trying to understand, in terms of workers comp claims, is a large portion of that mental health related or physical injury related? Which has a bigger proportion?

Assistant Commissioner McCUSKER: Of cost? The greater cost is psychological claims.

Mr EDMOND ATALLA: Psychological.

Assistant Commissioner McCUSKER: Yes. It is a very complex issue—workers comp.

Mr MARK TAYLOR: Perhaps I could ask the NSW Ambulance doctor. First of all, it appears from my reading that the injury rate has certainly dropped significantly over the last few years with NSW Ambulance. Is that correct from your understanding?

Dr MORGAN: That is correct.

Mr MARK TAYLOR: It also appears as though a large number of physical injuries are from lifting or what they call bodily stress. It that correct?

Dr MORGAN: Hazardous manual tasks.

Mr MARK TAYLOR: The union association in previously seemed to indicate or proffer that single-unit response or single-unit service was compounding or responsible for those types of injuries. Can you tell us about the policy in the rollout of single-unit response and any correlation with those injuries?

Dr MORGAN: What I am presuming they are referring to is where two paramedics are normally rostered to a crew and only is physically present. Up until 2013—and then there is a gap; I returned to New South Wales in 2016—but I am told in 2013, there was a major rostering reform within regional New South Wales. There was quite a number of rosters put into place during that dispute—56 to be exact—that involved a day each week where there was a single officer rostered. Last year we were successful in a case where we got a recommendation from the Industrial Commission to remove those rosters, and to date 47 of those rosters have now been replaced out of the 56. So we are committed to removing all of those single-producing rosters across New South Wales. I am terribly sorry; I have misled you. It was 59 rosters, and we have got 46 done.

Mr MARK TAYLOR: Is it the case that those single units are assigned certain jobs or tasks?

Dr MORGAN: No. There are other types of single responders—for example, a member of the special operations team. Additionally, we might have extended care paramedics that go to low-acuity cases in lieu of a double-crewed ambulance. I think the concern that our unions have had in the past has certainly been around the double-crewed ambulances as being the main issue. There are places where even the unions agree with us. Motorcycles is another example where it is entirely appropriate to mount a rapid response to a particular type of case. The one that has been a point of contention that we have made significant progress on historically was where there were rosters that produced single officers.

Mr MARK TAYLOR: In the documents here, there is an indication that there is a trial about body-worn cameras. Is that correct?

Dr MORGAN: Yes.

Mr MARK TAYLOR: Is there some relationship with that in reducing physical injury as well?

Dr MORGAN: Very much so. My colleague and I were funnily enough only discussing similar experiences outside. The body-worn cameras have been a really useful adjunct. We are approaching it in a very measured and methodical way because we are not looking at it primarily—I will take a step back. If you think about a paramedic's relationship with a patient, generally it will be in a paramedic's mind to protect their privacy at all costs. There is this nexus between occupational violence and the demonstrated benefit of body-worn cameras

in being able to produce a deterrent for individual behaviours. We have certainly had that feedback from our workforce.

Additionally, we undertook a study with Western Sydney University during the site trials. The feedback out of that, which I think was the headline figure, was that 62 per cent of our workforce said that they felt more safe with a body-worn camera. We are having this discussion with government at the moment as to whether we further expand the trial. At the moment we have only got three major sites that we targeted. We have used those cameras more than 11,000 times in the last 12 months. They have been, in our opinion, key pieces of evidence in gaining a number of convictions at court as well.

Mr MARK TAYLOR: Thus promoting the safety of the paramedics.

Dr MORGAN: Entirely.

Mr MARK TAYLOR: If you were a paramedic in a small regional area and you became unable to do your duties, how does the organisation go about redeploying that paramedic?

Dr MORGAN: Do you mean as in while you are recovering?

Mr MARK TAYLOR: Perhaps after. If it was considered that you could no longer perform paramedic duties are there options in other government departments to do work?

Dr MORGAN: There are. But this is the real challenge. As you can imagine, if you are a police officer or a member of emergency services—these are jobs that are very personal and meaningful to individuals. To not be able to do the career that you have committed to for your life is a really confronting thing. So to be able to find meaningful work after something you have given your life to is really difficult and really challenging, even for the most resilient people. You can imagine that the further we go away from large, big urban centres with a diversity of employment, your chances of finding employment that was anywhere near what you used to do and how you gave service to the community is increasingly complex.

In terms of people doing alternate duties while recovering from an injury, as we stand today we have 92 people that we are unable to give meaningful duties to. On 1 December 2018, paramedics became a registered health profession under the national law. This has actually opened up some opportunities for us to start discussions with the local health districts around, for example, paramedics undertaking immunisation. These are all things that many hospitals run on a daily and weekly basis. We are trying to move away from the notion that paramedics only work out of hospital and therefore do not have a role, but being health professionals now with professional skills that can be used arguably within a hospital environment now it is just a question of finding those skills that target their profession to the best possible level.

Ms TAMARA SMITH: Assistant Commissioner, I was really interested to hear about the prevention awareness recovery transition model, but I was shocked about the average service of 14 years. As a teacher I taught for 21 years. Your average teacher will teach 30-plus years, and certainly if you try and get out of teaching, once you get to a certain age it is very difficult. It is very difficult I think for people over 40, especially in regional areas, to transition into another form of work. I am worried about our police. Typically then a police person is quite young when they might be looking to do something else. It is interesting to hear that ambos, being now under health, might be able to work in health full stop. Whereas for police, what is there in place to transition police into other post-police employment opportunities?

Assistant Commissioner McCUSKER: Thank you for the question. I will explore that a little bit further in the sense that albeit that our average years of service is 14 years, we clearly have significant large numbers that have an extensive and long, sustainable career. In terms of actual medical retirement, the average years of service for medical retirement is around about 22 years, so it is somewhat different. Going back then to your question of transition—and can I say over the last couple of years we have done significant work over that transition for that very reason. Again, my colleague made mention that as a police officer or ambulance or emergency services, you really are investing your heart and soul and probably somewhat like teaching as well: investing heart and soul.

In terms of that transition, a couple of things have taken place. Twelve months ago our promotion process was changed and we are now aligned to the capability framework within our promotions process. I see that as quite significant and hand in glove with our transition program as well. Police officers are really understanding the capability that they do have, and I will use the phrase when we have a program that has been introduced—"I am more than a cop"—so really understanding the value of our police officers, having our police officers understanding their skill set, their leadership qualities, decision-making qualities and what they can take through to other employment. In that regard, we are working strongly with a rehabilitation program. Even before an officer does either medically retire, if that is what they choose to do, we have got some strong rehabilitation work going

on of exploring what their skill set is so that we can transition them into other roles, whether that is within government public sector or outside.

Around about June of this year there will be a career transition expo for New South Wales police officers, again, to actually explore capability and what is next and what else can be for that future, noting that they will be of a somewhat young age at the time that they exit New South Wales Police. Some specific work has been done, in particular in our southern region, over the last 12 months and we were able to increase officers that were exiting the organisation with capability of further work, sadly, from 0 per cent up to 20 per cent, ensuring that they have not the capability but the confidence and the understanding of the work that they can go into as well. Also what we are exploring—and over the last 12 to 18 months—is that at times when a police officer cannot perform the inherent duties of a police officer, transitioning into our unsworn staff as well, still keeping that connection to New South Wales Police but not necessarily on the front line as such.

Ms TAMARA SMITH: The Police Association was talking about more diverse looking at suitable duties—

Assistant Commissioner McCUSKER: Absolutely.

Ms TAMARA SMITH: Not that everyone has to just have the—

Assistant Commissioner McCUSKER: Be that frontline officer.

Ms TAMARA SMITH: Exactly, or the same as when they left the academy.

Assistant Commissioner McCUSKER: Yes.

Ms TAMARA SMITH: I imagine burnout rates in both of your professions are high. Maybe there is another time to talk about this, but is there also something where people can take a sabbatical? Teachers can take up to three years leave without pay. Is there something similar where they can do that and still have right of return?

Assistant Commissioner McCUSKER: Yes, absolutely. We have leave without pay options. We also do have the option that if an officer actually chooses to resign, then there is a re-joinee program as well that does not require them doing the whole academy six-month training again. We can get them back up to speed in terms of their training and they can come back and rejoin the New South Wales Police as another option, as opposed to the leave without pay.

Ms TAMARA SMITH: Dr Morgan, with regard to NSW Ambulance, the union was saying that the 2010 staffing levels are still being applied. In terms of the relationship with the rosters I was a bit confused. There is a million extra people in New South Wales in the last decade.

Dr MORGAN: Yes. Through the Chair, it is an industrial point of disagreement. It is simply not accurate to say that NSW Ambulance only rosters to the 2010 levels. Because I was advised of that claim prior to today, I happened to ask my team to just pull me today's data and that will give you an insight. The numbers that the unions were referring to, overall this is taking account of sick leave as of seven o'clock this morning: 39 crews over and above the historical 2010 levels of what they claimed and of 100 per cent of our rosters, so 359.5 crews. We were one down on the maximum number of rosters to be deployed. That was as of this morning just for today.

Ms TAMARA SMITH: Is 360 the number of crews in the State?

Dr MORGAN: That was for day shift today—359.5 crews that were to be rostered. The historical minimum operating levels back to 2010, as you can see, are significantly lower than that.

Ms TAMARA SMITH: Sorry, you said there were 39 crews over and above. But what would the 359.5 rostered on today have looked like at full roster in 2010?

Dr MORGAN: I am sorry, I have not quite got that.

Ms TAMARA SMITH: It does not matter, but I hear your point. I suppose it is hard because you would want the 39 crews over and above with a million extra citizens in the State.

Dr MORGAN: Absolutely. I would not for a minute discount the point that they are trying to make, which is the more paramedics we have, the better the community is served. It is valid. The point of how we get there is the point of contention. We are doing a great deal of work around increasing the number of casuals and the permanent part-time workforce for NSW Ambulance. There is a differing view about more people on flexible work practices versus existing staff doing additional hours.

Mr MARK TAYLOR: Assistant Commissioner, I just want to ask you a few things about the Physical Training Instructors Program. You may or may not be across it, so if not, there is no problem taking it on notice.

In the submission from the New South Wales Police, it indicated there was about 300 physical training officers across the State. I am assuming that they are spread fairly far and wide across New South Wales.

Assistant Commissioner McCUSKER: Yes, that is correct. There is, at last check, 300 across the State. Actually prior to leaving HR Command, I actually did do some analysis of whether we had that even spread and I actually made sure that we identified if there were particular commands that did not have a PTI. At that point in time there were about two commands that did not, so that was pleasing, and some commands even had around about four. So across the various police districts and police area commands, there is a good number—probably roughly about two to three—and then certainly in our specialist areas as well, so our State Crime have a good number as well. In actual fact, every TAU officer, our tactical officers, are physical training instructor [PTI] trained. So that is a good strong number of 300.

Mr MARK TAYLOR: So it is fair enough to say that just about anyone in New South Wales Police could access one of those physical training officers as necessary.

Assistant Commissioner McCUSKER: Absolutely. I am very confident to say that.

Mr MARK TAYLOR: And is it the case that a number of those are qualified, the whole certificate IIIs in fitness qualifications with things like that?

Assistant Commissioner McCUSKER: Yes. From the New South Wales Police perspective, and you will probably forgive me that I may not give it exactly but it could give them the qualification to be a PTI outside of New South Wales Police as well. The exact detail I could get for you. But it certainly gave them that capability and understanding as a base level PTI.

Mr MARK TAYLOR: So they do things like advising, introductions into the gym if there is one at the station and how to do exercises correctly and how to diet, nutrition, and all that type of advice?

Assistant Commissioner McCUSKER: Yes. To confirm that, certainly they can do all the introductions to the gym; they could do some base-level programs. In terms of actually doing blood pressure checks et cetera, et cetera in the police station, they are qualified to do that. You may have also seen—and it is certainly in this manual as well, the functional movement screening—which is about a 10-minute check to check your strength and your flexibility across various parts of your body. They are able to do those at all police stations as well. They can induct into the gyms, run some programs, check some baseline health standards and check the functional movement capacity of our staff as well.

Mr MARK TAYLOR: They do some initial testing for those who wish to go into specialist roles. Do they do some initial assessment of that or make some recommendations that involve that?

Assistant Commissioner McCUSKER: Yes. In terms of the officers that may want to go into, say, the Operations Support Group [OSG] or the Public Order and Riot Squad [PORS] or something like that, is that what you mean?

Mr MARK TAYLOR: Yes.

Assistant Commissioner McCUSKER: Yes. They can certainly put officers through that baseline check and then the actual physical training [PT] team in a human resources [HR] command are the governing body of that as such.

Mr MARK TAYLOR: Did you use these officers when you were doing the end of the 12-month probation tests?

Assistant Commissioner McCUSKER: Yes. That was part of—and, hence, why I needed to look to see that we had sufficient PTIs—that as we introduced the probationary constables to get tested at the end of their 12 months or before they are confirmed, that every command had a PTI that had the appropriate—well, they have all got that same training—so therefore I was not putting the onus on the field, that we had given them the skill and the capability and the ability to be able to test our probationary constables. The PTIs can put anyone through what we call the physical capability test.

Mr MARK TAYLOR: And you could go and seek them out if you were a member, if you wanted to.

Assistant Commissioner McCUSKER: Yes. Some of them, maybe the two-year constables because they are the right person to be a PTI; some may be the sergeants in the command. So just depending on when they did their PTI training and then ensuring that they have kept their accreditation up as well.

Mr MARK TAYLOR: But if I was a general duties officer and wanted some assistance I could go and seek them out to get advice.

Assistant Commissioner McCUSKER: Absolutely.

Mr MARK TAYLOR: But it is not the case, is it, that a commander can refer someone to those people to be tested?

Assistant Commissioner McCUSKER: As a commander you could, and I have done this myself—

Mr MARK TAYLOR: Provide it as a welfare-type arrangement rather than an official direction type of thing.

Assistant Commissioner McCUSKER: Yes, because any official referral, I would probably suggest, needs to be to the police medical officer [PMO] if there are any health concerns. But if I saw, or a commander saw, one of their officers just might need some guidance in training or you saw that a probationary constable might have been putting on some weight, you would have a quiet chat to the PTI and they could go and speak to that individual. It could then come from that colleague-to-colleague conversation as well.

Mr MARK TAYLOR: Thanks very much.

The CHAIR: Just one question. You suggested that shiftwork can contribute to poor health and physical sickness outcomes. What are the current shiftwork arrangements?

Assistant Commissioner McCUSKER: For our general duties officers, it is 12-hour shifts and predominantly 6.00 a m. to 6.00 p.m. There are rostering practices to ensure appropriate fatigue management, that they cannot be rostered for—mostly it is two days and two nights—three nights, and there are appropriate rostering practices in place for that. Our general duties staff roster operates on a six-week cycle and during that six weeks they will generally work 19 shifts. So as much as those 12-hour shifts we will call long, there is certainly opportunity for recovery, rest and recovery, and opportunity for training and looking after themselves as well.

The CHAIR: If there no other questions, thank you so much for appearing today. Your time is very much appreciated. There may be some further questions that we may like to put to you in writing. Are you happy to provide answers to those questions, which will be made public?

Dr MORGAN: Yes.

Assistant Commissioner McCUSKER: Yes, absolutely.

The CHAIR: Thank you again. We appreciate your time.

(The witnesses withdrew.)

LISA CHIH, Director, Health and Safety, NSW Rural Fire Service, affirmed and examined

PETER McKECHNIE, Deputy Commissioner, Field Operations, NSW Rural Fire Service, affirmed and examined

ALISON DONOHOE, Director, Work Health and Safety, Fire and Rescue NSW, affirmed and examined

The CHAIR: I welcome our next witnesses. Thank you all for your time today. Would any one of you like to make a short opening statement in regards to the hearing today before we ask questions? If not, are there any questions?

Mr MARK TAYLOR: Perhaps I can start off with Fire and Rescue NSW. Is it the case that there is pre-employment, periodic and also triggered assessments as you go through your career as a firefighter?

Ms DONOHOE: Correct, yes—pre-employment, medicals and a physical aptitude test. As well, for the incumbents we have an annual fitness drill and an aged-based scheduled periodic health assessment, and then any triggered health assessment and medicals as deemed necessary by any periods of sick leave or illness or injury that may occur to them in the workers compensation or otherwise space.

Mr MARK TAYLOR: So with the periodic assessment, the annual assessment, is that job role specific or age amended, or is it just a repeat of your pre-employment physical?

Ms DONOHOE: A mixture of all of that, if I can say that. First, just to clarify, it is not an annual assessment. It is age based. So up until the age of 60 it is every five years, between 60 and 65 it is every two years and then, after 65, annually, unless after that or as a result of that first assessment that is undertaken there is a need for more regular monitoring, and that would be determined by the independent occupational physician who we have oversighting that process.

Mr MARK TAYLOR: You had some involvement with the University of Wollongong, did you, about organising and looking at research considering physical aptitude testing et cetera?

Ms DONOHOE: Yes, we did. Yes, it was some really exciting research actually. It was the first that had been done besides some work that had been done in Canada back in the 1990s. We undertook a huge body of work in relation to taking the physical aptitude test and what that was made up of right back to the very first principles. So, rather than adopting what a lot of other agencies were doing nationally or internationally, going back to really looking at what are the inherent requirements of firefighters in New South Wales and then what are the physical attributes required to be able to meet those demands, and then what set of assessments were required to be able to determine the suitability of those individuals for the work.

Mr MARK TAYLOR: Just popping back to the periodical assessments, or the five-yearly ones, what happens if you do not pass that test?

Ms DONOHOE: There is not really a pass or a fail. There are five categories which you could be determined and that is either fit for your ordinary duties—and, sorry, I will just go back to your previous question while I answer that part there, which is, they are assessed to the role that they are performing at the time. We have reasonably accommodated some individuals for many years. If they have a major cardiac condition, for example, and they cannot be a frontline firefighter, they may be working full time and have won a position in our communication centres where they do not need that level of fitness.

So they could either be deemed fit for their ordinary duties, they could be deemed fit with some restrictions or a requirement for an annual review or a more frequent review, they could be deemed temporarily unfit for work with Fire and Rescue NSW as a frontline firefighter or their ordinary duties and fit for suitable duties, or they could be deemed permanently unfit. In that case, our occupational physicians internally would look at that outcome and see whether or not there are some accommodations that can be made. Then we would work with the commands to try and keep these people employed in a job somewhere in the organisation that is not a frontline role.

Mr MARK TAYLOR: But other than just reassessing their duty allocation, are they given assistance to raise their physical fitness standard?

Ms DONOHOE: Absolutely. Within the health and safety branch that I look after we have got about 50 staff and about half of those are dedicated to looking after their physical or mental health on a proactive and a promotional basis. We have a team of health and fitness advisers, wellbeing officers, a wellbeing coordinator and they are out all day every day promoting and being able to provide that assistance to help people get up to the level that they need to be, or being able to proactively offer support and they can do that in many different ways.

We have got a wide range of programs available too for them to be able to access in advance of their assessments or just when they feel the need to be able to reach out and obtain that support.

Mr MARK TAYLOR: Okay. So that I do not take all my colleagues' questions, this is my last one. What is the main cause of injuries in Fire and Rescue NSW?

Ms DONOHOE: The main cause of physical injury would be body-stressing injuries—slips, trips and falls. They take up about 60 per cent of all of our workers compensation claims.

The CHAIR: Can I just ask questions in regards to retained firefighters? Obviously there is a difference.

Ms DONOHOE: There is, yes, on call.

The CHAIR: What are the requirements for the retained firefighters in regards to physical assessment?

Ms DONOHOE: At pre-employment or for the incumbents?

The CHAIR: Both.

Ms DONOHOE: Either/or. From a pre-employment perspective they are required to undertake exactly the same medical prior to employment. That assessment is either conducted by GPs in their local area and oversighted by our occupational physicians or it can be done by our occupational physicians, just depending on where they are located and the most efficient way of doing that. For the physical aptitude test, it is a modified assessment that can be done locally to that area. Then, when it comes down to determining whether or not they are fit for the role of a firefighter or otherwise, we work very closely with the local areas and there may be some reasonable adjustments that can be made depending on the local response profile. So, for example, if you are in Balranald and you go to a hundred calls a year and 99 of them are motor vehicle accidents, you do not need that same level of cardiovascular health as what you would if you were attending frontline structure fires, for example. As for the periodic assessments, they are the same as what it is for the permanents.

Ms TAMARA SMITH: I have only a couple of minor questions with regard to Fire and Rescue NSW. From the police today we heard that modern policing in New South Wales is quite a sedentary role. I am interested that Fire and Rescue NSW does ongoing monitoring of health. In your view, is that because it is literally such a physical—it is not tactical. I mean, I have recently toured all of my Fire and Rescue brigades and I was amazed at just all the different roles that they undertake. I have no doubt that there is a huge amount required other than just physical strength. But would you say that it is because it is literally very much a physical role?

Ms DONOHOE: Absolutely. Absolutely, it is, in terms of not only muscular strength and endurance but the cardiovascular capacity and the level of cardiovascular health that you require is so much more than what you will find in any other emergency service or even the military because of the impact of the heat. From a physiological perspective it just increases the risk exponentially because of the response to that. That is obviously the radiant heat that they are exposed to but then also the metabolic heat that they generate because of the personal protective clothing that they are having to wear. It is obviously there to protect them from the heat but also requires a much more significant physiological response to be able to physically cope with the work.

Ms TAMARA SMITH: With the amazing work that the NSW Rural Fire Service do, and I notice that you have that pre-entry requirement of a physical assessment, do your volunteers have ongoing checks of how they are going? Because it is exactly the same demands.

Mr McKECHNIE: From a Rural Fire Service perspective it is role dependent. So volunteers that are joining, like a new member, fill out a medical declaration as part of their membership application. Certain staff roles such as our mitigation crews or what is known as our operational officer program, they both have a medical requirement and then for the mitigation crews there is also a physical fitness test requirement. So it is very role dependent and then different volunteer roles, roles that they take on in their brigades, have different requirements—remote area firefighters, compressed air breathing apparatus—which is based on the risk of those roles and the level of exertion that goes with them.

Ms TAMARA SMITH: So in the same way that there are levels of physical entry requirements, like the physical aptitude test [PAT] stages that Fire and Rescue NSW have—is that similar? Basically, once they are volunteering if they want to volunteer for overseas deployment or in remote areas they would then need to meet certain standards of fitness to be able to do that, is that right?

Mr McKECHNIE: Yes, role dependent.

Ms TAMARA SMITH: And also obviously the skills?

Mr McKECHNIE: Yes.

The CHAIR: It is a bit different for volunteers though. What I think Mr McKechnie was talking about was the substantive roles in the RFS.

Mr McKECHNIE: That is right. So volunteers, as a whole, do the medical declaration upon joining. Volunteer firefighters who look to take on specialised roles such as remote area firefighting do the medical and fitness, and certain staff roles—substantive position holders—will go through it as well.

Ms TAMARA SMITH: But there is nothing ongoing. We had an inquiry recently into assaults on police. Originally this was going to be about injuries. What I am trying to assess is whether you think there is a need for ongoing physical assessment of volunteers, given the past two years of New South Wales history. I guess it is a whole other conversation regarding the levels of mental health support. But do you think there is a place for ongoing assessments to see how people are going?

Mr McKECHNIE: Again, I would refer to—depending on the role. Again, for the volunteer who is just joining at their local brigade—I am not taking away from it—but is just performing some general firefighting duties, they face a different risk compared to those who look to take on offensive structural firefighting. That is the next step—the compressed air breathing apparatus. So they do regular checks. Then our mitigation crews, for example, or the remote area firefighters, there is an ongoing program for them. So, again, it is risk-based, based on the exertion of the role.

Ms TAMARA SMITH: Forgive my ignorance. With the Mount Nardi fires, which were those massive canopy fires, are you saying that for brigades in my area volunteers are only chosen based on their skills. Are you saying that your average person who has volunteered would not suddenly find themselves in a very intense situation?

Mr McKECHNIE: No. They certainly could but there would be a difference between those who operate from an appliance—so with all the support that goes with having a fully equipped truck with everything that goes with that—compared to a remote area firefighter who operates away from an appliance. It is all hand-tool work. It is very physical. There is no support of pumps and hoses—or unlikely to be.

Ms TAMARA SMITH: Is there any data that you can give us about injuries of volunteers over the Black Summer bushfires?

Mr McKECHNIE: I would have to take it on notice but certainly there is data available. I would have to take it on notice to provide the statistics.

Ms TAMARA SMITH: I would be interested in physical and psychological injuries. I wonder whether we are entering a new era where there are going to be a lot more volunteers, who might not necessarily have envisaged being in very intense situations, finding themselves in very intense situations.

Mr McKECHNIE: We can supply that.

The CHAIR: Does the Rural Fire Service have any initiatives to assist their volunteers in regard to physical and mental health?

Ms CHIH: Yes. For the past five years we have had the Your Health Matters program running and we are actually coming up to the end of the five-year program now. There has been a number of initiatives. For example, we conducted health checks. This is where we would conduct health checks and it is self—

Ms TAMARA SMITH: Referral?

Ms CHIH: Yes. We go out to the different districts to family events that might be run. We would have people available for a health check if they want to come and do a health check. That is where they find some information about themselves. It is a blood test, checking cholesterol, checking glucose, those sorts of things. Very recently we have also added the Kessler 10 for mental health and just checking—so I guess wellbeing checks as well. We have been doing those. We have also engaged a provider to provide assistance to us and to provide guidance for us for things like catering and putting together a service standard so that we can improve the catering capabilities for our organisation. A raft of initiatives has been put in place so that we can promote and increase the health and fitness of our members—staff and volunteers.

Mr EDMOND ATALLA: In relation to the Fire and Rescue staff, is there a program where you manage or monitor the wellbeing of your officers? Or do you only become aware when there is a situation that arises or a workers comp claim?

Ms DONOHOE: No. We have a range of mechanisms by which we can become aware of any wellbeing issues. We have got a number of support programs in place. Obviously, we have got the standard EAP, which is a confidential helpline that they can reach out to. But internally we have wellbeing staff who are out and about

having conversations with firefighters at stations all day every day checking in on their welfare. Then, obviously, if there is anyone putting their hand up requiring some help proactively, we certainly facilitate that through a range of existing programs that we have got in place. We have also got a number of initiatives such as a well-check program that we offer to our high-risk groups, so the fire investigation unit, for example, or areas where we know their call rates are significantly higher in relation to specific motor vehicle accidents or certain types of fires. We proactively reach out to those crews or to those individuals and offer that support. It is proactive as much as possible and then obviously we have got the reactive component. When someone does put their hand up, there is a wide range of programs available for them.

Mr EDMOND ATALLA: Do you believe over the past decade there has been an escalation of workers comp claims or a reduction?

Ms DONOHOE: Over the past decade I would probably need to take on notice. Over the past three years I would say it has probably remained relatively stable. We generally have around 500 workers compensation claims a year with about 10 per cent of those being psychological in nature. I would say that, while they are remaining relatively steady, the number of claims where there is time lost is actually decreasing. I think that is because for any of the claims that come in we have got a very proactive injury management model, which we have based on an initiative called work injury screening and early intervention [WISE]. That is where we look at people holistically and not only consider the injury itself but, irrespective of the injury, actually assess physical and psychosocial barriers that may be there returning them to work. So a very holistic, comprehensive rehabilitation program gets people back to work a lot quicker than what they have historically.

Mr EDMOND ATALLA: You have mentioned a 10 per cent figure of psychological injuries. Are you saying 90 per cent are physical injuries?

Ms DONOHOE: Or of that nature, yes. We have got some which are exposure to—sorry, yes. In short it would be 90 per cent physical and 10 per cent psychological. The causes of those physical injuries are quite varied though.

Mr EDMOND ATALLA: Just so I can get a benchmark measure with other agencies, what is the average length of service of your officers, say, in the last stats that you have taken?

Ms DONOHOE: Average length of service? No, I am sorry. I would have to take that one on notice if I could.

Mr EDMOND ATALLA: How is the Rural Fire Service monitoring the wellbeing of volunteers—so the non-paid staff.

Ms CHIH: We have a member assist program so that, where volunteers require assistance, they can always—it is available for all the volunteers and their families for support and assistance. Through the Your Health Matters program we conduct surveys and we get an understanding of the requirements and the needs of our volunteers so that provides that information back to us. Also with our volunteers we have peer support programs in place so that, if there are assistances required, they can reach out to our peer support.

The CHAIR: To the Rural Fire Service Deputy Commissioner: The SES obviously has a very large volunteer base as well. At the initial interview stage when they apply to become a volunteer they actually assess their capability. Does the RFS do anything like that?

Mr McKECHNIE: When you apply to become a volunteer member of the service, at the moment part of that process is you fill out your membership application form and you do an interview with the brigade captain or similar. The intent of that is a discussion about what it is to join, what roles the brigades perform—because different brigades across the State have different functions depending on their area—and what roles the volunteers in that brigade would like to take on. That is the first opportunity.

We are also reviewing our membership application process at the moment to move to an online format. As part of that, we are developing the requirements at the moment that they will be able to see what different roles in the service do so that they will be able to understand exactly what it is that maybe they wanted to apply for, or they may change their mind about the type of role that they are volunteering for in the service. That interview stage with the brigade captain or representative will still exist. It is the opportunity for a discussion.

The CHAIR: Do the captains get any training to make that assessment? They are obviously volunteers themselves.

Mr McKECHNIE: They work through it with their districts but they do not do specific training on conducting that interview. But they are best placed for the role of the brigade and what the roles within the brigade are.

The CHAIR: Are you aware of how many compensation claims associated with physical injuries have been sustained by volunteer firefighters? Were there any key trends in the last—obviously we have faced an enormous fire season. Did we see an increase in compensation claims?

Ms TAMARA SMITH: That is what I asked, Chair.

The CHAIR: Did you? Sorry.

Ms TAMARA SMITH: Yes.

The CHAIR: I beg your pardon.

Ms TAMARA SMITH: But could we clarify a time frame? For the benefit of the Committee, could we do 2019 to 2021 compared with 2016 to 2018? Would that be useful? I would think that would be useful, just to see if there is a—

Mr McKECHNIE: Yes, we can take that on notice.

The CHAIR: Are there any other questions?

Ms TAMARA SMITH: Fire and Rescue, what is your current workforce number, roughly?

Ms DONOHOE: Roughly it is close to 7½ thousand. There are, I am going to say, 300 or 400 administrative and trades staff and then the remainder is pretty much split between our permanent firefighters and our on-call firefighters.

Ms TAMARA SMITH: That figure of 500 workers comp claims a year, I wonder if that is high compared with other—it seems high, but I actually do not know.

Ms DONOHOE: Proportionally it is probably—

Ms TAMARA SMITH: It is about similar to the police?

Ms DONOHOE: —yes, about the same, if not a little bit under.

Ms TAMARA SMITH: To the police and other emergency service workers?

Ms DONOHOE: Yes.

The CHAIR: What about in comparison to other States?

Ms DONOHOE: With other States, we would probably be just under as well. I would have to confirm that, though, and I am happy to get some stats for you on that. But anecdotally I think the information that we have at hand—in terms of our costs, though, our costs are significantly less than our counterparts because we are getting people back to work so much quicker. We have got a lot of in-house resources in terms of our health and fitness staff, our mental health staff and our injury management staff, so we are able to do that a lot more efficiently and effectively. It is very specific and tailored to our individual needs.

The CHAIR: Thank you very much for your time. There may be some further questions—and obviously we have already asked some—that you will be provided in writing. The responses to those will be made public. Thank you very much for your time. We really appreciate your service. That concludes our hearing today. I thank those who have been viewing the hearing and staff who have participated and assisted in conducting the hearing today.

(The witnesses withdrew.)

The Committee adjourned at 16:29.