REPORT ON PROCEEDINGS BEFORE

COMMITTEE ON LAW AND SAFETY

INQUIRY INTO VIOLENCE AGAINST EMERGENCY SERVICES PERSONNEL

At Macquarie Room, Parliament House, Sydney on Monday, 14 November 2016

The Committee met at 10:00 am

PRESENT

Mr G. Provest (Chair)

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

The CHAIR: Good morning. Thank you for attending the public hearing of the Committee on Law and Safety. Today's hearing is held in the course of the Committee's inquiry into violence against emergency workers. This morning the Committee will hear first from representatives of the government emergency service providers, specifically the NSW Police Force, NSW Ambulance, the NSW State Emergency Service, Fire and Rescue NSW and the NSW Rural Fire Service. The Committee will then break for lunch, following which we will hear from the Health Services Union, the Office of the Director of Public Prosecutions, the NSW Nurses and Midwives' Association, the Australasian College of Emergency Medicine and the Australian Paramedics Association (NSW). At the outset, I thank the witnesses appearing today for making themselves available.

I remind everyone to switch off their mobile phones, as they can interfere with Hansard's recording equipment. For the benefit of the gallery, I note that the Committee has resolved to authorise the media to broadcast sound and video excerpts from the public hearings. Copies of the guidelines governing coverage of the proceedings are available. Please note that any filming is to be as unobtrusive as possible and should not disrupt the Committee proceedings or focus on Committee documents. In addition, filming of individuals in the public gallery should be avoided. I now declare the hearing open.

CARLENE YORK, Assistant Commissioner of Police, Human Resources Command, NSW Police Force, sworn and examined

The CHAIR: Thank you for appearing before the Committee today to give evidence. Do you have any questions on the procedural information sent to you in relation to witnesses and the hearing process?

Ms YORK: No, I do not.

The CHAIR: Would you like to make an opening statement?

Ms YORK: Thank you very much. In line with the submission that the NSW Police Force has given, the policing profession is an area that experiences injuries of our officers. It is quite a unique organisation in that, as our Commissioner often says, we run into danger instead of running away from danger, and, therefore, some serious injuries, injuries and assaults are occasioned upon our police. Certainly, over the last few years the NSW Police Force has taken a much greater focus on prevention of injuries and illnesses for the NSW Police Force. In the past we have certainly been very good on response and looking after our officers, but it is important to us to prevent any injuries or illnesses to officers, and that is not only the physical injuries that they suffer but also the psychological injuries.

We also are very active in relation to our safety strategies to make sure that we look at ways in which we can prevent injuries, with due diligence of our officers and taking those responsibilities seriously and putting in place some of the strategies to prevent injuries. We have also, through some changes to our workers compensation legislation, received an amount of money for some projects to look at prevention, education and training in relation to preventing injuries as well as responding to injuries, as well as making sure that any disengagement of our officers is done in a proper, ethical way and we can help them in transitioning into a new occupation or whatever they seek to do.

The risks and hazards that face police officers are often external and are often very difficult to control, and, therefore, our risk mitigation strategies need to take that into account both in providing proper personal protective equipment and proper strategies to make sure that officers are as safe as possible. One of our mantras is making sure that officers return home safely at the end of the day, and we try and do everything we can to assist them, knowing that some risks cannot be removed but certainly can be mitigated.

The CHAIR: With those formal risk assessments that you have put in place, have you noticed over time it has reduced the number of attacks on the police?

Ms YORK: I have not had it measured, but I know that our reports of injuries and assaults have gone down over the last few years. We also have improved the culture of reporting what we call near misses so that we can build that into any future risk mitigation strategies. We not only want to know when police get injured, we want to know when they were nearly injured, because there is a fine line between one and the other. So that assists us in providing that information and intelligence that we can build those strategies on. It is difficult to say that any one strategy has had a success because we have had multiple strategies both, as I say, in improving equipment and improving the intelligence that goes into operations and then building that safety structure. Certainly, we have noted that there has been an increase in commanders and executives doing audits, doing dip sampling of the ways in which we do our operations, and we report on that monthly.

The CHAIR: Is there a difference between metro and regional?

Ms YORK: There is a different in policing between metro and regional. The risks though to officers, the propensity or likelihood of injury, is very similar because you have the licensed premises or you have busy roadways, and we want to make sure that the risk assessments we do are valid. But obviously officers can take into account different factors such as isolation, distance from the nearest large towns, geographical differences such as in dense bushland and other injuries that can occur through, say, searches and rescues and things like that. So the framework is the same, but the risks that we have officers take into account are localised.

Ms JENNY LEONG: Obviously the police are part of this inquiry in relation to being subject to attacks or risks, but they also play a role in providing support and protection to other emergency service personnel. Could you talk in a little more detail about the preventative measures that are currently used in the NSW Police Force that may be measures that could be used in other areas—because the ideal aim is that we are preventing these violent attacks on our emergency service personnel? Do you have any thoughts as to what is currently used within the Police that might be able to be used in other areas to prevent some of those attacks occurring?

Ms YORK: Over the last couple of years we have worked more progressively with Ambulance and Fire and Rescue, and certainly if we talk about psychological injuries under the Mental Health Commissioner in New South Wales, they recently announced a strategy which was about the prevention of psychological injury for emergency service workers, and that came out of joint partnerships between the three agencies together with Premier's and the Mental Health Commission. Under my command, in Human Resources we have started what we call the Workforce Improvement Program, which is a safety, health and wellbeing program for all police. There are many areas of the program that could be adapted into other emergency services. I must say that I was provided with for these four years $17 million, because there is a cost to be able to put some of these programs in. I do not know the particulars of the other emergency services and their financial situations, but this funding certainly allowed us to be proactive in relation to our strategies.

If we look at some examples for physical injuries, I now run usually three physiotherapy clinics where we for a trial period of three years employ physiotherapists to allow police to get in very quickly when they have a physical injury to be concentrated on by the physios. We have started to put dieticians and physical training officers into those clinics, and we have had amazing success from that in reducing the cost per claim of workers compensation by approximately $300 per claim per week, because there is personal tuition. They go in and see the physio. It is not like a physio clinic where they have six or seven patients; they are seen rotating around at the same time. They have half an hour with the physio; they then go out to a personal trainer; they then get a plan to fix their injuries and then they come back each week and have personal tuition. That is working very well, and I know we have been talking with the Fire Brigade about the program. The program is giving personal treatment for the officers.

We have also started bringing in psychological injuries to the physiotherapy clinic, because we know that physical fitness, activity and personal support are very important for psychological injuries. Often they do not want to relate to police, do not want to go to police stations, so we are bringing them in. So far, early days, but it is looking quite successful. We also have nurses that travel around the State to do diabetes, cholesterol and weight testing. There have been significant improvements on the second round, when we go back and again test officers. Because of lifestyle and diet, they have a high propensity for ill health. And we are proactively doing mental health training. I have a psychologist and a police officer going around and presenting My Health First, which is about awareness of the symptoms, acknowledgement that police will feel down and depressed after incidents which physically and mentally affect them, but they can get better and we are here to help them.

That is a selection of some of the programs we do, but across the board there are 93 different programs that are designed to help police physical and mental health. There are peer support officers, chaplains, the Employee Assistance Program [EAP], Healthline. We send a psychologist to every critical incident to make sure that we can help the police. We train commanders on how to identify symptoms of mental health issues. We try to involve the families and get them to understand the signs, and we get out to the community to let the families of officers know. We are supporting officers who have left through legacy and the BACKUP for Life program, where they are told there is a life out there, there is the Men's Shed at Tamworth, there is Rotary, there are lots of good, positive influences in the community they can be involved in.

Without going through all the programs, as I said for us there is $15 million and $2 million for Legacy. Programs are specifically designed to make sure that we can help. They are trial programs, and we are going through the process of either extending them or saying, "That did not work as well as we thought; we want to change it or adapt it and move on". Certainly, I have had feedback from doing communications programs. We brought Professor Kevin Gilmartin out from America. He lectures the FBI in relation to the psychological survival of police officers, as he calls it. He was very well received.

We opened that to families, so that they understand what is involved in policing. Certainly, I push the message out through the Commissioner and the Executive about the need to keep healthy outside of work and not be too focused on police work all the time—keep up the sporting activities and other activities. The program is very much about what the organisation can do for police officers, how we can prevent or react to illnesses and the individual's responsibilities to eat a good diet, reduce alcohol intake and keep physically active. We are sending a different message now.

Ms JENNY LEONG: You mentioned in your submission specifically the risk of police and staff being targeted as a result of terrorist activities. While I recognise that is a serious and genuinely concerning risk, a lot of the submissions we have received from others talk about attacks on emergency service personnel as a result of drug-related and addiction issues and the aggression associated with those. At least anecdotally it seems to be another emergency service area in which there has been an increase in the number of those kinds of incidents, but you have said that you have seen a reduction in the overall attacks on police—I believe that is what you have said in your introduction—

Ms YORK: The reported injuries, yes.

Ms JENNY LEONG: I wonder if you could talk specifically in relation to the attacks by people in a drug psychosis or an altered state. What do you believe is the best thing to do to prevent harm to our emergency service personnel involved in such incidents at the time?

Ms YORK: I am not in a position to talk about the statistics, because that is not my area as I am in charge of Human Resources [HR]. If you want those statistics, we could provide them at a later stage. But I would not disagree with the other submissions that there has been an increase in those attacks. We work very closely with Ambulance and the transport of mental health patients and violent patients they have. We assist them when they are unable to ensure the safety of their own officers or the individual involved. The transporting of mental health patients is an increasing issue for us, and we want to work with Ambulance to make sure that they have the resources and the capacity to do what they should be doing and not always call upon us to assist them.

Obviously, the issue of drugs in the community is a big issue for the NSW Police Force. We will continue to investigate and move to arresting offenders, both large suppliers and smaller suppliers, to make sure that the community is safe. It has certainly been an issue that has been raised in many forums in the country areas, with the increase in crystal methamphetamine—ice—and other drugs in the community. We try to prevent incidents by providing the right equipment for police officers to respond and the right training. There is certainly mental health training for all our officers across the organisation. We have a unit solely dedicated to the training of police officers in how to respond to mental health patients, so that they recognise that it is also a medical issue and not just a policing issue.

As I say, we work with Ambulance and their response in how to calm down situations. We train our officers in relation to conflict de-escalation. The use of force, I suppose, is more towards the last resort, but we provide the tasers and their use is videoed. We have taser reviews to make sure they are appropriately used—not that I am saying they should be used but they are a way to handle the situation if a patient or an offender cannot be calmed down. There is a balance between what damage they can do to officers in emergency services and the damage to the offender or the patient. Any incidents are reviewed and we have formal processes in place to do the reviews, and then we take strategies to make sure that we are using them appropriately. We are guided by ambulance officers for those, and we would call upon medical assistance if we are the first responders, so we work in partnership together.

Mr DAMIEN TUDEHOPE: Assistant Commissioner, I do not think you really answered Ms Leong's first question. I think the impact of her first question was that a lot of the material before us relates to potential assaults on emergency service workers in other areas, including fireys, ambos and State Emergency Service [SES] workers. What do the police do to assist them?

Ms YORK: When they are the first responders, certainly they can call on our assistance. If they do not think that it is safe for their officers to transport the patient to hospital, the police will definitely respond—respond urgently and assist them to make sure that they are safe. The first thing that we want to do is to make sure that they are safe, make sure that our officers are safe and make sure the patient is looked after as well.

Mr DAMIEN TUDEHOPE: I accept that that is the case but it appears to me that a level of coordination needs to exist between each of the services for the purposes of ensuring the safety of the people who are there. The first call-out in relation to ensuring safety is the police. What is the process for ensuring that the police are there in circumstances where a potential call-out relates to either a drug-related incident or a mental health incident?

Ms YORK: We have shared radio communications. Ambulance officers would call over the radio for assistance. That gets conveyed to our communications area and they would get the first available police vehicle in the area to respond.

Mr DAMIEN TUDEHOPE: Do you have response times in relation to that?

Ms YORK: We do measure response times to all categories of reported crime or requests for assistance. I do not have them with me today but I could get them to you and take that question on notice if you want it.

Mr DAMIEN TUDEHOPE: I would like that because part of the analysis that needs to be done here is in relation to the 000 call that is received and in respect of how an analysis is made of that about whether it is an ambo only, whether police are required or whether other personnel are required on site?

Ms YORK: Sure.

Mr DAMIEN TUDEHOPE: Is any profiling done in respect of the person or potential risk of the situation that they are attending?

Ms YORK: In general I can answer that profiling is done. Radio operators are trained in prioritising whether it is what we call a category 1, 2, 3 or 4 job and going to 000 certainly raises their consciousness of making that call. That is conveyed to the police officers who are available at the time. If it is a category 1 job, that will get our priority, subject to the car being available at that time and going there, but the radio operators would continue to make sure that somebody gets there. I can take that on notice and get some more detailed information for you.

Mr DAMIEN TUDEHOPE: The Chair asked you about the difference between metropolitan and regional. You can receive a call in relation to a regional call-out. Do you have any position that the police would take in respect of those circumstances where they ought be involved as part of that call-out before ambulance officers attend on a particular incident? What I am concerned about is the ambulance officer who attends at a remote situation which is either a drug or alcohol-related incident and they are at risk. What is the position that they should be adopting in relation to handling that risk?

Ms YORK: Their response would be no different from in the city in relation to the ambulance officers. They would call for assistance.

Mr DAMIEN TUDEHOPE: How long would it take them to get there?

Ms YORK: It depends where it is. Throughout the regional areas a lot of the crime happens in the more urban areas but I also do accept your point that there are some in the more remote areas such as farmlands and properties that are remote from the cities, although they are fewer in number. Police will respond as quickly as they can to physically get there.

Mr DAMIEN TUDEHOPE: Significant penalties have been imposed in relation to assaults on police officers and mandatory sentencing for the murder of police officers?

Ms YORK: Yes.

Mr DAMIEN TUDEHOPE: Do you have a view on whether that should be extended to other emergency services personnel?

Ms YORK: No, I am not instructed; I have not provided a view but if you have some more detail in relation to some of those proposals, we are very happy to take that on notice to provide it to you.

Mr DAMIEN TUDEHOPE: Are you satisfied with the current sentencing regime relating to assaults on police officers?

Ms YORK: If it was the position of the inquiry that it was to be extended after hearing all the evidence today, again we would take that on notice and provide some details back to you. Certainly the police were very much involved in the recent reviews that we had in 2013 on sentencing and some of the decisions made out of that were in response to our requests. Anything that would assist in the safety of officers would be greatly appreciated, although having said that, I balance it by saying we are looking at a lot about prevention as opposed to sentencing after the event has happened, but anything that makes it safer for police or emergency services would be greatly appreciated.

Mr DAMIEN TUDEHOPE: Do you accept that part of prevention involves deterrence?

Ms YORK: Yes.

Mr DAMIEN TUDEHOPE: If a deterrence regime is in place that might reduce the potential for attacks on police officers?

Ms YORK: It certainly might.

Mr DAMIEN TUDEHOPE: Do you accept though that sometimes it is hard to prevent an attack on a police officer or emergency services personnel when someone is affected by an illicit substance?

Ms YORK: Yes, or intent on creating the havoc that they want to create as well. I think I covered that in my opening remarks. The likelihood of some injuries to emergency services personnel—and I was restricting it to police—is we cannot sometimes remove that risk; it always remains there and, as I say, anything to make it safer for any emergency services worker is greatly appreciated.

Mr DAMIEN TUDEHOPE: Some time ago police officers were issued with tasers for the control of persons?

Ms YORK: Yes.

Mr DAMIEN TUDEHOPE: Is it the experience of police that the issuing of tasers has reduced the number of assaults on police officers?

Ms YORK: Again I would have to take that on notice because it is a specific question. Certainly in my area of responsibility the reported injuries of police has decreased and I would have to take some more research or get someone to do some more research as to whether or not it was as a result of the use of tasers.

Mr DAMIEN TUDEHOPE: I take it you do not have any information which would indicate to us the number of times tasers have been used for the purposes of subduing people?

Ms YORK: No, I do not, but again I could get that for you if that was a question on notice.

Mr DAMIEN TUDEHOPE: This might be a little controversial but I will ask anyway. Would you recommend that the use of tasers be extended to other emergency personnel?

Ms YORK: I would not comment on that. That would be a matter for the other areas of emergency services.

Mr EDMOND ATALLA: Thank you, Assistant Commissioner, for your submission today. You spoke comprehensively about the risk assessment that is undertaken by the police. How do you draw the balance—and I will talk specifically about my area—between those risk assessments and the implementation of safety measures for the risk assessments and public confidence—people feeling that they are still safe? I refer to my electorate of Mount Druitt. Recently the local area command [LAC] put up full screens on its counter. Members of the public have commented that when they walk in they feel unsafe. They advised that if the police are using these measures for protection what do we, as members of the public do to protect ourselves? Do we walk about with barriers and so forth? How do we draw a balance between protecting police officers and at the same time not sending the wrong message to the public that this is an unsafe environment?

Ms YORK: That has been an issue, that grey area of getting the balance right between making sure the community feel safe and are safe and the protection of our officers. There are a number of reasons and I will use your example of the protection inside the community—and it was raised earlier with the heightened risk in relation to terrorist activity—the targeting of police officers overseas is significant and we want to make sure that Australia does not encounter that type of risk to our officers. Police officers will always respond to the community's needs.

In relation to the barriers, though, we also have to balance the fact that one of our strategies is to get police officers back to work even though they are injured and a lot of the police stations now are actually resourced at the front counter by police officers who are not able to be passed as fully operational. They do not have access to all the equipment that they have in the station and obviously some civilian staff work alongside them.

It has been an issue that we have discussed at some length with the New South Wales Police Association of getting the balance right with putting non-operational police back into employable and motivating positions, and that is often at the front counter, and with the fact that we have had a couple of incidents over the last couple of years of aggressive community members coming in and injuring police at the counter. That led to a project in which I am not involved but which certainly has a safety, health and wellbeing aspect as to how we make police stations safer for police and civilian staff that work on the counter. That led to the barriers.

As I understand it, and again I am not specifically involved, they look at those barriers to try to make them less confrontational for members of the public. They have looked at other ways to design police stations as well. I know a lot of thought goes into our new police stations and into designing that front counter area to make it as comfortable as possible for community members to come in whilst protecting our employees at that counter, which we know can be a target for people who want to do something wrong by us.

Mr EDMOND ATALLA: Following on from that, are the risk assessments a formal process?

Ms YORK: There is a formal process in relation to risk assessments. There is documentation made in relation to some of the risks. Certainly we look at the risks of the geographical areas—for example, if you are doing a search warrant, the risk of the person and any relationships they have with other offenders or other risks, and the risks of the location so that the strategies can be designed to make sure that the police are as safe as possible when going into those premises, noting that, as I said before, a lot of external hazards are forced upon us in relation to our policing response.

Mr EDMOND ATALLA: Is there a quality assurance system? Is the process of doing the risk assessments documented? Who does the risk assessments? Do people need special training or certain qualifications to do those risk assessments? How do they go about doing them?

Ms YORK: Certainly the managers of operations are involved in doing those risk assessments. I would have to take it on notice as to the specific training, but we do try to create a consistency across the organisation of how they do those. The risks and the decisions taken as a result of those are documented and then they are assessed on the risk rating as to what the risk is and what strategies are in place. Again, usually the senior team or investigating officer with their managers will be the ones doing the risk assessment, but they take into account operational risks as well as safety risks.

Mr EDMOND ATALLA: Is there a requirement of frequency, a requirement that they must be done in a particular period of time, or is it up to each commander?

Ms YORK: They are done for every operation. Sometimes if it is an urgent one, they are making decisions on the run but if it is a planned operation there is a formal risk assessment process that is done for, say, search warrants, going into houses to make arrests, or whatever strategy we decide in relation to the arrest of the offender.

Mr EDMOND ATALLA: What about the local area commands themselves? Somebody must have done a risk assessment to determine barriers are needed at a particular police station. What is the frequency of risk assessments done at local area commands? Does the same frequency apply to all of them, or is it up to the commander?

Ms YORK: It is often up to the commander. Properties branch will be involved in the program of the foyer security, because that is an actual program that has been funded over this year and next year to improve the security. My Workforce Safety Command is involved in that in relation to the safety of the officers as well as that balance between the community and our needs. Then it is done as a response to some change in circumstances. The command can self-initiate a further risk assessment, so it might get information about a particular risk to an officer or a station, and it would reassess the risk assessment.

As well as that, we have—and the name eludes me—a committee at the moment as a response to the increase in terrorism, a program where there is a safety committee with a number of representatives across the organisation who meet to assess the safety overall of the organisation and what strategies can be in place. We have had increased communication. For example: Where there is a security swipe, do not let people follow you in the door. We continually send those communications out dependent on the risk to the community. We look at it as multilayered. There is organisational risk, there is officer risk, there is station risk and operational risk as they go about doing their duties.

Mr EDMOND ATALLA: On the subject of mental health patients, I know of a situation where a mental health patient became homeless and decided to set up a tent and camp in a public reserve. Neither the police nor the ambulance wanted to relocate this patient. I presume they were concerned about the risk to them. The reason they gave for refusing was that the person had not demonstrated signs of violence. The police said, "It's definitely not our role to act as a transfer," and the ambulance indicated that it would not use the force to transfer the patient if the person did not voluntarily come along. You spoke about preventive measures. Certainly this raises extreme concerns about the risk this person posed to frontline respondents who were unable to resolve the situation.

Ms YORK: I do not know the circumstances of that case. I will not particularly comment on that. In our responses, we try to take into account the safety, health and wellbeing of the person. I cannot comment as to why they did not respond; I cannot respond as to why ambulance did not. But there are many government services available for people like that, and I would hope that if we did not respond to the person we might in other cases get the support services out there to assist that person. I am not quite sure of the circumstances. Again, we do like to respond to the community's fear of crime as well. Maybe that person was making people unsafe—I do not want to go down into the detail of the case.

Mr EDMOND ATALLA: Without going specifically into the detail of that particular case, the question is: Whose role is it to deal with mental health patients and transfer them to an institution? Is it the role of the police or is it somebody else's role? Do you see it as not the police's role?

Ms YORK: Unless there were some criminal behaviour or safety issues, police are not the primary response. But given that we are a 24/7 response, from time to time we are called upon to be the first respondent when perhaps another government agency is more appropriate but not available.

Ms JENNY LEONG: I have a couple of questions. I am wondering whether or not the use of tasers is used as part of your de-escalation mental health training.

Ms YORK: I would have to take that on notice but, as I have said, it is certainly not our primary response. I am aware that we would try many other strategies to make sure we did not have to use a taser.

Ms JENNY LEONG: Are you aware of the detail around the sentencing regime that currently exists for assaults and crimes against police officers and emergency service personnel?

Ms YORK: No.

Ms JENNY LEONG: Would you think that someone suffering from a mental health issue or in the middle of a drug psychosis would be aware of those sentencing details when they were committing an act of violence against emergency service personnel?

Ms YORK: I think there would be various levels of understanding, depending on their mental health. We, when responding, would try to make sure that that person's safety was looked after.

The CHAIR: Finally, have you ever seen any frustration from police in relation to the sentencing regimes around convicted offenders who have assaulted police?

Ms YORK: I have not personally witnessed it, but that might be reflected in some appeal provisions to some of the sentences.

The CHAIR: Thank you, Assistant Commissioner, for appearing before the committee today. The Committee may wish to send you additional questions in writing, the replies to which will form part of your evidence and be made public. Would you be happy to provide a written reply to any further questions?

Ms YORK: Yes, I would.

The CHAIR: Thank you for your attendance.

(The witness withdrew)

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

ALLAN LOUDFOOT, Executive Director, Clinical Services, NSW Ambulance, sworn and examined

The CHAIR: Thank you for appearing before the Committee. Before we proceed, do you have any questions concerning the procedural information sent to you in relation to witnesses and the hearing process?

Mr LOUDFOOT: No.

Mr MORGAN: No, I do not.

The CHAIR: Would you care to make an opening statement?

Mr MORGAN: I am pleased to have the opportunity to come here today. Importantly, I had a 23-year career with the NSW Ambulance up until the last 6½ years where I worked interstate. I returned to New South Wales in February. I have been travelling around on what I refer to as a listening tour of the workforce in the State. It was four weeks after I came back that two significant issues were raised with me by the workforce. One was the issue of occupational violence prevention and the other about mental health and wellbeing. I feel particularly strongly that these two issues are inextricably linked. It was from that that NSW Ambulance commissioned a capstone strategy around occupational violence prevention within the workplace. Allan Loudfoot is the chair of the Occupational Violence Prevention Committee and has led that since my return. Mr Loudfoot is here to assist with the detail of what has happened in the last 6½ years.

The CHAIR: As the Commissioner have you sensed any level of frustration in sentencing practices with convicted offenders for attacks on your ambulance workers?

Mr MORGAN: Generally speaking, the workforce has not reflected frustration with the levels of sentencing. We do know that generally speaking emergency service worker assaults are dealt with more strongly in the courts.

The CHAIR: Section 21 or 23 of the Criminal Code.

Mr MORGAN: There is a significant cultural shift, which I fully support, where the workforce says this is unacceptable now. In the days gone by occupational violence was seen as part of the cut and thrust of being a paramedic, police officer or emergency services worker generally. I think our workforce is now far more sophisticated and is saying this is not acceptable. When I go to work and I do my job I do not expect to be assaulted for doing it.

Mr DAMIEN TUDEHOPE: You have given us two specific examples in the submission. You have stated there is a 12-point action plan prepared in relation to building skills with staff. Can you give us an indication of what that 12-point plan involves?

Mr LOUDFOOT: That was following a meeting between Health, the industrial bodies and paramedics. We worked through some issues and there were some high level areas in relation to those 12-point actions. The best way to respond to this is to say that all the actions from that particular meeting became part of the Occupational Violence Group which was a far more embracing group and they have been encompassed in that piece of work. What that entails is primarily around, as our colleagues in the police said, de-escalation and situational awareness. It is all the various elements that can reduce the risk to the paramedics themselves.

Mr DAMIEN TUDEHOPE: Let me put you in this position. You arrive as the first responder to an incident. At what point do ambulance officers take the view that they will take no further action until police arrive?

Mr MORGAN: I can answer that. If it assists I could ask Mr Loudfoot to describe shortly a little of the outcome from the Occupational Violence Prevention Group. The short answer is from the time the 000 call is made the call takers are following a structured algorithm which includes eliciting answers to whether or not there are potentiators of violence. If there is an affirmative answer to that the police are automatically notified through what is called the Inter-CAD Electronic Messaging System [ICEMS]. Automatic notification goes off to the police. Within the computer-aided dispatch [CAD] system there are what are referred to as caution notes where there may be a previous history of violence or a violent perpetrator at a particular location.

These are flagged to note caution for paramedics in responding to those scenes. In rare circumstances it will say up-front, "Co-respond with police". The important thing to note is that it is an historical record so it is not definitive in terms of whether or not we respond. In responding to that incident, taking account of the information elicited by the call taker or by the caution note system, paramedics are trained to take account of various circumstances in attending and approaching a scene.

That might be as simple as attending a domestic residence that is isolated, whether or not the lights are on, whether it looks like normal circumstances, or are there loud noises emitting from the property. They are undertaking a risk assessment and are trained to do so at that point. The difference is that the paramedics will then make a decision, based on the risk assessment, whether or not it is appropriate for them to approach a victim that has called 000 for help.

Mr DAMIEN TUDEHOPE: Is there anything you would like to add to that?

Mr LOUDFOOT: I fully support the position of my Chief Executive.

Mr DAMIEN TUDEHOPE: It relies on historical material.

Mr LOUDFOOT: There is also, similar to the NSW Police Force, a systematic questioning of the caller and within that questioning we are attempting to identify risk areas. We ask specific questions if there is assault, "Is the perpetrator still in attendance? Are there weapons being used?" That allows us to understand the level of risk—but clearly it is an indication. Unfortunately, the reality of our work is that we do not know the truth until we are confronted with the situation itself. From that point on the paramedics would determine the action to be taken in terms of whether we can approach the patient or we stand off and wait for our colleagues in the NSW Police Force to assist us.

Mr DAMIEN TUDEHOPE: In your view, has the strategy involved in filtering the information you are receiving resulted in a reduction in assaults on your officers?

Mr MORGAN: We have had the medical priority dispatch system since 1998. My experience tells me that all these things are multifactorial. As Members would know from our submission, we have done a lot of work in this area in terms of specific campaigns. The data indicates that each time we do a campaign, whether it be community education or a chemical intervention, there has been a drop in the incidence of occupational violence. However, generally speaking, that will turn over time and go back towards the normal trend.

Mr DAMIEN TUDEHOPE: You mentioned chemical intervention.

Mr MORGAN: Correct.

Mr DAMIEN TUDEHOPE: What is that?

Mr MORGAN: We use pharmaceuticals to restrain violent patients. This has been very successful for certain patients who are at risk of injuring themselves further. The pharmaceutical currently used by NSW Ambulance is used extensively by the medical profession. It has very few side effects. One of the most significant risks of sedating medication is that it can cause depressed respiratory function. The pharmaceutical that we use does not do that. The reported experience of paramedics is that it leads to good compliance from otherwise very difficult patients.

Mr DAMIEN TUDEHOPE: How is that administered?

Mr MORGAN: It can be administered intra-muscularly.

Mr DAMIEN TUDEHOPE: Would that require restraint of the individual?

Mr MORGAN: Correct. That would normally be done by NSW Police Force officers assisting paramedics. Not all patients are violent, but they may have the potential to be violent. Where those people can assist in that treatment, obviously we engage them to do so. It is by far and away the preferred strategy.

Ms JENNY LEONG: I am unsure about police restraining the person while—

Mr MORGAN: Not necessarily, but they may do. There is obviously a range of circumstances in which it is preferable. Everything that paramedics are trained to do relates to the de-escalation of any situation. Generally it has been my experience that most people are compliant when they are thinking rationally about the situation and they do not want to do harm to paramedics coming to their aid. Where there is a serious risk to an individual and they are actively violent, we will call for the assistance of the NSW Police Force to restrain them. We will usually then use a combination of chemical and physical restraint. The physical restraint is a Velcro suit that they cannot get out of. Ultimately, that is far more dignified for the patient because we can treat them as a patient again. It is also safer for police officers and for paramedics.

Mr DAMIEN TUDEHOPE: What are the differences between alcohol-affected patients and drug-affected patients? Are there different protocols involved?

Mr MORGAN: No, not in terms of the behaviour per se. However, paramedics are always looking at different thermodynamics in the patient. Some pharmacological substances can cause significant increases in blood pressure, whereas alcohol can reduce blood pressure, which can lead to issues with the patient's cognitive

function. All of that is taken into account when deciding whether it is appropriate to administer a certain pharmaceutical.

Mr DAMIEN TUDEHOPE: Anecdotal evidence appears to suggest that people affected by ice or amphetamines have a greater propensity to be violent than other patients. What is the protocol for dealing with them?

Mr LOUDFOOT: This is obviously a complex issue in terms of what confronts the paramedic, such as acute behavioural disturbance. The reality is that a significant number of those patients will be mental health patients, and a smaller subset will be mental health patients who have consumed alcohol and/or some form of illicit substance. As my Chief Executive Officer indicated, we look at all of the symptoms displayed by the individual to determine how each element is contributing to the acute disturbance. We then put in place the appropriate care pathway for that patient. It is a complex issue that we face literally thousands of times.

Mr DAMIEN TUDEHOPE: What is the care pathway for someone affected by ice?

Mr LOUDFOOT: The care pathway for ice is the same pathway as that used for mental health issues and alcohol-related issues. Obviously, the safety of the officers is of paramount importance. We must also ensure that patients do not harm themselves. We go through a de-escalation and restraint process, and potentially we can employ chemical restraint. Each is escalated depending on the patient's condition and whether we require assistance from the NSW Police Force. Sometimes this occurs in health facilities, and we obviously work with our colleagues in the health sector.

Mr DAMIEN TUDEHOPE: What chemical is used?

Mr LOUDFOOT: Droperidol. It is longer lasting, which helps us in regional areas to transport patients demonstrating acute behavioural disturbance. That is a great benefit for our regional paramedics.

Mr DAMIEN TUDEHOPE: Do you have any figures on the number of ambulance officers who have been assaulted as a result of alcohol abuse, mental health issues, or drug abuse? Can you provide the Committee with a breakdown of the numbers?

Mr MORGAN: I will take the issue of causative factors on notice. Last calendar year there were 142 instances of occupational violence reported to the police. When we take account of a range of other non-intended assaults that can occur and put it into perspective, we could assume that one person in this room would be assaulted in the course of their work each year.

Mr DAMIEN TUDEHOPE: Can you provide any more detail on notice?

Mr MORGAN: I am not sure whether we have it broken down to that level. I will take that question on notice.

Mr DAMIEN TUDEHOPE: You may have been here when Ms Carlene York was asked questions about whether there was a difference between assaults occurring in metropolitan areas and regional areas. Are ambulance officers in regional areas exposed to any greater risk than those in metropolitan areas?

Mr MORGAN: That is two different questions. That is interesting.

Mr DAMIEN TUDEHOPE: It might be the other way around.

Mr MORGAN: No. The answer to the question about whether more regional officers are assaulted is no. However, the risk profile is potentially different, and I will come back to that. Generally speaking, we see a slightly higher risk of assault for paramedics in metropolitan areas than in regional areas. However, as you touched on with the Assistant Commissioner, in rural areas our service delivery is largely based on cover simply because there is a smaller population base and greater distances to travel. If the question is whether the risk is higher, distance travelled and backup assistance are the issue. Within a metropolitan area we can be reasonably assured that backup, whether it be another paramedic crew or the police, would be within reasonable proximity. The challenges of remote service delivery for our regional staff mean that we must be cognisant of just how far away their backup might be. Therefore, there may be a level of risk aversion, and we must be very alert to that when dealing with a potentially violent situation in a remote area.

Mr DAMIEN TUDEHOPE: Would you like to make any changes to provide greater protection to regional ambulance officers?

Mr MORGAN: I go back to the earlier question about whether a determined perpetrator is cognisant of penalty. In my experience, it is very uncommon to have an isolated, single individual who is truly angry and determined. There will usually be other people present who have either contributed to the situation or are trying to de-escalate it. That is the target audience that we need to really challenge, to say that there is no such thing as

an innocent bystander. People have influence over other people. They will usually be family or friends. While the perpetrator may not be cognisant of the penalties, the community has a role to play in standing up and saying that occupational violence against emergency services workers is completely unacceptable. We all have a role to play in that. We need good people to come forward and play these roles. Saying, "I do not know what is behind that darkened door and therefore I am no longer going to knock on it," is not good for our community. Targeting community bystanders and saying, "You have a role to play here in saying no," is critically important.

Mr DAMIEN TUDEHOPE: I compliment you on that.

Ms JENNY LEONG: In the past there have been public awareness campaigns promoting no tolerance for this kind of behaviour. You seem to suggest that you believe they are effective or that it is important to have them. Do you think those campaigns have been effective? Is there evidence of that, or have there been assessments showing those campaigns to be effective? Is it time for another one? What are your thoughts on that?

Mr LOUDFOOT: Within the organisation we have been tracking the trend in occupational violence for more than 10 years. As each major initiative is undertaken we can see that there is a corresponding dip in occupational violence. That is relatively short-lived. Nevertheless, it is an absolute benefit. My view is that there is a need for ongoing education. To what degree and how often would it need to be clearly identified and explored. It is something that I am sure the service would support.

Mr EDMOND ATALLA: Are risk assessments done at the time when a call comes in to the emergency callout centre? Do those people make a decision as to whether police assistance is required before you even get there? Is that documented in your risk assessment?

Mr MORGAN: Yes. That touches on what I was referring to earlier. We have an internationally recognised software algorithm that takes a call through a pathway. It initially assesses the priority of response to the patient we are being called to, then goes into a series of safety questions. They range from whether it is indicated that there are weapons present right down to the simple question of whether there is a dog on the premises, for the information of the paramedics. That might sound trite, but it is a genuine consideration.

The CHAIR: Absolutely.

Ms JENNY LEONG: We have all door-knocked.

Mr MORGAN: Our approach would be to always whistle up the dog before going into a backyard. That is the procedure, the level of sophistication, that the algorithm will take people through to ensure that as much information as possible is recorded in the computer-aided dispatch. That information is then sent down a mobile data terminal to the paramedics. Either through that assessment or through a caution note on the system, police will be notified by Inter-CAD Electronic Messaging System [ICEMS] if that is appropriate.

Mr EDMOND ATALLA: Who notifies the police? Is it the call centre or the paramedics?

Mr MORGAN: It can be both. In the initial instance, if there is a clear indicator of violence that we are required to attend because a person is potentially injured then we will usually co-respond with police. In 2008 we worked extensively with the NSW Police Force on a joint communication protocol to determine what both agencies mean when they use certain language. So when a paramedic says, "We need you urgently," does that mean urgently within a time frame or with lights and sirens? We clarified interagency language. We are far better able to understand each agency's needs, given that one is medical and one is policing.

Mr EDMOND ATALLA: Where an assessment is made and police assistance is deemed to be required, when ambulance officers arrive at the scene and police officers have not arrived, do ambulance officers then wait for the police or do they start to do their work?

Mr MORGAN: The short answer to that is that they make an assessment. Every situation will be different. It will be multifactorial. It will look at whether they have reasonable grounds for believing there will be some risk to their safety. It will also look at whether there is a greater risk to the person of not intervening. For example, a higher risk tolerance may be taken by a paramedic to attend to the victim of gunshot or a stabbing. If that same crew were called to someone who had a fractured hand, following an incident, then they may consider it highly unlikely that that person would succumb to the condition and therefore they will wait for assistance, where it is in reasonably close proximity.

Mr EDMOND ATALLA: Has there been situations where the ambulance officer has arrived but the police have not arrived? Are the response times captured anywhere? Do you have statistics to show how long ambulance officers have waited when police assistance has been required? Does that need to be improved?

Mr MORGAN: Not directly. We do have a provision for crews to stage, but that can be multifactorial. There can be many reasons. We may have been asked to stand off by police who are already on scene, as distinct from a crew making a decision to stand off. It is not instructive in that regard. As emergency services, both police and us are commonly affected by demand. There will be periods where there are enough resources to meet the demand, but when particular incidents occur in large volumes both services can be overwhelmed. That is the nature of emergency services. While we would love New South Wales Police to be on the doorstep every time we are, it is really not practical. Having said that, the same occurs when they call us. If we are dealing with other immediately life-threatening conditions sometimes our response time to back them up is not what we would like, as a rule. That is the nature of emergency services. We have policies and procedures to make sure that we best target our resources to meet the needs of the community at any given time.

Mr EDMOND ATALLA: Do you have a view about whether the legislation should offer the same protection to all first respondents at the same level? For example, the Police Act 1990 contains sections about how perpetrators are dealt with. The ambulance service and other emergency services are mentioned in the Crimes Act 1900. There are so many Acts involved. Should there be specific legislation that covers all first respondents equally in offering protections and in its view of perpetrators? Is that something that the Committee should consider?

Mr MORGAN: Generally speaking, the issue is not so much whether things are equal. Subtleties will be taken into account, either by the government of the day or the courts, to determine those things. There is good evidence that the courts deal with perpetrators of violence against emergency service workers more harshly than they do members of the general community. I support that, from the perspective that this is very different. These are a group of people who come to work to help, whether they are police or paramedics. If we want good people to come forward and take on these roles, they need to feel protected by their employer and by the legislation. To go back to my earlier point, the biggest row that we all have to hoe is to achieve community acceptance of the fact that we all have a role to play in this. My opening remarks talked about 25 years ago when it was just seen as part of what we do. We have shifted so far to say that this is not okay that I think these next few years, in the same way as random breath testing was such a big shift in community attitudes towards drink-driving, our whole community stands up and says, "I find occupational violence against emergency services workers to be abhorrent".

Ms JENNY LEONG: You talked about an awareness of risks when officers go out versus when they are in attendance dealing with an incident that escalates. What duress or communication systems are currently available and is there space for those to be improved when a situation changes to a higher level or it is not identified as a risk and then changes?

Mr MORGAN: It was absolutely something that was dealt with under the Occupational Violence Committee, so I might pass that on to Mr Loudfoot.

Mr LOUDFOOT: We have certainly done the preparatory work looking at what we currently have. We do have duress systems in the vehicle and we have portable radio systems that also have the duress systems. We also have geo-location so we can know exactly where the incident is occurring, and that gets flagged within our computer-aided dispatch system. Just to give you a brief idea, it actually freezes the entire system. Every work station has an alert that comes up and everyone then realises there is a potentially significant event happening. The advisory group, we have indicated within one of the recommendations that we look at the potential to use additional technology. What that would be and how that is explored, there were things like obviously vehicle cameras, body cameras and all that sort of thing. So that will certainly be fleshed out as the recommendations come out of the advisory group.

Ms JENNY LEONG: The Committee heard from the Assistant Commissioner earlier about the need for funds and resources to be able to implement plans. In relation to the advisory group and from the plans that you have been looking at, where is the best place for immediate attention to try to address some of the violent acts that are occurring against officers?

Mr LOUDFOOT: I think there would be a number of strands. Again, there would be the area around public awareness, to which Mr Morgan has indicated has shown to be valuable. I think the other area is really around training the workforce, and that is quite a challenge for NSW Ambulance with 4,500 people throughout the entire State. Any money that would be invested would certainly see a great return. I know it is the view of the Executive and leadership team and Mr Morgan that it is really about investing in prevention up-front. That is really where you get your best return. Then we have obviously the areas around how we address incidents that do actually occur. I would suggest there would be significant funding required to help support what we would like to roll out in the future.

Ms JENNY LEONG: The Committee has heard a lot about the challenges around mental health and drug addictions that are faced both in terms of first responders from the police and ambulance. Is there a need for an additional specialist service support gap or is it just about training within those individual services? I think everyone recognises that that is a huge issue that the community faces. As to the crossover between whose responsibility it is, based on the mental health needs, the health needs versus the violence and aggression, do you have thoughts on additional expertise services needed within that space to be able to assist our first responders in such a situation?

Mr MORGAN: Particularly from a staff perspective, do you mean?

Ms JENNY LEONG: Yes. I think the challenge is which service is most responsible but also the different elements, depending on the circumstances. I think we would agree that there is a need around mental health and drug addiction that is different and can sometimes fall in the scope of one area and sometimes in the other. We realise it is a problem.

Mr LOUDFOOT: Our challenge is that there is a significant amount of work that goes around the mental health patient and that is impacting on the Police and on Ambulance. One of our challenges is that the individual can be a prisoner one moment and a patient the next moment, and that is very difficult for us. I would say that a significant amount of work has gone on between New South Wales Police and Ambulance in terms of having a Memorandum of Understanding which has just recently been reviewed. Nevertheless it is a challenge in regional New South Wales around how we respond, just the practicalities of actually delivering those services. We also have fairly sophisticated and mature Local Protocol Committees. I think that is important that we put in local committees to look at mental health patients, protocols, what works and what needs to be potentially refined or addressed in a different way.

Mr DAMIEN TUDEHOPE: Should there be specialist units if they are alerted to the potential for that sort of incident?

Mr LOUDFOOT: I think again the issue is how do we provide that specialist care or units throughout the entire State, from the practical side. Having said that we have looked at within Sydney, we have Mental Health Acute Assessment Teams that we have actually brought out and that has been very, very successful. We have actually put mental health professionals on an ambulance with extended care paramedics and they are specifically targeted to particular cases and then they can refer the individuals directly into mental health facilities. That is something that we are keen to explore further.

The CHAIR: Are you aware of the mental health training program of the police? I have done that three-day course at Goulburn and it is very good and then I have done a few ride arounds.

Mr MORGAN: In relation to the impact and the intersection here between occupational violence and the mental health and wellbeing of our staff, I can honestly tell you we would not have enough time to talk about how important an issue this is for our workforce. We simply look at assault from the impacts of the physical event, not only the psychological impact on the individual but the ripple effects into family and extended family is quite profound. When perpetrators do walk away from the justice system, there are often staff members who are left dealing with this for many, many years, and the ability to then go back and face that darkened door in the middle of the night becomes a repetitive challenge for our colleagues who are doing this.

There is terrific work being done between the three agencies, particularly now, under the guise of the Mental Health Commissioner John Feneley, who is really leading the way in this State around mental health structures and strategies for first responders. The collaboration and the recognition between the services is remarkable, which I have been struck by since I have come back. Importantly, the issues and the nature of the work that paramedics and first responder agencies do, if you think about it in its logical sense, in some ways our colleagues are exposed to things in a week that many in the community would never even see in an entire lifetime.

There is good evidence in the literature about how the cumulative effect of that can be quite devastating over time. All agencies are reasonably good at dealing with our colleagues once they are damaged. But, sadly, the reality is that the evidence is saying that is only part of the investment. The big new work needs to be done at the front end in preparing our workforce to be resilient and deal with these issues so that they are fully charged and can deal with what they are confronted with on a day-to-day basis and go home well. A lot is going to unpack in this space over the next decade, that is for sure.

Mr DAMIEN TUDEHOPE: Can I ask you about the people who man the call centres, the 000—

Ms JENNY LEONG: Or staff them.

Mr DAMIEN TUDEHOPE: I stand corrected. Those who staff the 000 centres, are they subject to violence when they are taking calls and, if so, how do we put in place strategies to assist them?

Mr MORGAN: Absolutely. Earlier this year I launched a campaign that the organisation had been working on for some time, which stated there is no excuse for 000 call taker abuse. Having been a call taker at an early part in my career, it is a tough gig. You are on the 000 telephones from morning to night and there is a certain finality about it. As paramedics, we get to follow up on cases and see what happened ultimately. Our call takers get the end of the call and pass it on for a crew to be dispatched, so there is never a level of finality that comes from that. It can be quite cumulative over time as to the trauma that they are exposed to.

From an occupational violence perspective, some call takers have said that they will get at least one abusive call during their shift. Again, that is unacceptable, so we have strategies and policies in place with the aim of trying to give them a break, trying to give them access to peer support officers. But it is very, very difficult, because quite often you have disempowered people who may not necessarily be able to articulate what it is they are experiencing at that time and can become quite abusive in an effort to get the call takers to comply with what it is they are needing. The call takers are only there to help. They are trained professionals, and they have at their hands the best information to assist the member of the public in resolving the emergency that they are confronted with.

Mr DAMIEN TUDEHOPE: Are we seeing any reduction in that?

Mr MORGAN: The launch of the campaign, as I understand it, had a positive effect. Again, this is persistent and we have to continue these sorts of things.

Mr DAMIEN TUDEHOPE: There has been a suggestion that the NSW Ambulance Service ought be disassociated with NSW Health. Do you have a view on it?

Mr MORGAN: I do, and I reject it. That is the short version.

Mr DAMIEN TUDEHOPE: It is part of a submission to us.

Mr MORGAN: I will give a basis to that, rather than being quite as glib as I was. Paramedics are health professionals. Right across this country most paramedics are moving to education through the tertiary sector. They are on the cusp of becoming registered health professionals. The conversations that paramedics have with themselves is about clinical governance and patient safety. Thirty years ago it was true, when the paramedics were only a small part of the Ambulance Service, most were not as highly trained as the paramedic. But with the level of advanced clinical intervention that is now occurring, it is only right and proper that we are with other health professionals and we continue that professional dialogue. Of course, at the end of the day, things like that are a policy decision for the government of the day and you can make any model work if you need to. There are other examples of that occurring elsewhere in the country.

The CHAIR: Do we call you Commissioner or Chief Executive?

Mr MORGAN: Commissioner was put to me as a rank; chief executive is a role. Generally speaking, I tend to go by Dominic.

Ms JENNY LEONG: Thank you, Dominic.

The CHAIR: It was great information that you put forward. We thank you for appearing before the Committee today. The Committee may wish to send you additional questions in writing, the replies to which will form part of your evidence and be made public. Would you be happy to provide a written reply to further questions?

Mr MORGAN: More than happy.

The CHAIR: On behalf of the Committee, thank you very much for your informative answers.

Mr MORGAN: Thank you.

Mr LOUDFOOT: Thank you.

(The witnesses withdrew)

KATHLEEN IACURTO, Director, People and Culture, NSW State Emergency Service, sworn and examined

GARY ZUIDERWYK, Manager, Work Health and Safety, NSW State Emergency Service, sworn and examined

The CHAIR: Thank you for appearing before the Committee today to give evidence. Before we proceed, do you have any questions concerning the procedural information sent to you about witnesses and the hearing process?

Ms IACURTO: No.

Mr ZUIDERWYK: No.

The CHAIR: Would you like to make a brief opening statement before we commence questions?

Ms IACURTO: Not necessarily, no.

Ms JENNY LEONG: Can you talk about the seriousness or otherwise of violence and assaults against State Emergency Service [SES] workers, whether it is an issue that you see in this area, and how much of an issue it is, as you see it, as part of your workforce?

Ms IACURTO: I will commence. The first thing we need to appreciate is that the workforce of the NSW SES are primarily volunteers, so we have approximately 9,500 volunteers across New South Wales spread geographically. We also have a paid workforce, again also in regional centres. The primary concern for us is in relation to our workforce in the field, who are our volunteers in the orange uniform. We also have a communication centre, which takes the form of a call centre, which receives calls from anybody in the community who requires our services, and that is our 132 500 number. Our volunteers, in particular, are exposed on a day-to-day basis to a wide range of incidents.

The NSW SES is the combat agency for flood, storm and tsunami. However, we are called on by the Police and other emergency services to support, as required, in a wide range of instances. We also provide first community response services, particularly in rural and regional communities, so we will have volunteers, for example, who are trained not to the extent of paramedics but in advanced first aid so they are able to provide support to their communities as required. Even in the field of medical support, they need to be able to refer people as needed. They are exposed to a wide range of situations. They will be called upon from time to time to doorknock, for example, when people are required to evacuate from their homes or their businesses and will potentially have exposure to people with violent tendencies, depending on the role.

Ms JENNY LEONG: Obviously, we can see that from time to time that would be the case. In respect of risks faced by volunteers and workers within the SES, what are the highest risks you would see and are these violent attacks one of the higher risks we see for SES workers and volunteers?

Mr ZUIDERWYK: Yes, particularly for our volunteers who are at the front line and facing the community and out there dealing with the community in a whole variety of situations from, as Ms Iacurto said, road crash rescue to doorknocking. Generally speaking, doorknocking is a low-level risk for the majority of the community because they are very supportive of the SES and like to do the right thing for an evacuation. However, from time to time we do have threats of violence. We have had a number of instances where our volunteers have been assaulted in the course of travelling to and from or in the course of their duties doorknocking when people are not too happy about having to evacuate.

Ms JENNY LEONG: Do you have data around the number of incidents compared with the number of volunteers and how regularly it occurs? You may not have it right now.

Mr ZUIDERWYK: I do have three reports in the last four years that we do have of acts of violence. The verbal abuse is something that our members do not report and that is their personal choice, so we do not have any data around that side of it.

Ms JENNY LEONG: Is training done? We have heard from other services about the importance of training to try to deal with prevention. What kind of training is currently provided and is there space for additional resources and support to provide additional training to protect our SES volunteers?

Ms IACURTO: We might start with mentioning a program that we have been rolling out just this year which we call "Take 5". That is a program that has been specifically designed to assist our volunteers in terms of their own personal resilience and understanding, mindfulness and mind on the task and how to address situations and be able to identify when their colleagues or they themselves are potentially at risk in a range of situations. We also provide training to all our volunteers in safety risk assessments and they are required to undertake a

Take 5 risk assessment prior to commencement of any job. They are trained in doing that and they are mentored through that process when they first commence as a volunteer within the emergency service.

Mr ZUIDERWYK: That Take 5 is a simple process: stop, think, identify, assess and control, and continually monitor the risks. In addition to that, in each training package that they go through to improve their skills as a volunteer, that is reinforced. In any situation they approach, we as a service mandate that they do a Take 5 to look after themselves and those around them. If the position is unsafe and they recognise the risk then they will pull away from the situation. That is what we teach our members. But with the unpredictability of people, sometimes things happen with no warning.

Mr EDMOND ATALLA: The statistics show that the level of incidents, as you have indicated, are fairly low compared with other first responders, being the police and the ambulance. Section 24 of the current State Emergency Services Act offers protection from people obstructing or hindering you during the carrying out of your role. Do you believe that the penalties imposed or those protections are sufficient?

Ms IACURTO: The protections that are provided under section 24 of the New South Wales State Emergency Services Act are not as strong as those provided in the Crimes Act for law enforcement officers. We have a view that it would be a benefit in terms of reduction of the risk for our members and our volunteers if the penalties were to be increased to the same level as for law enforcement officers.

The CHAIR: Taxidrivers are in that category as well.

Ms IACURTO: That is right, and school staff.

Mr EDMOND ATALLA: You believe that strengthening the Crimes Act to cover the SES is recommended by the SES?

Ms IACURTO: Yes, we do.

Mr EDMOND ATALLA: You have mentioned that your operations are prominently done by volunteers and you would have certain training for those volunteers when they join your organisation. Is any specific training given as part of your training model to address the issue of violence against emergency personnel working in the SES? Because they are volunteers, do you also train them in dealing with those situations?

Mr ZUIDERWYK: We only have a small part within our first aid course. That is about asking for consent to assist the casualty; however, it comes back to the Take 5. Where they are not comfortable or there is a risk of being hurt themselves is when they withdraw and seek assistance from the police.

Mr EDMOND ATALLA: I will be specific. You indicated in your submission that there were two incidents of violence during doorknocking. Did those people who were doorknocking receive specific training to deal with a situation when violence arises so that they are able to walk away or follow particular instructions? I think one of the people you mentioned in your submission was punched as a result.

Mr ZUIDERWYK: That is correct.

Mr EDMOND ATALLA: Obviously that person did not walk away in that situation. Is that because of a lack of training which needs to be addressed? What I am getting to is; Do we need to address the training that is given in the SES as part of your training module to cover that element when those situations arise?

Ms IACURTO: Our training, as indicated a moment ago, is primarily focused on generic risks. Any specific risks that are identified for the particular task at hand, we could absolutely benefit with a greater focus on prevention of violence or identification of risks associated with violence. This actually does happen at a local level. In one of the examples that we have submitted, for instance, there was more than one occasion where our volunteer members were given to appreciate the fact that there may be violence at a particular location and at a particular address from an individual. Once that is known, then that is built into their Take 5 and their risk assessments prior to going out to a job at that address or nearby. It certainly happens at a local level but at a broader level we could certainly benefit from an increased focus in that space in our training.

Ms JENNY LEONG: My understanding is that sometimes in regional and remote areas—and you mentioned this in the beginning—volunteers will be called on in a situation where it may be taking a longer time for the ambulance or police to arrive on a scene. In those circumstances, the risk is much higher. While I appreciate that the Take 5 initiative may assist in general situations, obviously there is the situation where the volunteer knows they are being called upon because of the delay in an ambulance or police officer being able to be on the scene. Are there specific suggestions you might have to the Committee in relation to what could assist in those circumstances? That is a very different circumstance to one where the volunteers are doing their role as a volunteer; they are actually stepping in to assist in another capacity.

Ms IACURTO: Our volunteers are very clear that where they are required to wait for potential police assistance or other emergency services support they will, particularly in rural and regional areas, as part of their risk assessment, and generally not go alone to an address to deal with a situation; they will go at least in pairs. Where they are not confident of the circumstance, they will actually not necessarily attend. We do specify in our training up-front—and this relates partly to the earlier question—that it is okay to say no where you feel that you yourself are at risk, and that is embedded in our training from beginning to end. They do make that assessment at the beginning.

The CHAIR: As you saw in the terms of reference, this Committee is looking at sentencing patterns and how courts are dealing with that. Is that a concern that your membership has brought to you? Is it a major concern to them or where is it on a scale of one to 10, do you think?

Mr ZUIDERWYK: Our health and safety representatives form our consultative mechanism with our volunteers. There is a level of risk. It is not something that they have raised as a major issue that we need to address. We look at it holistically as an organisation, and believe the risk is there. With the changing and unknown environments, I believe that we need to do more in this space.

The CHAIR: I should probably declare an interest. My sister-in-law and brothers-in-law are involved in the SES. The SES seems to be more active and more involved in search and rescue. I assume that the big emphasis is on counterterrorism so that if a major event happened the SES would be actively involved. So the risks levels for your people are unfortunately climbing. Are you factoring that into your training?

Ms IACURTO: Absolutely. Those are some of the directions that we are taking. We talked just now about preventative mechanisms, risk assessments and the up-front component, but we also have a number of mechanisms in place to support our people, to assist them in making decisions when moving into a situation, and also to be able to deal with circumstances after a potential or real event. That includes our peer support team and chaplaincy service which is available to all members. They are a very active group who are trained in mental health and psychological first aid and are able to provide that sort of support and assistance for planning events as well as after action.

The CHAIR: They would see some pretty horrific things from time to time.

Ms IACURTO: Indeed they do, particularly at road crash rescues and at others.

Mr ZUIDERWYK: I will just add that we do a lot of land searches for the police, so they come across a lot of horrific scenes there as well.

The CHAIR: That concludes our questioning. Thank you for appearing before the Committee today. The Committee may wish to send you some additional questions in writing, replies to which will form part of your evidence and will be made public. Would you be happy to provide a written reply to any further questions?

Mr ZUIDERWYK: Yes.

Ms IACURTO: We would be very happy to.

(The witnesses withdrew)

(Short adjournment)

MALCOLM CONNELLAN, Executive Director, People and Culture, Fire and Rescue NSW, sworn and examined

GERRY BYRNE, Assistant Commissioner, Metropolitan Operations, Fire and Rescue NSW, sworn and examined

The CHAIR: Thank you for appearing before the Committee today. Before we proceed, do you have any questions?

Mr CONNELLAN: No.

The CHAIR: Would you like to make an opening statement before we start questions.

Mr CONNELLAN: Yes. I thank the Committee for inviting us here today. Firefighters are generally met positively when they arrive at an incident. They are highly regarded by the community for the services they provide, and security concerns are generally not an issue. In general, firefighters consider each incident in the same way, regardless of its type. They assess the situation and respond accordingly. There have only been 24 recorded incidents relating to violence in the five years since 2011. These range from punches and assaults against firefighters by bystanders and residents, including those affected by alcohol or other drugs, to bottles being thrown at firefighter crews. Occasionally firefighters will be verbally abused in certain areas. A recent example was when firefighters responding to a grass fire in a rural area faced threats and abuse by a group nearby.

In other situations where firefighters may be at risk of a violent response, the police will be called before firefighters proceed. An example of this is at a clandestine drug laboratory or a recent case where an abusive home owner intentionally set fire to the house. In response to verbal or physical threats against firefighters, section 35 of the Fire Brigades Act provides an offence of obstruction of firefighters and other personnel. Since 2011, five convictions were recorded under section 35 of that Act. While there have been limited convictions for this offence, the legislative safeguard acts as a deterrent to obstructive behaviour. Fire and Rescue supports any message that will strengthen the protection and safety of firefighters as well as emergency service personnel, particularly in situations where they are carrying out their duties. We also support extending the special offences for injury and murder of police officers to other emergency service workers on the basis that they all deserve these special protections. Given that the current terrorism threat is probable, and the fact that Fire and Rescue NSW works very closely with the NSW Police Force, there may well be an increase in the type of dangers all emergency personnel face in the future. Thank you.

The CHAIR: Do you wish to make an opening statement?

Mr BYRNE: No, thank you.

The CHAIR: Could you briefly describe the protocol between Fire and Rescue NSW and the NSW Police Force in responding to incidents with potential threats?

Mr BYRNE: If there is an incident and we are aware from some of the details that there is a threat, the police are requested to respond to assist Fire and Rescue NSW personnel at the incident. In those circumstances Fire and Rescue NSW personnel would not take any action unless there was an immediate threat to personnel and civilians, that would be the priority.

The CHAIR: We heard earlier that the Ambulance Service of NSW has a protocol in place when it takes 000 calls.

Mr BYRNE: Yes.

The CHAIR: Is that the same for Fire and Rescue NSW?

Mr BYRNE: We have a response protocol that says essentially we dictate what appliances go to what situations. There are always basically two fire trucks that go, so a crew of a minimum of eight will arrive on scene. One of the differences with Fire and Rescue NSW is that even if it is only one truck, there are four personnel on that truck, as opposed to a police officer who might arrive one out or two. There is safety in numbers. Essentially if we arrive at an incident and there is a threat of violence to firefighters at the incident we will not proceed unless there is a risk or a threat to life, we will back away and request the police to attend. That is the way we will deal with nearly all incidents where there is a threat to the individual firefighters.

Mr DAMIEN TUDEHOPE: Do the five convictions recorded since 2011 represent the totality of the allegations that have occurred since 2011?

Mr BYRNE: To the best of my knowledge that is correct. There have been occasions when there has been civil unrest where firefighters have been at the scene but, as I said, we will generally retire from that zone of risk and allow the police to carry out the law and order issues before we come back into the incident.

Mr DAMIEN TUDEHOPE: Can you describe some of the facts and circumstances that gave rise to those convictions?

Mr BYRNE: The relatively minor incidents were abusive behaviour at small fires where residents were agitated at Fire and Rescue NSW personnel. I do not think there have been any incidents of actual physical harm to firefighters; it is more sort of abusive comments and threatened behaviour. There have certainly been no incidents of injuries.

Mr DAMIEN TUDEHOPE: Can you tell us about the risks involved in attending a fire at a methamphetamine laboratory?

Mr BYRNE: The risks associated with meth labs or clandestine labs are pretty serious because what often happens is the offenders will booby trap the buildings and leave devices that could cause serious harm to responders. Generally a risk assessment is undertaken generically around that type of incident—for example, if it is a clandestine lab is suspected police will inform Fire and Rescue NSW that is the case. The protocols around how you respond—our specialist HAZMAT teams would only make entry with police under certain guidelines and the processes that they follow are determined to eliminate the risk as much as possible.

Mr DAMIEN TUDEHOPE: So the real risk is the booby trapping of the premises?

Mr BYRNE: That and any clandestine lab, if you have ever had the good fortune to see one, is a very messy environment.

Mr DAMIEN TUDEHOPE: I have not actually.

Mr BYRNE: Basically hygiene and good order is not the priority. Essentially when a lot of chemicals are being used in that kind of circumstance there is a risk to personnel entering there from vapours, contaminated liquids and materials, et cetera.

That is more understood, particularly hazardous materials, by specialist units that enter those areas. They work very closely with the police to do a risk assessment before entry. They know generically what kinds of issues they will be facing. The real risk around them and the danger would be going to an incident not identified as that and then arriving and, on entry, discovering that it is a clandestine lab and you are really not expecting that. That would be firefighters who are first arriving on the scene—the first responders.

Mr DAMIEN TUDEHOPE: What sort of training do those people have to deal with that?

Mr BYRNE: All firefighters undergo hazardous materials training from the beginning when they are in the training college.

Mr CONNELLAN: Yes.

Mr BYRNE: They are aware of the risks involved and the processes and guidelines. We have standard operational guidelines around all these kinds of emergency incidents. That goes all the way through to our specialist units that work particularly with the police—hazard teams, as they are known. Those personnel are trained to a much higher level and have a greater understanding. We have Hazmat technicians as well. Those personnel would be responding to any kind of incident like this along with a fire truck, if it is known that it is a clandestine lab.

Mr CONNELLAN: If I might add to that, we work very closely with the police in relation to these incidents. You talked before about the communications centres. The communication centres are connected by an Inter-CAD Electronic Messaging System so that we can instantly transfer messages between the communication centres, which triggers an automated urgent response from the police if we require them. Mr Byrne is right: If we do come across a clandestine lab that has not been identified, with no life risk, we tend to withdraw and protect the firefighters' lives and those of the people in the surrounding areas rather than actively fight that fire, especially until the police arrive to assist.

Ms JENNY LEONG: The scope and desire of this inquiry is to look at the violence inflicted on emergency service personnel. It is a positive thing to see that in relation to the experience of firefighters generally, it does not seem to be such a significant issue. While there are a number of reasons why you would be included in this and part of this discussion, I would ask whether or not you believe there are changes that are needed to address this in regard to firefighters and what specific changes you believe need to be in place to provide protection. It seems very different to the experience we are seeing in relation to the ambulance and the

police. It would be good to get your thoughts on whether or not there is a need for the inclusion of firefighters in this consideration, or whether the safety and risks are a different consideration to the type of violence we are seeing against police and ambulance.

Mr BYRNE: We support the strengthening of the provisions for all emergency service workers, like we said in our statement. We generally see in firefighters that there is not a great deal of violence against them from the community, as society stands at the moment. If we are projecting into the future and there is more civil unrest, et cetera, that would potentially be an issue. But this agency, for whatever reason—

Ms JENNY LEONG: Can I ask you to clarify what you mean by civil unrest?

Mr BYRNE: I mean riots, and I suppose stuff driven by the social demographics and the economics of some areas like we see in other countries where people are agitating politically, or whatever. All uniform personnel are in the target group. At the moment we have not got that in this city and in this State, but if you look overseas that tends to be an issue. If we are looking at the current state as is, Fire and Rescue is pretty confident with the provisions and part 35 of the Act which covers protection for firefighters. However, we would consider it to be part of the general emergency service provisions to be included in that.

Mr CONNELLAN: If I might add to that, your observations are correct. If we looked overseas for experiences and tried to align our experience to that, you would have to say that the civil unrest that is happening in the United States probably would not occur here to that degree. However, there is also an underlying issue in the United States where emergency service is seen as part of an arm of government and there is, hopefully, a small growing trend where emergency service ambushes are occurring.

Mr BYRNE: Yes.

Mr CONNELLAN: Random shooters are calling emergency services to locations to make a point. We hope that that never crosses to this country here, but we would always have an eye on what happens in other jurisdictions and in other countries because it is quite possible someone would pick that up as a possibility in this jurisdiction. As Mr Byrne said, we would support the strengthening of any requirement that aligns emergency services because we would not like to get into a situation where emergency service workers are subject to a similar type of event, but the outcomes for the offender would be different.

Ms JENNY LEONG: I guess that is what we are seeing as the current situation.

Mr BYRNE: Yes.

Mr CONNELLAN: Yes.

Ms JENNY LEONG: And I would be curious about whether it is your position that we should be increasing their protection and the sentencing that currently stands with the NSW Police Force through to the same level for firefighters? Really, the current regime has a difference and a distinction recognising the specific roles that police officers play.

Mr CONNELLAN: We would support that.

Mr BYRNE: Yes. If we are looking at the current situation, as I said, you have to look a little into the future and what potentially could happen. At the moment it is not a huge risk for firefighters, but should there be more attacks on firefighters in the future, we would want to see any separation or differences in how they were treated—that is, the offenders, for example.

Ms JENNY LEONG: When you refer to incidents and examples overseas, in regard to being able to assist the Committee can you give us some specific examples of where we have seen that kind of attack on firefighters and whether or not we should be looking to other places where that kind of attack has got to that level?

Mr BYRNE: As Mr Connellan just said, there are incidents in the United States where firefighters have been ambushed on arrival at incidents and shot at and killed because they are seen as an arm of government and wearing a uniform.

Ms JENNY LEONG: Has there been any indication that that is the case in Australia?

Mr BYRNE: No, there has not. We are talking sort of macro. We think in the future if that kind of society evolved, it would be wise that you would not have any difference in how the emergency service workers are treated in terms of outcomes from the judicial point of view.

Ms JENNY LEONG: But currently, given we do not have that type of civil unrest, there is no need at the moment for that.

Mr BYRNE: No.

Ms JENNY LEONG: But as a future protection, you are saying that if we saw that type of civil unrest, that may need to be something we address.

Mr BYRNE: Yes. That would be the driver.

Mr CONNELLAN: That is correct but, as I said before, you could have two emergency service workers being subject to the same attack and the offenders have had different outcomes.

Ms JENNY LEONG: As is the case.

Mr BYRNE: Yes.

Mr CONNELLAN: Yes.

Mr EDMOND ATALLA: You mentioned that there have been 24 incidents in five years. In the eyes of your staff, that is probably 24 too many.

Mr DAMIEN TUDEHOPE: Is it 24?

Mr BYRNE: Twenty-four.

Mr EDMOND ATALLA: In five years. In relation to training provided to front-line fireys, is any aspect or element of that training related to how to deal with a violent situation when it arises? Is it formalised in the training process? If that is something that is not, would you consider it?

Mr BYRNE: I would answer that in this way. Basically, when a crew arrives at an incident, you have a station officer and a station commander in charge of the crew and the appliance, the truck. That person undergoes promotional programs to get to that position. Part of that is understanding how the legislation is applied in reality from a practical point of view. Also, during that experience—we are talking probably eight to 10 years for that to occur—there would be a number of instances where they have experience along those lines. The promotional programs call it legislation. For example, 35 would cover the responsibilities of the officer and advise around the standard operational guidelines of when to withdraw and ask for police support and what is safe and not safe.

At the end of the day, health and safety provisions apply as a priority. A station commander would not put his personnel into any situation. If on arrival someone is violent, it would be withdrawn unless, as I said previously, you are advised there was a risk to life and you needed to take an action to save a life. On every other occasion it would be: withdraw, call for the police, and wait for the police to deal with the law and order issue.

Mr CONNELLAN: If I could add to that? The officers also undergo scenario training: realistic simulations where they use interjects, because it is one thing to put out the fire but it could be a reporter is an interjector or an owner/occupier; it could be that person is upset with the stress. It is practised practically as part of the practical training program to be promoted to officer ranks.

Mr EDMOND ATALLA: You have mentioned a couple of times the situation in the United States with attacks on the fireys there. For you to mention that, that means you are considering at some point in time this might transfer to Australia, although you said that this is not evident here yet. For forward planning, are you considering changing your training patterns? Are you considering addressing those situations, if they do arise in Australia?

Mr CONNELLAN: We have circulated active shooter guides to our plain commanders as a consideration. We also have an officer embedded in the police counterterrorism command who works with the police very closely to look at emerging trends and provide input into our plans and procedures and guidelines to consider all those eventualities.

Mr EDMOND ATALLA: In the submission there is mention of section 35 of the Fire Brigades Act that deals similarly to the ambulance and others in their particular Acts, dealing with people who provide obstructions and so forth. Do you believe that this is sufficient to deal with violence against fireys or would you like to see more strengthening under the Crimes Act that deals with all emergency services personnel equally, rather than have all these separate Acts, given the different benchmarks that my colleague has indicated in how offenders are treated if they assault police officers, how it is different from how offenders are treated if they assault a firey? Do you believe that as part of our recommendations we should consolidate all of those separate Acts into one Crimes Act that deals with all emergency personnel equally? Do you have a view on that?

Mr BYRNE: We would support consistency, as Malcolm said earlier—a consistent approach across emergency services. How they are defined—police and emergency services—would be important: what professions you are ruling into that group. But certainly the standard police, ambulance, fire, SES, RFS we see as all carrying out the same type of work. The risk is greater for police, obviously, and ambulance officers, but there should be no difference in how all those employees are protected or how they are dealt with.

The CHAIR: Do firefighters have duress alarms in their vehicles or on their body other than their radios if they get into a difficult situation?

Mr BYRNE: When they leave the truck and they go to an incident, no, that is not part of our standard operational guidelines or procedures. Obviously there is contact while they are in the vehicle; so they have got radio contact, mobile phone contact, all that. But, generally, when they are at an incident, apart from the hand-held transceivers, no.

The CHAIR: Because there would probably be a needs basis?

Mr BYRNE: A needs basis. We look at the enterprise risk, what is the risk here, and it is a bit like I said, that as an organisation we are fortunately not seeing a great deal of this kind of event with firefighters. That is not to say in the future that would not change.

The CHAIR: In relation to the regions, do you ever experience problems with electronic communications between the trucks and head office and things like that? There have been a few submissions you would have seen on the public website.

Mr BYRNE: Yes. There are certain blackspots around the State that are well documented and known, and we would be no different to any other agency with the same issues.

The CHAIR: So you have a protocol to deal with that?

Mr BYRNE: We have a number of contingencies that we use in those situations. One of the options at the moment is a satellite dish that we are exploring through the telco to be able to ensure 24-hour coverage no matter where the blackspots are. But that is an innovation that is on the cards at the moment.

Mr CONNELLAN: And all of our trucks are tracked through AVL—automatic vehicle locators. So we can look on a map and work out where they are at any time. We do have layers of redundancy. Apart from the government radio network, all the trucks have mobile phones on board as well. So there are layers of redundancy within those vehicles.

The CHAIR: So they have got mobile phones?

Mr BYRNE: Yes, there are mobile phones.

The CHAIR: With the rollout of the new helmets there was the desire, when I was slightly involved with it, that down the track you would have video and voice comms to all your firefighters, so a commander or a chief could talk to them and know exactly where they are. How far away in the future is that?

Mr CONNELLAN: We have voice.

The CHAIR: You have voice now?

Mr BYRNE: We have voice. I think one of the issues around that is more about telemetry: being able to track. It is difficult in large buildings. Concrete and all those substances, glass, that can actually impair communications no matter how advanced it is. But the issue for us long term, the goal is to be able to track individuals inside a building, for example, at an incident. That is not there yet, but there are some early innovations in that area as well.

Mr CONNELLAN: But the new helmets do have integrated voice in them.

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

Mr CONNELLAN: Yes.

Mr BYRNE: Yes.

The CHAIR: Once again, on behalf of the Committee, thank you and thank you for your great organisation. Part of our process here is just trying to make it safer for your workers out there. Well done, and get back to work.

(The witnesses withdrew)

ROB ROGERS, Deputy Commissioner and Executive Director, Operations, NSW Rural Fire Service, sworn and examined

The CHAIR: Thank you for appearing before the Committee today to give evidence. Before we proceed, do you have any questions concerning the procedural information sent to you in relation to witnesses and the hearing process?

Mr ROGERS: No, I do not.

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

Mr ROGERS: Firstly, I place on record my appreciation for being given the opportunity to appear before the Committee and provide input into the inquiry into violence against emergency service personnel. The Rural Fire Service is the world's largest volunteer firefighting organisation, covering a majority of the State's landmass, and current membership stands at 74,000 people. The safety of our members, both volunteer and salaried, remains of vital importance to the Rural Fire Service. Between 2010 and 2016 there were 14 reported incidences of violence against RFS volunteer members whilst undertaking operational activities. Of these incidences, there was one incidence of an actual assault with minor injuries and thankfully no significant injuries or fatalities. The remaining 13 incidences involved verbal abuse, with the majority of those incidences reported to the NSW Police Force.

It is my belief that, particularly historically, many incidences such as verbal assault were significantly under-reported. By that, I mean they occur in the midst of an incident and we carry on with the incident and do not bother to report those things. While the statistics I have given you represent a very small occurrence of assault when compared to the thousands of incidents attended annually, it is important, in my opinion, that the Government sends a clear signal to those who would commit acts of violence against emergency service personnel that this behaviour will simply not be tolerated.

It is important that the Committee recognise that each one of these incidences is an attack on a volunteer whose sole motivation is to protect the community without any financial reward. Any incidences of violence also have the potential to be a disincentive to volunteering, which could have a long-lasting impact on volunteer numbers. Additionally, there is the potential for abuse of RFS staff members carrying out regulatory roles such as investigating hazard complaints, issuing regulatory notices like fines and undertaking fire investigations. In closing, I am sure that I would be speaking for our 74,000 members when I say that the Committee should carefully consider the adequacy of the current sentencing regime and, if appropriate, look at any additional measures to ensure emergency service personnel, particularly volunteers, receive the protection they deserve.

The CHAIR: Recently we passed legislation to grant emergency service personnel greater access to land: you can cut a fence or break a lock on a gate.

Mr DAMIEN TUDEHOPE: Greater access to property.

Mr ROGERS: Yes.

Mr EDMOND ATALLA: I read that in 2013 the Act was amended to bring it in line with legislation for other first responders in relation to obstruction and hindrance. What prompted that change to the Act? Why was that deemed necessary?

Mr ROGERS: I believe that there was an omission in the original drafting of the Act, that it was restricted to employed staff and did not cover volunteers. It was obviously appropriate to make that accessible for volunteer members. I do not believe there was any intention to restrict it.

Mr EDMOND ATALLA: So it was not because there was an increase in incidences?

Mr ROGERS: No, it was looking for consistency across the legislation and to ensure that volunteers were treated equally.

Mr EDMOND ATALLA: Given the RFS has a lower number of violent incidences against emergency personnel, do you believe that the Act is sufficient to deal with those situations at the moment, or would you like to see a strengthening of the Act or a more consistent approach to violence against emergency service personnel for all frontline responders? At the moment there are separate Acts for the police, the ambos and the fireys. In your opinion, should there be a more consistent approach to dealing with violence against emergency service personnel?

Mr ROGERS: I think that would be appropriate. As has already been acknowledged, police and ambulance personnel suffer more frequent assaults than any other emergency service, and obviously it is very appropriate that they be covered. Irrespective of the number of assaults, the fact that one happens against emergency service personnel, we need to have consistent and clear community expectations of behaviour when people are dealing with these types of situations. In my experience, the typical occasion that our members come across, particularly with verbal abuse potentially escalating into violence, is when they get called out late at night—normally a Friday or a Saturday night—and people have a fire on a rural property with a lot of alcohol involved. Sometimes there might be a fire ban, so they will be asked to put out the fire or the brigade starts to put out the fire, and people get very angry about that. Then there is a lot of verbal abuse with the potential for that to escalate into violence and, of course, police are called quickly. I think that not only the laws have to be in place but also it has to be advertised that it is clearly not an acceptable behaviour to do this and it is viewed very dimly. I would support consistency, but there needs to be some public awareness with that.

Mr EDMOND ATALLA: Given the low number of incidences, in the training model is there any emphasis placed on dealing with violent situations?

Mr ROGERS: It is not specifically covered, but our people are in consistent radio coverage. As soon as there is a suggestion that a situation is escalating into potential violence, number one, our standard operating procedure is to send in police. If there is a concern for safety, we withdraw until police arrive and then let police stabilise the situation before the firefighters re-engage. Obviously each situation is different, and there could be a situation where there is a need to continue firefighting operations. But I think that would only be where there is a threat to life.

Mr EDMOND ATALLA: If dealing with violent situations were specifically included in the training module, do you believe that would frighten away volunteers? If they were informed that they could come across violent situations and were told what they should do in these situations, do you believe formally including this training, given the low incidence of violent situations your volunteers face, that might dissuade some of your volunteers from joining?

Mr ROGERS: I guess depending on how it was done. It could be aimed more at awareness and more targeted towards our officers as opposed to every single firefighter, because obviously the officers are responsible for the crew and they are the ones who would make the decisions about withdrawing. I would suggest if we do something specifically, it would be at the officer level. Again, if there were to be measures to change the current regime and that was accompanied by some sort of public awareness campaign, I think it would then be appropriate for us to provide some similar emphasis on training for our officers.

Mr DAMIEN TUDEHOPE: The other side of that potential risk to your members are circumstances where your members are engaged in critical situations and they are giving directions to people about safety and protection. Do you have concerns about the failure of people to comply with directions given by firefighters when faced with critical situations?

Mr ROGERS: That is always a problem. You get situations such as the fires we had yesterday in Llandilo, where you are trying to say to people they need to carry out a particular action, and we tell people that such as by sending out text messages. In that case, the message was remain where you are because it was too late to leave. But sometimes people have adrenaline going and they get it in their head that they want to do something else. Our role is to give advice, but we are not going to stand in the way and physically restrain someone. If police choose to do that then that is their call. But if someone is going to ignore our directions, as long as they are not putting our own firefighters at risk, then we cannot physically stop them—and I do not believe it is the role of firefighters to do that.

Mr DAMIEN TUDEHOPE: Similarly, there are circumstances where there are people who come to stickybeak and people are trying to give directions about staying away. Is that an issue for volunteer firefighters?

Mr ROGERS: Absolutely. It is an issue for all firefighters. It is a big problem, because particularly where people travel by vehicle, say, to look at fires, then they often clog up the surrounding streets when we are trying to get additional resources into the fire because it is escalating very quickly. Yes, that is a real, big problem for us. We try to encourage people to stay away and we say it is not a place to rubberneck—we use that term—because people like to have a look. That is human nature, and we accept that. That is why we try to support media outlets by letting them do their job so they can film and people can see it from the safety of their own home, because they are curious about it.

Mr DAMIEN TUDEHOPE: I know that your primary position is that it is the job of the police to ensure there is compliance with directions. Would you be in favour of increasing some powers for the

commanders of firefighting units to be able to give legitimate directions to people where it would be an offence to fail to comply?

Mr ROGERS: I think we have to look at the specific provisions but there are provisions about following directions in the Rural Fires Act. I do not know the actual sections right now and how well that would apply in each situation. It is probably worth seeing if there is anything that needs tightening up in there, but there is certainly provision; there are powers for the Commissioner. It is how far that passes down to firefighters and officers on the ground.

Mr DAMIEN TUDEHOPE: Certainly in circumstances where you have insular suburbs and there are only one or perhaps two ways out of the suburb where people are trying to get in and blocking it, that creates a real risk potentially to the people you are directing to leave?

Mr ROGERS: Yes. There are far-ranging powers that officers—and this includes volunteers—have. There is a catch-all at the end: Do any other matter or thing that is relevant to containing the situation. So there is a catch-all there but obviously we would have to look specifically at what instances you are referring to as to whether the legislation as it stands now adequately covers those. I think it is important when you have an incident whether or not police are in attendance because until those other emergency services arrive, whatever emergency service arrives first is acting in the role of all emergency services and indeed police.

If you have a car accident, our vehicles, particularly in rural areas, will be there for a long time before other services get there, so they will have to control traffic, whether that is blocking the road or controlling traffic. They will have to render assistance to people who are injured, carrying out the role of an ambulance, and obviously fire protection. They would do all those roles until the other services arrive. The point you are making about the ability to preserve the scene and make sure that no further people get affected by it or hinder the access of other people, it is important to do that, but normally obviously where it is a big incident, police are already there and they can obviously carry out those actions. It is probably in the emerging times before all the services get there when it is more important.

Mr DAMIEN TUDEHOPE: Because it is the case, is it not, that your personnel are more at risk if people do not do as they are asked because there are additional resources trying to ensure the safety of people who should be leaving the area or alternatively complying with some request that your people already know about?

Mr ROGERS: Yes. I would say that a lot of it is also about people's awareness of what the particular instruction is. For example, if people live in a particular area then our text alerts, if it is a really serious situation, will reach those people. But if someone is not in the area at the time or does not have a registered address in that particular area they may not get that. Then we rely on media to transmit our warnings for us. But if someone is not listening to a radio or anything like that there may be a level of ignorance that someone has as well. I guess large aircraft and helicopters flying over might get your attention but there are people with different levels of situational awareness.

Ms JENNY LEONG: Has the incidence of violence against members been raised by volunteers?

Mr ROGERS: Certainly there was a physical assault, I think it was last year, and I think it was a head butt that happened and that certainly attracted the attention of volunteers in the area. A level of concern was expressed and I think it was more after the fact. Certainly, as I mentioned, when brigades go to those late night parties where they have got fires and there is a lot of alcohol, a level of concern has been raised about the safety of firefighters when they go to those scenes, particularly because sometimes it takes a while for police to get there because they are in more rural areas, which is understandable. There is a level of concern that people have. It has not been a huge issue that has been raised but it is around the actual incidence of something like that happening that there is a level of concern expressed at the time.

Ms JENNY LEONG: Given the incident around the head butt and increased concern with turning up at incidents where there are fires and where alcohol has been an issue, what has been put in place in response to that by the Rural Fire Service [RFS]?

Mr ROGERS: We have obviously critical incident stress debriefers who talk to people about how they are feeling about it. There is re-enforcement of that where you suspect there are people affected by alcohol and behaving in a way that seems potentially aggressive we call for police and, if need be, stand back until police arrive. I recall one incident as well where we called police and someone was hurt. I think an ambulance got pelted—I cannot remember what it was; I do not think it was rocks but it was something else they were throwing around. It was one of those situations that had the potential to escalate.

When people particularly are under the influence of alcohol sometimes it is really difficult to predict what these people will do and at what point they go over the edge and become violent. We all have seen people like that. When you are in the situation where there is an actual incident, you are coming onto a property, you have the responsibility for the welfare of other firefighters and indeed the other people around, I think that is what gives rise for people's concern. This is one of the things that comes back to that awareness. There is not a tolerance for this sort of behaviour irrespective of whether it happens one time or 10 times; it is not accepted by society.

Ms JENNY LEONG: So is it fair to say that you would also be supportive of a broader public awareness campaign around this?

Mr ROGERS: Absolutely. There is no point in just having a legislative response; there has to be education. We saw with the king hit issue where there was a significant public awareness campaign that that sort of behaviour was going to be treated very differently from someone having a bit of fisticuffs. I think that was quite an effective campaign. I am not suggesting it has to be that grand but it does need two sides to it, not just legislative.

Ms JENNY LEONG: On the one hand I see that you are raising this and I would agree that any incident is of concern. But on the other hand I am not sure—I may have misheard when the member for Mount Druitt was asking questions—that this kind of de-escalation and these risks are covered in your current training program?

Mr ROGERS: No, they have not been traditionally. As I mentioned in my opening statement, I think there has been quite a lot of underreporting and I think it is only in the last few years that we have got a lot better at trying to encourage the recording of those statistics.

Ms JENNY LEONG: What initially has been put in place to encourage that reporting?

Mr ROGERS: That is where the problems have occurred—re-enforcing to people about that standing off and calling for police. We have done that but we have not got a specific part of our training program.

The CHAIR: Do you offer any of your officers mental health training? In regional areas, as you quite rightly point out, they are often the first responders and they can be on the scene for hours, particularly with car accidents. I am just wondering whether the other services offer some mental health training or mental health awareness.

Mr ROGERS: For their own welfare or people they are helping?

The CHAIR: No, for people they are helping.

Mr ROGERS: There are discussions in training about people's behaviour at fires but it is not necessarily about the violence side of things; it is more about how we support people, particularly medically, which is part of that general first responder training about sustaining life. I would have to check, to be honest, because as you would imagine it has been a long time since I have done my training. If the Committee would indulge me, I will go back and check on that.

The CHAIR: It just seemed that the other organisations have a policy, if not a training package, be it little or big.

Mr ROGERS: I will check on that, if I can, because there are a lot of things we have put into training over recent years. For the life of me I just cannot remember that specific part so if it is okay I will come back to you.

The CHAIR: I know the number of assaults is relatively small compared to that on volunteers. I am just curious: Do they occur more in regional and remote areas or are they scattered all over?

Mr ROGERS: In my experience, a lot of the instances that happen are on those urban fringe areas. Not always but sometimes they are in areas where there might be a high level of unemployment. I am not saying that is an absolute but I think it is to do with the demographics of the area. It tends to correlate a little with that.

The CHAIR: The Committee has no further questions. Deputy Commissioner, thank you for appearing before the committee today. The Committee may wish to send you additional questions in writing, the replies to which will form part of your evidence and be made public. Would you be happy to provide a written reply to any further questions?

Mr ROGERS: Of course, and I will get the other reply back to the Committee.

The CHAIR: On behalf of the Committee, thank you for your great work and I thank all of your volunteers in the field keeping us safe.

(The witness withdrew)

(Luncheon adjournment)

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

The CHAIR: Good afternoon. Thank you for attending this public hearing of the inquiry into violence against emergency services personnel. I remind everyone to switch off their mobile phones. The Committee has resolved to authorise media to broadcast sound and video excerpts of the public hearing. Copies of the guidelines governing the coverage of the proceedings will be available. I welcome Mr Hayes to the hearing. Before we proceed, do you have any questions concerning the procedural information sent to you in relation to witnesses and the hearing process?

Mr HAYES: No, thank you.

The CHAIR: Would you like to make a brief opening statement before we commence questions?

Mr HAYES: Yes, that would be much appreciated. I also appreciate the Committee having me here today. There is no doubt that the issues we face in today's day and age are getting worse. We have supplied some statistical information in relation to illicit drugs and also in terms of community anxieties, which I think is something that goes a long way towards the behaviour that is witnessed. Our members—who are health professionals, health workers, junior doctors and so forth—see this on a regular basis. At the end of my submission today I would be prepared to offer a photo of one of our members who was recently assaulted in Morisset. I warn that it is graphic, but it is what people see.

In terms of how the Health Services Union sees addressing these types of issues, we can take some comfort from the issue of the lockout laws. The Health Services Union was involved with that. I am a paramedic who spent four years in Kings Cross in the 1980s and saw some pretty harsh behaviours. I know it is a debate that is not for this Committee; however, one idea that I would like to draw from that is that there is a proactive and a reactive approach. We see increased sentencing and so forth as something that a lot in the community have an appetite for, but it is a reactive approach—an approach after the fact that will not resolve the issue. We see that when we proactively address issues we can see a decrease in assaults, a decrease in presentations and a decrease of paramedics, particularly those we are interested in, being assaulted. That is an example and, as I say, the only thing I am trying to advocate to this Committee.

There is a range of other things we see with the community itself and how the community is changing. It would be surprising, I think, for this Committee to know of a couple of events that I will list quickly: the Riot Squad was called to a maternity ward at Prince of Wales Hospital and an aged care ward at Royal Prince Alfred Hospital; nurses were held hostage at Bathurst; there was a shooting this year at Nepean; a nurse was stabbed at Blacktown; and a nurse was killed at Lindfield and a patient killed in Kempsey hospital. There is a whole range of different dynamics that work at this point in time. Clearly for us, from the point of view of paramedics and hospital workers, particularly security in hospital—and you will see in our document that there are examples of issues there—training and resourcing are two very important matters to use to proactively deal with the issues as opposed to reacting to them.

I will conclude by providing a classic piece of evidence. There are places like Bathurst Base Hospital, which has a whole room with a bank of CCTV monitors that no-one monitors until someone is attacked. It is a recording process that is used to deal with the matter after the fact. Many people are subject to substance abuse and mental health issues that they will not take into account before taking action. We must work with these things. As we say in the health sector, irrespective of the behaviour of the individuals, they are still patients and we must treat them as such.

The CHAIR: You appear to be advocating an holistic approach. There is the deterrent factor, training for your members, and a public awareness issue.

Mr HAYES: Very much so. We must educate young people—that is, children 10, 11 and 12 years of age—about social norms. Those social norms are drifting, and we need to be able to focus on that. It is very important that people can go out and have a good time and then get home safely, not end up in an ICU bed, or that a worker does not come home at all. They are really important things. I do not say that to be dramatic; it is reality. We must grapple with that as a society.

The CHAIR: Does the Health Services Union offer any courses or advice to its members on dealing with these situations?

Mr HAYES: We are moving down that path as we speak. We recognise that substance abuse is an issue for society, but it is also an issue for our members. Our union now contributes $100,000 a year to Foundation House, which is a drug, alcohol and gambling rehabilitation service. We intend to promote those

activities more. It is not good enough for a union to sit back and point fingers at others without ensuring that we are part of the solution. That is the first step, and we will be moving further in that direction as time goes on.

Ms JENNY LEONG: Representatives of the NSW Police Force spoke earlier today about putting in place preventative measures for police officers and the need for resources and funding to ensure there are adequate protections. I agree wholeheartedly that prevention is the key rather than addressing a situation after the fact. What resources should be provided, especially to protect paramedics and emergency department personnel, to ensure that we prevent these attacks rather than deal with them after the fact?

Mr HAYES: That is very important. The simple answer is that we must have appropriate resources. We are short 800 ambulance paramedics at the moment, and that is a conservative figure. There are ambulance paramedics in the country who respond singly. About two years ago a paramedic responded singly to what turned out to be a murder. We must ensure that we provide support, such as having two people in the vehicle, and they must have backup. They are trained to anticipate these incidents. I was involved in the Crescent Head shooting when police officers were killed. They turned up to a job that looked like another domestic issue. That was tragically wrong. These things occur.

We must understand that paramedics in particular work in a very fluid environment. A person can be stable one minute and very unstable the next minute. It is about reinforcing that education and working out different ways with academics to predict the unpredictable. In terms of security in hospitals and other health workplaces, we consistently see a simple scenario. Police officers will bring in people in handcuffs and hand them over. The patient will then be with one security officer and that officer will then try to manage a very unmanageable situation. That is not meant to be disrespectful of the police; their time is constrained.

We have been working with NSW Health over the past nine months to develop a more robust system that will allow health workers to look after not only patients but also violent patients. That could involve appropriate seclusion rooms, or security officers within the health sector with appropriate powers. I do not think people can be security officers one minute looking after the local pub and the next minute be health security officers. There is a completely different dynamic. Emphasis on those sorts of understandings and training is very important.

Ms JENNY LEONG: There has been discussion about duress systems, various sorts of communication devices, and physical infrastructure that could provide adequate protection. Do you have an opinion about what is needed that is not now provided? Where are there resourcing shortfalls? What is needed to ensure those communication devices are accessible to prevent these attacks from occurring?

Mr HAYES: Many of the attacks occur within the central business district. It is all credit to NSW Ambulance that it has taken many steps to ensure safety. However, the bottom line is resourcing. If you are by yourself trying to deal with a complex issue—and we have seen on television paramedics being assaulted; we need to have the appropriate resources in the first instance—then you are in a volatile, fluid situation that may be okay or may not be okay. It is very difficult to get an end point. We do not seek to have restraints. We do not seek to have weapons or anything along those lines. In Queensland they are talking about having body cameras. We would see that body cameras are a reactive issue; they are not going to address the matter. There are a whole range of privacy issues that come with that as well. We would see that it needs to be worked through further. A lot has been done with the ambulance service, but I am not too sure at this point in time how you control an unpredictable situation, given that your communications are generally good. In some of the rural areas it is not as good as it could be. We would see that the bottom line is that the appropriate staffing levels would deliver those outcomes.

Ms JENNY LEONG: One of the issues that has come up so far is the distinction between the role of the police and the role of front-line health workers, particularly paramedics, and looking at where the line is drawn as to whose responsibility it is to deal with it and the rise in mental health and drug addiction related issues that we are seeing that results in aggression, such as the use of ice and other things that are becoming more prevalent in society. Do you have an opinion on what additional resources might be needed to support the safety of police and first responders? Are specialist mental health or drug addiction services needed, or is it additional training or resources? How do you see those specific issues being addressed?

Mr HAYES: In respect of mental health training, it is an important issue. A lot of people do not understand the complexities of mental health, even in the health setting. People outside a mental health unit do not have a full appreciation of it. However, I am sure everybody in this room would understand what a broken leg or a broken arm looks like. We need to invest in that. We had a great opportunity this year after the shooting to bring the police into the roundtable discussions. That was never done. We are of the view that there is probably pushback between Health and Police about resourcing and so forth, and whose responsibility is it at the door of the hospital. That is concerning. We had an opportunity to address the Memorandum of Understanding

between Health and Police to clearly identify whose responsibilities are in play. Ambulance paramedics have been given extra drugs and therapies to be able to deal with mental health patients, but as it is such a fluid area that is very difficult to do.

If you can imagine in the middle of the night trying to put a syringe into somebody's arm, there is a complexity of health issues that that person may have, so you are certainly not going to do it by yourself. You are probably not going to be able to do with it a second person; you will need to have the extra resources to manage that patient properly. I keep saying that that underpins a lot of the problems that we have. Then when we work with the police, as opposed to trying to achieve a direction, but with limited resources to be able to achieve it, everyone is doing what they can with what they have and generally it is not enough when a situation goes bad.

Ms JENNY LEONG: If you were to recommend one area for this Committee's recommendations that would improve the safety of and prevent violent attacks on your members, what do you say is the main area that should be focused on?

Mr HAYES: I heavily work towards the proactive side, not the reactive. People go to jail; the jails are full of people. People who are convicted of these matters probably will not even remember they did it. If people have mental health issues it is very difficult to hold them responsible for their actions. There are other bad people who, by all means, the book gets thrown at them. We need to educate people and look to society as to why drugs and alcohol are key factors. Alcohol is predominantly the key factor. People talk about ice and so forth but, predominantly, alcohol is the key issue here. If we can de-escalate that absorption—and the statistics already speak for themselves—that will abolish a lot of the issues. That is only something that the community can do and that is not an easy option.

Mr EDMOND ATALLA: Thank you, Mr Hayes, for addressing this Committee. Some definitions of emergency services personnel are clear—police, ambulance, fireys, and so forth—but when we talk about health services and front-line emergency officers, doctors and nurses come to mind. If we were to define clearly in the legislation who emergency services officers are, do you believe security officers should also be included ?

Mr HAYES: Very much so. The security officers in a hospital are part of the clinical framework. You may have heard that in the mental health setting and in the emergency department there will be times when a patient needs to be taken down. On a good day, what that means is you have five or six people around that patient. One person is taking the head, there is one person for each arm and one person for each leg. The patient is safe, the people doing the takedown are safe and the clinician can medicate, and that is all under the direction of the clinician. Unfortunately, what we see is generally one or two security officers doing a takedown. It becomes hostile, it becomes violent, it becomes uncontrolled. Patients can or cannot get hurt. The same thing goes for the security officer. The patient, ultimately, is medically restrained—clinically restrained. They are an integral part of the health function.

More and more in the mental health areas some of the security people will have dual roles. They are not wearing badges and carrying batons and handcuffs; they are there as part of the clinical team and if things get out of control then they are involved in that process. I will take a very quick step back. There needs to be clear identification of the role of the security officer. You will go to some hospitals and they will have batons and handcuffs. They have absolutely no right to apply handcuffs. They have no powers to detain or restrain anyone, or to search anyone. That is what we want to be able to talk through with the emergency departments, but they must be seen as part of the clinical function and understanding through education what their role is and what the patient's issues are. Otherwise we may as well get someone from the local pub and you cop what you get. That is not going to be acceptable to the service and delivery of care in the health scene.

Mr EDMOND ATALLA: I will come back to security guards. Are there any other personnel that you would consider in the health system to fit into the definition of emergency service officers other than doctors, nurses and security guards? Administration staff, for example?

Mr HAYES: The security officers, the doctors and nurses, paramedics, police, they will respond to the particular issue. You will see in some hospitals that they have health and security assistance, so they are not a purpose-built security officer but, again, there are responsive issues. So if something develops they will leave their cleaning or their admin work and they will respond. In terms of being a first responder, I would include those people as well because I think we run the very, very dangerous—

Mr EDMOND ATALLA: Include which people?

Mr HAYES: Health and security assistance, because we run a very dangerous process at the moment of relying on responding to an issue where, in respect of controlling a matter, we should prevent the issue in the first instance. That will limit a lot of issues within the health setting, and then it gets to the point—I am getting

away from your question to a degree—that having a relationship between the police and the hospital is a key part to the whole resolution of the problem in the health scene.

Mr EDMOND ATALLA: You have indicated that some hospital security guards carry batons and so forth and others do not. Am I presuming there is no standard that is applied to security guards across our public hospital system?

Mr HAYES: You are absolutely correct, and I worry a lot that it puts an imposition on our members who may undertake activity with equipment they have been supplied with which, in our view, they have no right to utilise. Indeed, if they use their baton, they would probably be in a whole heap of trouble. These are messages that are being sent out that need to be resolved.

Mr EDMOND ATALLA: Do the security guards come under the Health Services Union?

Mr HAYES: Yes, they do.

Ms JENNY LEONG: Can I follow up on that? Presumably they are private contractors who are providing those security services?

Mr HAYES: No.

Ms JENNY LEONG: How does it work that there is no consistency and what would be the quickest and most effective way to address that, because obviously that is a serious concern?

Mr EDMOND ATALLA: It is an issue.

Mr HAYES: Absolutely. We have taken the shooting at Nepean Hospital very seriously. We have met with the Roundtable set up by the Minister. The Ministry of Health has moved this along, now, for nine months. We have seen some minor changes, but we have not seen the real changes that are needed. At some stages there will be contract security. At other stages there may be no security. In other areas there will be a health security assistant. Ninety per cent of the time it is reactive. So the problems will occur; it is a matter of how they are dealt with. We promote the fact that this should be resourced appropriately. There should be health security people who are trained. I give credit to the Ministry of Health; there is a TAFE course now for health security people. That will help alleviate the problems for first responders within the hospital system.

Mr EDMOND ATALLA: In your submission you made reference to your members requiring additional security staff at the hospital for assistance. Is there a formula or a benchmark? How do you determine how many security guards are required at each facility? Who determines that, and on what basis is that determined?

Mr HAYES: I go back to the Roundtable that was held this year. A statewide security audit was done of selected hospitals. That was undertaken in February or March. We are now approaching Christmas but we still have not seen the result. That will formulate what the requirements ultimately are. Then we will see the amount of issues at, for argument's sake, Tweed Heads Hospital. You would have read that we have been in the courts on a workplace health and safety [WHS] issue because the security people are being assaulted and injured—limbs have been broken—when there is just one person trying to do this. I will show you a photo at the end of this evidence. Nobody should come to work and find themselves, through a lack of resources, to be a punching bag. That will not resolve the issue; it will just mean that they are part of the calamity.

Mr EDMOND ATALLA: Nurses are employed on the basis of a ratio between beds and nurses.

Mr HAYES: That is correct.

Mr EDMOND ATALLA: Should security guards have a similar ratio so that the size of the hospital would determine the number of security guards? Could that be one of the measures? Has the union thought of what measure you could put in place so that the employment of security guards is consistent?

Mr HAYES: We can do this very easily. Most hospitals around the State work on bed numbers. There are two different approaches depending on whether it is Royal Prince Alfred Hospital [RPA] or Bellingen Hospital. We can work through that. Clearly in large hospitals you need people monitoring the monitors. You need people on the ground ensuring that issues for young children in the emergency department do not escalate because someone on ice has just come into the room. We should be able to proactively deal with those matters. There will be a very easy way to work out that formula. But the first thing that we have to do, with the Ministry of Health, is to look at the audit that has been done. My criticism of them is that we still have not seen it. This worries me because people are still being hurt. These are visitors to hospitals—or whether it is a patient, a co-worker or a visitor. There was a situation where a riot squad had to turn up but people said, "There is nothing to see here." I think there is.

Mr EDMOND ATALLA: How long ago was this audit done?

Mr HAYES: It would have been finalised about three months ago.

The CHAIR: I think you are right; it was about that time.

Mr EDMOND ATALLA: I have a question in relation to the qualifications of the security guard. At the moment, I presume that anyone with a security guard licence can be employed to work in a health facility. You have indicated that there is a difference between the work of a security guard who is working at a pub and a security guard working in a health facility. If we were to make a recommendation, should there be specific training and specific licensing for security guards who work in a health facility to differentiate them from other general security licences? Would you support that?

Mr HAYES: I would totally agree with that. This is a speciality area. I give credit to the Ministry of Health; it has been looking at these areas and looking at legislative changes. I do not know how far that will go. With the greatest respect to security people who work in pubs and clubs, they have a different clientele. In hospitals you have patients; patients' relatives, who are quite anxious; people on drugs; and people who are alcohol affected. People in those situations have huge anxiety and one really needs to understand that.

With respect to mental health, de-escalating these matters is far better than responding to them. So I think there needs to be a classification of "health security person"—for want of a better name—who has qualifications in the health area and who has understanding. In that way there will be longevity because this qualification would only be utilised in that situation; it would not be utilised everywhere else.

Mr DAMIEN TUDEHOPE: Does your criticism of security measures at hospitals extend to the lack of CCTV?

Mr HAYES: Yes.

Mr DAMIEN TUDEHOPE: Do you know of specific hospitals that lack CCTV?

Mr HAYES: I cannot name one straight away, but I think many regional hospitals would lack CCTV. The last time there was a major review and funding for security was when the patient was killed at Kempsey Hospital. That was in 2004, if I recall correctly. A lot of money was spent on lighting and putting up screens and so forth, but not a lot of money went into CCTV. If it did, in Bathurst Hospital and a whole range of other regional hospitals there is nobody monitoring it. It is only an evidentiary process.

Mr DAMIEN TUDEHOPE: So more monitoring of CCTV footage would be something that you would recommend?

Mr HAYES: Very much so.

Mr DAMIEN TUDEHOPE: You would not suggest that we need security guards for oncology wards?

Mr HAYES: I would not think so, but at that point in time I would not have suggested that you would need the riot squad in a maternity ward.

Mr DAMIEN TUDEHOPE: It would depend on who the father is.

Mr HAYES: I have mentioned anxiety several times. I do not see the security guard as just being someone in a uniform, moving around. There may be great distress in an oncology ward and people may be acting out a bit. We need someone who can calm and de-escalate the situation. Changing the focus of what we think a security officer is is a very important part of this. I do not see them as controlling people—

Mr DAMIEN TUDEHOPE: But you would agree with me, would you not, that training in de-escalating potentially anxious situations is part of the training that a lot of health workers would go through.

Mr HAYES: That is correct.

Mr DAMIEN TUDEHOPE: So dealing with people in oncology wards would be within the range of training that most health workers already have. You would not need specialist security personnel to deal with the anxiety that is attributable to someone's deteriorating health.

Mr HAYES: I would agree with that.

Mr DAMIEN TUDEHOPE: Correct me if I am wrong, but the areas of particular concern for your union would be the security around emergency wards. Is that right?

Mr HAYES: Emergency and mental health.

Mr DAMIEN TUDEHOPE: Emergency and mental health intakes is where we would need a significant amount of resourcing in relation to security personnel?

Mr HAYES: Those are the areas where the general public will be coming through.

Mr DAMIEN TUDEHOPE: When an ambulance is bringing someone to a hospital, if they are in a psychotic condition as a result of a drug overdose or the like, generally the hospital is on notice that they are arriving in that condition. Is that right?

Mr HAYES: That is right.

Mr DAMIEN TUDEHOPE: So there would be an opportunity to ensure that resourcing is in place before they got there.

Mr HAYES: That would be the case for that particular situation. However, that emergency ward may have 20 or 30 beds. This may be one of several different issues. Many security officers will be required for special patients, to stay with one particular person. So there is a complexity of issues.

Mr DAMIEN TUDEHOPE: But in advance they would know that they would have to make provision for that, before the patient arrived.

Mr HAYES: That is true.

Mr DAMIEN TUDEHOPE: So in many respects what you are calling for, in terms of a proactive situation, is good communication between paramedics who are bringing people to hospitals who are potentially dangerous so that there is resourcing at the hospital when they arrive to deal with that potential dangerous situation.

Mr HAYES: Very much so.

Mr DAMIEN TUDEHOPE: It is not the case then that you would be suggesting we need 24/7 resourcing around the clock in circumstances where there was not necessarily a risk at that time?

Mr HAYES: I think many places now have 24/7 but they only have one person. If we were to talk about Tweed Heads, that one person, if I recall correctly, had a major injury to themselves that kept them off work for some time. The responsibility for security officers in hospitals is not just the patient. There are a whole range of other activities that they do, whether they are securing the outside or walking people to cars, that is, people finishing shifts.

Mr DAMIEN TUDEHOPE: That is a lighting issue, too?

Mr HAYES: A lot of the lighting stuff has been dealt with, that is correct; but it is, I think, fair to say that many hospitals would have already security officers on 24 hours a day. I do not think there would be many who do not, but it is the support that they have to be able to manage an individual by yourself and address the policies which is really important. There are some very good policies already there but they just do not get complied with. If you have to have five or seven people to take someone down, have five or seven people. Do not just put it on two people, which consistently is the approach.

Ms JENNY LEONG: Mr Hayes, can I just follow up on those questions? That pre-warning works when we are talking about a patient who may be in an aggressive situation. But obviously there cannot be a pre-warning if the person is a family member who is coming to visit the patient and that is the one who is the aggressor. Going back to this idea of prevention, on the one hand there can be the pre-alert from the paramedics if it is the individual being brought to the hospital. But obviously hospitals are public and open and visitors are not able to be the subject of a pre-warning.

Mr HAYES: That is correct, but a further extension of that is that I have brought patients in myself and it has been fine, got to the front door and the patient just punched my partner in the head. I did not see that coming at all. The changes and things that we are dealing with are a volatile situation. You do not predict it coming.

Mr DAMIEN TUDEHOPE: But if you were going to make a specific recommendation in relation to increased security, you would be specifically recommending that in relation to emergency wards and mental health units.

Mr HAYES: I would probably be making it once we could see the audit that has gone forward. The audit should be comparing the activity that has gone on within those respective hospitals as well, so that you can make an informed decision. I think that would be a more appropriate way of dealing with it.

The CHAIR: You mentioned a couple of times Tweed Heads hospital.

Mr HAYES: Yes.

Mr DAMIEN TUDEHOPE: You probably know a bit about that, do you?

The CHAIR: Yes. Can you update the Committee on the outcome of the dispute and what the current arrangements are?

Mr HAYES: At this point in time, we ended up running the dispute down the workplace health and safety [WHS] line: People have the right to turn up to work and be safe. The recommendations, no doubt you have read, are that two security officers should be there for the handover or the police and/or ambulance and paramedics wait until such time. That is all about the care for the patient but also the staff. At this point in time, that is working well. We have not had any negativity since then. Bear in mind that this was brought to a head where one of the security officers there was targeted by an outlaw motorcycle gang. It was just quite bizarre that those sorts of things occur. We do not see that every day, thank goodness, but these are the sorts of things that bring it to a head. At this point in time, it looks like it is working through.

The CHAIR: Would you advocate that approach at other hospitals, perhaps?

Mr HAYES: I think it is very important to look at each hospital on its own merits. If we look at some hospitals like the Wellington Hospital, it does not have a lot of support. The police can be out of town, two and three hours away. There is a very large amount of ice in that area, so that is one area. If we look at the Lismore hospital or Dubbo and then Royal Prince Alfred [RPA], they have their own different needs, in my view. I think a blanket approach is probably either going to be wasteful or not going to address the needs that that community requires. So I go back to that audit.

Mr DAMIEN TUDEHOPE: I agree with that.

The CHAIR: Do you see a difference between metropolitan hospitals and regional ones?

Mr HAYES: Very much so, yes. A lot of that goes to the police's ability to respond. In a lot of police areas, they are out and they will not get back for an hour or two, so you are then limited with what you have and things can get out of control very quickly. Whereas a hospital in a metropolitan area will get a quick police response and you may have an extension of police response. Each area is really quite different in its own terms.

Ms JENNY LEONG: I have just one question on an issue that was raised earlier by a member. I note in your submission you have made it pretty clear that your members do not want additional powers or equipment. I just want to ask you straight out: Would your members want to be provided with tasers?

Mr HAYES: I think, in my submission, I say that one of my members was hit with a taser. I do not think they work particularly well, certainly not in a closed environment. But at the end of the day ambulance paramedics are there to care and look after patients. If the situation is so far out of control, it is probably best to walk away or stand away. But by giving people weapons and so forth, all you do is start to lose trust from a community perspective. There is law enforcement, which stands quite clearly in one area, but paramedics are there to help and do no harm. Suggesting any kind of non-medical restraint or intervention, I think that has to be thought through very, very carefully.

The CHAIR: Finally, if there are no further questions from members of the Committee, as we spoke about earlier, there obviously has been a significant amount of media on this across not only New South Wales. Are you sensing a level of frustration from your membership in terms of a sentencing pattern by the judicial systems?

Mr HAYES: Clearly, that comes through. Nobody wants to go to work to be assaulted, particularly by people who clearly do not care. I think that is the first step that people will go to—enhanced sentencing—but that, in our view, while it is of interest, is not necessarily a resolution. If we do not load in the front end, we will keep putting people in jails. We do not support paramedics being assaulted. I do not know how you stop someone who has a psychosis or someone who is loaded with illicit drugs, or how you can reason with them. They certainly will not talk to their solicitor before they attack someone. That is the real problem. There is a call in the community for absolutely more accountability, and we would support that, but we would also support making sure that the front end is loaded into pretty heavily.

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

Mr HAYES: Very much so.

The CHAIR: Thank you very much. On behalf of the Committee, thank you for coming and thank you for all the good work you and your members do in the wider community.

Mr HAYES: Thank you. If it pleases the Committee, I would like to pass to you this photo. I apologise for its graphic nature, but it is what a security officer will do when he goes to work, or how he will come home. These are things of great concern to us. That individual has a broken nose, a broken eye socket and a broken cheekbone because he went to work.

The CHAIR: This was at which hospital?

Mr HAYES: Morisset Hospital about two weeks ago. When we talk about these things, we are passionate only because we want people to be safe but we want to care for patients at the same time.

The CHAIR: For sure. I fully understand.

Document tabled.

Mr HAYES: Thank you very much for your time today.

(The witness withdrew)

LLOYD ADAM BABB, Director of Public Prosecutions, sworn and examined

The CHAIR: Thank you for appearing before the Committee today. Do you have any questions concerning the procedural information sent to you in relation to witnesses and the hearing process?

Mr BABB: No, I do not.

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

Mr BABB: No, thank you. Our submission was put in by the then Acting Director in my absence, and I am content with the document that has gone in.

Mr EDMOND ATALLA: When we visited the Local Court and spoke to the magistrate, we learned that the maximum sentence that can be imposed by the Local Court is two years and that 90 per cent of assault cases go to the Local Court and not the District Court because of the waiting time at the District Court. Would you support an argument that the two-year minimum be extended?

Mr BABB: There are a number of things to your question. There is a jurisdictional limit of a two-year maximum sentence for each individual offence with the capacity to accumulate up to five years.

The CHAIR: To be fair, the extension was put forward to the Committee by the current Chief Magistrate.

Mr BABB: The question about the extension of the jurisdiction of the Local Court is an important policy question. Personally, I do support an extension of the jurisdiction of the Local Court, not simply in relation to particular offences. I think that there is the expertise in the Local Court to deal with serious matters, but as the Committee is probably aware, it is a controversial topic and you could call other senior lawyers who would not share my view.

Mr EDMOND ATALLA: Do you believe, in terms of the prosecutions, that the different Acts utilised in prosecuting an offender should be consolidated into one Act, say the Crimes Act. That would mean that when dealing with someone who assaulted a firey you would refer to a different Act from when dealing with someone who assaulted a police officer. Would you support an argument for all emergency service personnel being defined and included equally under one Act?

Mr BABB: I think there is great benefit in all crimes being easily located in one Act. That is part one of your question, and the second part was a general definition of emergency personnel and whether that should apply across the board. It is an interesting question. At the moment, police and law enforcement officers are singled out in the Crimes Act.

The CHAIR: In the other part of section 21A of the Crimes Act—

Mr DAMIEN TUDEHOPE: That relates to aggravation.

The CHAIR: —you have school teachers, taxidrivers and a whole manner of people.

Mr BABB: That section is a good example of some of the difficulties in singling out particular classes and making that an aggravated offence. It makes for a less easily usable Crimes Act. You could conceivably not have an offence for assaulting emergency services personnel but have sufficient scope within very simple, very basic offences. At the moment the tendency has been whenever we are concerned about something to add on a circumstance of aggravation. Perhaps rather than dealing with it in terms of sentencing principles—and section 21A reflects the common law sentencing principle—that an emergency service worker is someone who is there to serve the public by doing a difficult job that puts them in touch with oftentimes violent people and that assaulting that sort of person is a more serious offence than many other examples of assault. You are touching on an area that I am very interested in, which is simplifying the law rather than doing it in a piecemeal way. Because as you add on one particular profession, it is going to become clear with the next high-profile case that we have missed another public servant or another profession doing good for the community and putting themselves in harm's way in that way.

Mr EDMOND ATALLA: Would you support that if they were all consolidated into one Act that an assault on a police officer should carry equal weight to an assault on a nurse, for example?

Mr BABB: Yes, I would support a simplified Crimes Act that gave scope for the crime to be assessed and for the right penalty to be imposed in each instance. Each case has factors. The occupation and how the victim came to be in harm's way is a very important factor but one of a number of factors. Mental illness is

another which instead of focusing on the victim is focusing on the offender. A seriously disadvantaged or deprived background can do much to explain why people do not behave acceptably and why they are more prone to lash out when they are frustrated. My bottom line is to have the crimes collected in one Crimes Act with penalty provisions that enable good judicial officers to take into account all those factors and come up with the sentence that fits the crime and fits the offender.

Ms JENNY LEONG: Following on from that, do you want to make any comments in relation to standard non-parole periods?

Mr BABB: Yes, standard non-parole periods are now a settled part of our sentencing structure. They are not as prescriptive as mandatory minimum sentences. I think that the history of their imposition would show that they were in a sense a compromise. They are another indication to a sentencing court about how they should approach the sentencing exercise. They add something, but again it is a layer of complexity and perhaps we would be better off with a simpler sentencing Act that would enable each individual sentence to be fitted to each individual crime and offender.

Ms JENNY LEONG: In your experience, what impact does stricter sentencing or standard non-parole periods have as a deterrent on the crimes being committed?

Mr BABB: It is not really my area of expertise. I am dealing with people at the front end.

Ms JENNY LEONG: Are you aware of other reports or research that have a view on this that you might want to direct the Committee towards?

Mr BABB: Sure. Again, I am not the expert in relation to the effectiveness of deterrence. I have read a lot of material in the area that tends to suggest that deterrence varies in relation to different types of crimes and it may have a greater effect in relation to white-collar crime than it does in relation to crimes of violence, particularly crimes of violence that occur where you have a mental illness, are affected by intoxicating substances or where you have a deprived background that has seriously impacted on your ability to control your behaviour as compared to more premeditated crimes like fraud offences committed by people in positions of trust who do not have the sort of deprived background that violent offenders do.

Ms JENNY LEONG: The Director of Public Prosecutions does not collect specific data on cases around emergency personnel. I wonder whether it is something for which you see there being a need. Would there be a scope or a way for that to occur going forward?

Mr BABB: In my submission we have two bodies that do collect data: the Bureau of Crime Statistics and Research and the Judicial Commission. It is really desirable to have them change their data collection techniques, because that is their core work. For me it will always be non-core work and my statistics will not be as reliable as they will be where it is an organisation's core work. My preference would be—

Ms JENNY LEONG: For that to be adapted.

Mr BABB: —for those organisations to be adapted, because as much as we collect a lot of data, we cannot make it our core business. However, if there were recommendations, of course we would take that into account, cost it and do what we could.

Ms JENNY LEONG: My final question is in relation to resourcing. It has been raised with the Committee earlier in some of our discussions that there is potential for a lack of resourcing to result in a lack of appeals in certain circumstances to what might be lighter sentencing in the incidence of assaults against emergency personnel. I wonder whether you have any comments in relation to that.

Mr DAMIEN TUDEHOPE: Who was that raised by?

Ms JENNY LEONG: It was in our discussion. The member was not present in the meeting we had where that was raised.

Mr DAMIEN TUDEHOPE: I cannot have been!

Mr BABB: In any event, I would completely reject that. There really are no funding applications for me taking on appropriate appeals. I have protocols with the NSW Police Force, which prosecutes the majority of matters in the Local Court, that it will send me for consideration any matter that it recommends is worthy of consideration for an appeal. In the document that came to the Committee, we reproduced the statistics in relation to emergency services workers—25 matters sent and 12 of them taken on, with a variety of results. The factors that determine my decision as to whether to appeal are always legal considerations, and analysis of the judgement in the lower court, the application of the facts to the sentencing principles and whether it could be said that the decision in a lower court was wrong. If it is going to be an appeal from the Local Court to the

District Court, I am looking for some indication that the decision was outside the legitimate discretion of the magistrate to impose. There is perhaps an even stricter test in an appeal from the District Court to the Court of Criminal Appeal where it has to be manifestly inadequate and I have to take into account the fact that it is always a discretion to reject a prosecution appeal, because you should take into account a number of features that might lead to even a sentence that is manifestly inadequate not succeeding on appeal.

Ms JENNY LEONG: To make it completely clear, the question was no reflection on the work that you do. It is very much that I feel we need to make sure that the resourcing is there to ensure we are addressing the needs we have.

Mr BABB: Thank you for that.

The CHAIR: I have one final question. The Australasian College of Emergency Medicine suggested that:

> … the lack of specific reference to nurses, doctors, or support staff could be one of the many drivers against reporting assault or charging perpetrators of assault—

And that was against emergency workers. Can you comment on that? What do you think?

Mr BABB: There are offences of assault and assault occasioning actual bodily harm. We have a graded system of assaults, and we have a Sentencing Act where the very first aggravating feature would cover medical workers. That should not in any instance be a deterrent to someone coming forward. It would always be taken incredibly seriously. As I have indicated, the common law mirrors the statute and it mirrors my personal view that there is nothing more important than protecting our emergency services workers—and, without high-quality people being attracted to that sort of public service, society is much the poorer.

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

Mr BABB: I would.

The CHAIR: Thank you very much.

(The witness withdrew)

BRETT HOLMES, General Secretary, NSW Nurses and Midwives Association, affirmed and examined

LESLIE GIBBS, Work Health and Safety Professional Officer, NSW Nurses and Midwives' Association, sworn and examined

BERNADETTE COMPTON, Endorsed Enrolled Nurse, Ryde Hospital, sworn and examined

The CHAIR: Thank you for appearing before the Committee today to give evidence. Before we proceed, do you have any questions regarding the procedural information sent to you in relation to witnesses and the hearing process?

Mr GIBBS: No.

Mr HOLMES: No.

Ms COMPTON: No.

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

Ms COMPTON: I have a few pages of information about my experiences. I am an enrolled nurse employed at Ryde Hospital. I have a police statement, but I do not know whether it can be submitted. I will leave that for another person to decide.

The CHAIR: The Committee will look at it.

Ms COMPTON: I was attacked by a mental patient while working at Ryde Hospital as a nurse in April 2015. Initially I chose not to recount all of this because it is very traumatic. Even coming here today is very stressful. However, I decided to come because I think it is important for the Committee to hear from people about their experiences. I will tell members briefly what happened. The attacker was a mental health patient and he was in the department with seven other patients. He was very mentally unwell. I do not know if I can use the term "psychotic" because I am not a psychiatrist.

However, he said that he was the Antichrist and if I allowed him to touch all the other patients they would freely rise from their beds cured. He was out of control, but he was also very compliant when I asked him to return to his area, which he did. If he had not done so, I would have immediately called the one security guard we had in the entire hospital and he would have come. The patient was very compliant. I have worked there for 20 years and I have a lot of experience with mental health patients. I deemed that he was not a risk to me or to the other patients.

I will continue with what else I have written. When this patient came into the department, the habit of the ambulance is to give me handover, so they gave me handover on this patient and they reported to me to be careful. They arrived and they called the police because there was a kitchen table full of knives. He stated to them that he felt like he wanted to kill somebody. When I took this handover, I took that on board and I was extremely careful about his appearance to me and his behaviour, because he was a very big man. He continued to tell me he was the Antichrist, he would be able to cure all the patients. He had been drinking, he was intoxicated. He was a recognised mental health patient in the community.

Our emergency department is not an adequate environment to keep mental health patients. We do not have the same training as people who work in that specialised area. It is already a very stressful environment for patients and relatives who also may have to witness a loud, aggressive patient being taken down by those who are also looking after their loved ones, which is me. Since this incident, my personal and professional life has dramatically changed. I find myself hoping when I go to work that I get to leave work alive. I feel constantly worried that the patient I have been assigned to will become aggressive, especially if they are acting bizarrely or are alcohol and/or drug affected. Even though my colleagues reassure me that my nursing practice has not changed, I feel that it has. I find myself stepping back, looking for the nearest exits or backup, either other staff members or security.

I have also become hyper vigilant of my surroundings outside of work, particularly when dealing with men because at the back of my mind I wonder, "Could this guy attack me?" I realise this is irrational, even as I am thinking it, but it is no comfort. After returning to work I was looking after a patient one night who suddenly became distraught and anxious because she recognised me as the nurse who was attacked previously. She had been visiting her daughter in emergency who was a patient at the time. She was venting to me how upset she was reliving the whole scene, and she was worried that they could all be in danger that night. Other patients and visitors also witnessed this event and were exposed to the whole scene. As far as I am aware, no counselling or debriefing was offered to them. To this day, I often wonder how those people are and if they are okay.

Scheduled patients, I am aware that patients who have been scheduled—like my attacker was—cannot be charged for anything that they do whilst scheduled. It makes me feel extremely angry and upset. I feel he has no remorse, is aware that he can do whatever he likes and I am the one who must live with what he has done to me forever. I will also say that he has been back to the emergency department since this event earlier this year. I was not there, thank heavens, and I honestly do not know what I would do if he did come back to that department. I would probably leave the premises. I believe that he was cold and calculating in his attack. He positioned himself in such a way in the department that he could see everyone coming in and going out. The nurse who was working with me had left the department and he would have seen that, and that is when he attacked me, when there was nobody there.

It was a ferocious and vicious attack. I am not a short, delicate person; I can pretty much defend myself. I feel he was trying to rip my arm out of my socket and choke me at the same time. He was 112 kilos; he was a very big man. I had had advanced aggressive training against violence in the emergency department, and it was no help at all because the attack was instantaneous. There was no agitation, no warning sign. It went from him being a completely compliant patient to him attacking me from behind and, I felt, trying to kill me. It was very quick. It keeps coming back to him, my attacker, who has changed my life. He now knows what it feels like to strangle a defenceless person. I believe he did know what he was doing and he had positioned himself so he could see everyone coming and going.

Mr EDMOND ATALLA: Which hospital is this?

Ms COMPTON: Ryde Hospital at Eastwood. It is a very small hospital. I attended annual defence training because it is mandatory. I did this about a year before I was attacked. The next heading I have is "Sentencing Laws". The police informed me that night that the patient would not be charged because a psychiatric registrar scheduled him at the time. I felt very disappointed and dejected by this information, and also there was no other avenue for me under the existing law. On reflection, I decided to proceed to make a statement to the police regarding the incident. The officer I had been dealing with asked me on behalf of the police prosecutor at the time, "Why has it taken so long for her to make a statement?" It made me feel unsupported in the eyes of the legal profession. Also, it took me a month to be able to leave the house. In our small 21-patient area at Ryde emergency department, I believe there should be a dedicated security officer in the acute admissions area at all times, closed-circuit television directed at the nurses station only so it does not compromise patient privacy, and duress alarms placed in accessible areas that will call local security immediately.

Our current alarm is a paging system that contacts someone at Parramatta who contacts our security at Ryde Hospital. It takes several minutes for this process to be effective. Psychiatric hospitals have their own fully functioning emergency department rooms where police and ambulance officers can be triaged and treat a person they believe is mentally unwell or suffering from a mental illness and whom they are about to schedule. There is a major problem in finding safe beds for our scheduled patients and they are waiting long periods of time, sometimes up to 48 hours, before they are treated in a dedicated psychiatric hospital. I remain angry, very angry, because for him nothing has changed. I believe I can still care for patients despite what he did to me. I refuse to let him think that he has won. I will continue to work in my chosen field because I am not a victim. I am angry, but I refuse to see myself as a victim.

The CHAIR: Thank you. Mr Holmes, do you care to make an opening statement?

Mr HOLMES: Yes. Thank you to the Committee for this opportunity. I understand the role of the Committee to be one to look, first of all, at what legislation may be possible to affect it. I would concur with my colleagues at the Health Services Union that many of the perpetrators of violence against health workers do not have in their mind the consequences of their actions. In fact, they are often affected by drugs, alcohol, or a mental illness. There is a small group, of course, who are accompanied patients who lash out as a result of their frustration. Those people, I believe, are in a different category when it comes to having an understanding of what they are doing. I appreciate what Ms Compton has said about her particular circumstance. My experience with violence in the health system goes back to my days as a nurse in the mental health facilities and in the emergency department at Royal Prince Alfred.

My first experience of the death of a nurse was when I was the first organiser on the ground after the murder of Sandra Hoare in Walgett. That was a life-changing experience for everyone involved. As a result of that there were significant improvements across the health system—in terms of a significant change of policy, which required that no nurse work alone. Sandra had been pulled out of an aged care ward, where she was working alone, and was separated from the hospital. There was a rule put in place. Surprisingly, we have to raise that issue from time to time when staffing becomes stretched and people think that they can make a saving by saying that nurses or other health workers can work alone and that there will be some level of supervision

further away. The provision of prevention via appropriate staffing—a combination of security and clinical staff—is probably the first order from the perspective of the NSW Nurses and Midwives' Association. One cannot predict everyone's behaviour, as Ms Compton has demonstrated, but there does need to be an adequate and fast response to incidents.

That brings technological opportunities. There has long been policy around the New South Wales health system being required to provide up-to-date equipment. Unfortunately, it is not always the case that technology is constantly maintained and updated. There is a need in our health system to focus on all those issues about staffing. The education and training of those staff is important. Being able to avoid situations may well save people's lives. And we need the appropriate security physical activities. With those observations, we have seen the recent Roundtable that followed the Nepean Hospital incident. NSW Health started to focus on safety following that incident. Disappointingly, two years before that, our annual conference had resolved to call upon NSW Health to make a complete review of health safety and security, and were rebuffed on the basis that they thought it was all adequately managed. Clearly, that was not the case.

There are now 170 trainers in the system, as a result of the Roundtable, who are going out and trying to provide a one-day self-protection course. The Ministry of Health allocated, in the last budget, $5 million to enhance safety and security. I would say that $5 million across the New South Wales health system does not go very far when you need to look at additional security staff and the training of all the staff across emergency departments and other staff who have interactions with potentially dangerous situations. One of the most important things we need in emergency services is a complete oversight and understanding of how big the problem is. I would like to submit to the Committee, for information, the Victorian Auditor-General's report entitled "Occupational Violence against Healthcare Workers". My recommendation to the Committee would be that the New South Wales Government should engage our own Auditor-General to conduct a similar inquiry into health and emergency services to oversee what is being done across the system, and where the shortfalls in compliance with the workplace health and safety legislation is. I submit two copies; it is available online.

Mr GIBBS: Our members of the NSW Nurses and Midwives' Association are also members of the ANMF—the Australian Nursing Midwifery Federation. We cover 62,000 members. Occupational violence has become one of the main things that gets reported—it is one of the main things we work on. The amount of violence that we follow up on is increasing every year. In a survey that we recently conducted, more than half of the respondents said that they suffered workplace violence on a daily basis—or more than once daily. Almost 80 per cent said that it occurred at least weekly. The actions of not only the clients but also the visitors result in incidents. The nurses are dealing with drug and alcohol matters and the like. Drugs and alcohol is one of the underlying causes.

Mr EDMOND ATALLA: Sorry, how many members are you representing?

Mr GIBBS: Sixty-two thousand.

The CHAIR: That is not just in New South Wales, is it?

Mr GIBBS: No, that is in New South Wales. We are a big union. One of the complaints we get is that the incident response is often inadequate. There is no feedback to the staff as to what happened. In many cases, nothing happens. That is one of the things that people get upset about.

People have spoken of being grabbed and thrown across the room, being grabbed by the throat, being struck by a person or with objects, being thrown against walls or furniture, being threatened with weapons—knives or other things—by visitors or clients. People have been struck with chairs or IV poles. There was even a case where someone was hit by a guy with a walking stick. Staff are exposed to patients or visitors who are intoxicated and there is verbal and physical intimidation and aggression. They make death threats and put things on Facebook. There are documented issues—

The CHAIR: Do you consider it a rising trend?

Mr GIBBS: Yes, it is.

The CHAIR: What do you put that down to?

Mr GIBBS: I have only been with the association for 18 months now. When I first arrived there I was expecting manual handling to be my biggest concern. As a workplace health and safety person out there, that was the major thing I heard about; it was the major thing reported. But that has not just occurred over the 18 months. It relates to the underreporting. Why is that? Is it our staffing arrangements? I am seeing in our rural areas that there is inadequate staffing to cover incidents. Many of the incidents have occurred where there is not adequate staffing to maintain normal care, let alone manage such an incident.

We have reasonably good systems in place for bigger facilities such as Liverpool Hospital and Royal North Shore Hospital, but if you go out to little places like Narrandera and a little place called Quirindi outside Tamworth, you see that it is totally uncontrolled. We talked about pagers that go back to a base which rings up to see if everything is okay, but people are not going to answer the phone if something is happening. Then there would be an hour to get police response because there is no security.

The CHAIR: Do you have anything further to add to your statement, or are you ready for questions?

Mr GIBBS: I would just like to talk about the incident management system [IMS]. It has been very poor. I admit that it is under review. One of the problems is that there is a definite underreporting out there.

Ms JENNY LEONG: Thank you very much for the work that you do in representing the nurses and midwives. Having recently had the experience of engaging with some of your members—the midwives at RPA—I acknowledge the incredible work that they do. Ms Compton, thank you very much for your story. I think one of the risks or concerns I have as a member of this Committee is that we focus too much on the idea of punishment after the fact. I would like to ask you, as someone who has experience working in a hospital: What do you think could have been done to better resource and prevent the attack on yourself? I thank you very much for coming and sharing that with us because it is important to hear. We have heard from the Health Services Union [HSU] concerns around closed-circuit television [CCTV] recordings being done, but no-one is monitoring those in real time. In actual fact what you are getting is the ability to go back after the fact, but it does not prevent incidents from occurring. From your point of view, what could this Committee recommend that would prevent these attacks from happening again and that would make you feel safer in your workplace?

Ms COMPTON: Well, I have worked in emergency for 20 years. I have been a nurse for 26 years. Mr Gibbs is right when he says the increase is marked, and it is—very much—in the last couple of years. The numbers of people that you are getting in who are affected by various things—drugs, alcohol, mental illness, or all of the above—makes it a very stressful fairly small environment that we are in at Ryde. We are very ready for a bomb to go off. They have one security officer at Ryde. I would like to see a dedicated security officer in or closer, very much closer, to emergency. He is quite a distance away and there is no way of immediately contacting him.

There are particular devices throughout the rest of the department that are very isolated but that will get an immediate response from everybody. It is like a CPR alarm; perhaps one of those. But, I mean, in emergency, an event could happen anywhere. An event could happen 100 yards from where the alarm is. I think a dedicated security officer in or near the emergency room would probably prevent a lot of aggression. I could tell you dozens of incidences. Unfortunately, nurses tend to adopt the super nurse attitude where they deal with whatever situation because there is nobody else. If someone throws an AV pole, well, you just duck and you just get on with the next task at hand. If someone picks up a big food trolley and throws it on the ground and makes a big hole in the floor, well, you call the police and they deal with that gentleman, and then you get on with the rest of looking after people.

A lot of these incidences do not get reported as there is not the time because, especially in emergency, you are dealing with seriously ill people. As well as having to deal with people with very acute mental health problems, which take a lot of staff, there are other people having life-threatening conditions that nurses are trying to deal with as well. It is a very difficult and stressful situation to deal with just as a nurse.

Ms JENNY LEONG: Thank you. Maybe I will open it up, if there are other contributions in relation to what resourcing could we see to prevent these incidences taking place? Have there been recommendations made previously that might be worth bringing to the attention of this Committee in relation to preventing violent attacks on emergency personnel and front-line personnel?

Mr HOLMES: Yes, thank you. Currently there are some recommendations out of what we call the roundtable at the New South Wales Ministry of Health. I fear that, as usual, budget constraints will hold back some real decision-making that needs to occur around adequate provision of security services in our hospitals and emergency departments. Society has changed. The environment has changed. Unfortunately, people coming to our emergency departments—and it does not matter whether it is at North Shore, or Prince Alfred, or Liverpool, or in my home town of Wellington—there are people coming there who are under the influence of drugs, particularly drugs that induce violence. We are no longer in a situation in which we can rely on people respecting health workers. There used to be a lot of respect in the community for a nurse or a doctor, but people under the effects of illicit drugs have absent from their thinking that level of respect. It has either been burnt out or it is completely washed away in their addiction.

I think we are at the time where our health system, if it wants to look after people, you cannot look after people if your staff are injured or out of action. We really do need to get to the point where we need to have

security staff in all of our emergency departments [EDs]. It is not good enough to wait for an hour for a response just because you live in a small country town. You can be dead in a whole lot less time than that, if that person is particularly intent on doing that. We do need to make sure that every single emergency department has the most up-to-date personal duress alarms and that they are connected to someone who can respond. Staffing in small hospitals makes this very difficult. If you want to respond to someone who is attacking you, you need at least six people if you are going to take that person down. Even just two security guards will not solve the problem. Everyone has to be trained in what the role could be in that situation.

Some training is well underway. I think there needs to be greater resourcing of that. To get people fully trained, the best course or the most comprehensive course is a five-day training. Training 100,000 health employees for five days is a very expensive exercise. Logistically, it takes years. They have pared that back to at least some self-preservation training, but even so we need to go further. We need to know more about what is happening. As Mr Gibbs has said, the reporting mechanisms are inadequate and people stop reporting when they find that they do not get feedback about anything happening. In relation to the issue of sentencing and so forth, there is legislation there. It is about whether it is used or not and whether the staff who have been confronted or their colleagues—because it affects everyone—can be assured that somebody who has perpetrated a crime is not then going to be presenting back as soon as they get out of the police cells.

The CHAIR: Mr Holmes, we never thought of that re-presenting until Ms Compton brought that up. Initially we were focused on whether they were being dealt with appropriately at court, not realising that technically, if they did not get a custodial sentence, they could come back next week.

Ms COMPTON: And have another go.

Mr HOLMES: One of the other issues that we often face is the desire of our staff not to be confronted by that and seeking an apprehended violence order to restrain that person. There are fundamental difficulties around that, if you work in an emergency department, and saying to someone in a small country town, for instance, "You can't come back to the emergency department if nurse so-and-so is on duty", because we cannot particularly exclude someone from completely receiving health care. That issue of apprehended violence is difficult in itself in that our members often do not get enough support from their management to undertake that quite challenging process. It is sad that we as a union are often asked to provide legal assistance to our members in taking out apprehended violence orders when in fact it occurred in the workplace as a result of that nurse being attacked at work. We would want a much more proactive approach being taken by managers to support their staff, and for management to actually provide the necessary assistance and guidance to people about how to properly take out apprehended violence orders against patients. It is a bit of a management nightmare, how to deal with those people, but it has to be done because being confronted again by the same person who has recently perpetrated is—

The CHAIR: I could imagine it would be horrific.

Ms COMPTON: I do not know that you could deal with it and I would not wish that upon anybody.

Mr GIBBS: That happened at Nepean, with the guy there who re-presented back to Nepean thereafter.

Mr EDMOND ATALLA: Mr Holmes, I refer to your submission which states:

> A survey of Nurses in Emergency Departments across NSW demonstrated that 53% of respondents experience workplace violence and aggression daily or more than once daily while 79% experienced violence weekly or more often. 85% of incidents from the survey related to client/ patient aggression whilst 12% to clients family or visitors.

That is a very strong statement about your 62,000 members. Mr Holmes, you said the reporting mechanism is inadequate. Reading those statistics, I would say it is not only inadequate but also non-existent. If the statistics reflected the number of actual incidences, those incidences would exceed the workplace violence confronting the police and the ambos, who we thought faced the highest number of incidents. Please comment on why the reporting mechanism is not adequate.

Mr HOLMES: What I would acknowledge is that when we undertake surveys, they are undertaken on a voluntary basis, so you are more likely to get responses from people who have been directly impacted. There is a bit of skewing of the numbers, but nevertheless these are passionate people who have said, "I have had this experience and I want to get it on record." We do have major issues around underreporting because of the thinking, "It is just another incident; I will just get on with it and if I spend 10 or 20 minutes writing an IMS then I will not have time to do that until after I have finished my shift, so that is 20 more minutes of unpaid overtime." The other thing is that the old system that we are hoping is replaced soon failed to give any feedback. There was an opportunity for managers to downgrade it or to dismiss it. As we have said in the report, there are incidents where staff are given a strong message that we are having far too many incident management system [IMS] reports. The inference from that is, cut down the reporting.

There is a big culture shift that needs to happen in health. I am glad to say that one of the Deputy Secretaries has recognised that and is trying to send the message from the top, but there definitely needs to be major recognition that underreporting occurs because you do not get feedback, you do not get support or you get criticised for raising issues that then cause more work for the people. That change in culture is one of the essential things, for everyone in the health system to understand that their safety—the workers' safety—comes before patient safety. That is a message that has to be given to everyone. Maybe that is a message that the community should understand—that health workers do not have to put up with violence, that health workers are required to put their own safety first and that they will not be stepping out and putting their lives at risk in order to save someone else. A dead health worker cannot save hundreds of future lives. That is at least recognised now at the top; it just needs to be promulgated throughout the system. A very strong and important recognition that could come out of this Committee is that, whether it is health workers or other emergency service workers, they should not be putting their lives on the line, particularly in the case of someone acting violently towards them, in order to save that person from themselves.

Mr EDMOND ATALLA: Ms Compton, is there a culture where nurses are frightened to report incidents because the hierarchy might not like that? Please do not answer this question if you feel uncomfortable doing so. If so, how do we overcome that and get the hierarchy to promote a culture that encourages reporting? How would organisations learn how to deal with problems, if they do not know the extent of the problems?

Ms COMPTON: Unfortunately, I think more and more serious assaults on nurses will happen and that will force, to some degree, management to take stock and re-evaluate everything from reporting, to acting, to supporting, to changing. As far as the culture of nurses is concerned, there is a culture to downgrade and get on with things. Everything is on a time constraint in nursing. However, I feel that because there are more and more incidences of nurses being assaulted in the workforce, they are being forced to redirect things and to really look at how everything is managed. I think that is a start, but it is a very slow start and it has a long way to go. It is not just management; it is across the board in my whole culture. Sometimes nurses can be their own worst enemies. They tend to fob things off and get on with the next thing. They need to stop and really look at the situation and realise that we are important people. We should be taking more steps to collate these incidents so that they are written down, even if somebody says nobody is going to take any notice of them and they are going to be downgraded. People still have to act, even if it is an ineffective system, until we get something that is more effective.

Mr EDMOND ATALLA: In relation to the specific incidents that you have outlined—and I thank you for sharing that incident with the Committee—what action has management taken, first, to support you and, secondly, to put in place policies and measures that will prevent a similar incident from occurring in the future?

Ms COMPTON: I find answering every part of that question a little difficult. I can answer some parts; some parts I cannot answer. Management have been fairly supportive of me. They have put in place a temporary measure of not letting any particular mental health patient go to a certain area that they could access when they attacked me. I gave you the very short version of the details of the attack. That is one thing that has changed and it is not a very big change. Because I work in a very small hospital, the people I work with and my immediate management have been very supportive. The hospital recognises what happened to me, and I think in their capacity they have tried to sympathise with me, not too much in the way that security has changed and my suggestion of closed-circuit television [CCTV] on nurses in that immediate area to be filtered to security, who already have CCTV in various parts of the emergency department, because that suggestion was knocked back. I do overall feel supported by my manager and by the people I work with and to some degree by the administration of the hospital. That is about all I can answer.

Mr EDMOND ATALLA: Mr Holmes, it has been indicated that there is one security guard employed at Ryde Hospital. How many beds are there at Ryde Hospital?

Mr HOLMES: Ms Compton tells me over 200.

Mr EDMOND ATALLA: How does the number of security guards at Ryde Hospital compare with the number of security guards employed at other hospitals of similar size?

Mr HOLMES: Mr Gibbs may be able to tell us. It is very variable.

Mr GIBBS: Look at Campbelltown, which is a little bit bigger with probably 260 or 280. It has an interesting model, a Health and Security Assistant [HASA] model which is its patient service assistance as well as security guards, and it has about six staff on. At Liverpool they have four to six for each shift, and it is a massive hospital of 900-odd beds.

Mr EDMOND ATALLA: Why is there a discrepancy between hospitals when it comes to security? Is it because there is no benchmark and no formula to calculate the number of guards that are required at each hospital?

Mr GIBBS: I believe that would be a fair statement, yes.

Mr EDMOND ATALLA: Is that something you would recommend?

Mr GIBBS: If nothing else, risk assessment, which is something that we always advocate: having appropriate risk assessment for the appropriate staff.

Mr HOLMES: I would support the contention by the Health Services Union that you also need to make sure that those security guards are safe. Just one lone security guard trying to deal with a critical incident is a recipe for disaster for them as well. It needs to be a team effort, but you need minimum numbers. Frankly, it does not matter whether you are at Ryde or Campbelltown, the unexpected will occur. NSW Health has had this attitude, outside of Ambulance, of saying, "We can't staff for the unexpected." I think there needs to be a proper needs and risk assessment that the unexpected is going to occur more and more in our health system and it does need to staff appropriately. Entry points and risk points need to be where staffing occurs for security staff to back up the clinical staff.

Incidents involving patients should be under clinical direction, and there should be a team approach to managing patient aggression incidents. I do not believe they should simply palm it off to security guards alone, but for everyone who is involved in that there needs to be a team response, a code called and people with a complete range of training on dealing with aggression to be able to respond to those circumstances as if it were a medical emergency, a cardiac arrest, so that security is not the only ones expected to respond. It can certainly take a major role and its presence and visible capacity are important, but when you are dealing with patients you need to make sure their clinical needs are being managed as well.

The overall environment of hospitals is that hospitals are large, often open public access areas. I think at some point we need to make the decision about just how open and public they are and, if so, what security risk prevention do we need to have for people coming into our health facilities carrying weapons, for instance. It would be sad to say New South Wales has got to the point of the USA where you need to scan people. But I fear that as the level of violence seems to concentrate a bit around health, we actually need to consider on a risk basis where that needs to be put in place. The seriousness of risk is quite amazing. We are fortunate in health. We are not like the construction industry: we do not see one person die on average every week. But when we lose a person in health, it has a massive impact across not just the health community but also the wider community. I think we should be equally concerned about the loss of any other worker on a building site or elsewhere, but it is critical that nurses, midwives and other health workers know that they have the very best safety and security in place so that they can get on with their jobs.

Mr EDMOND ATALLA: I understand from your submission that the union has developed an app to encourage the culture of reporting. What are you doing as the association to promote that? Are you getting resistance from hospital management in promoting this app and encouraging your members to use it?

Mr HOLMES: No, I am not aware of any resistance. Of course, we have carefully designed it so that our members do not disclose patient names and so forth, so the confidentiality issues are recognised. We are advertising it regularly in our journal. We obviously promote it every opportunity we can and the uptake is growing. We have had instances where it has worked very well. We have got back to an injured nurse a couple of days before management has approached them, so it has an effect in that we follow up as quickly as possible to find out the circumstances and to see whether the nurse who has experienced the incident is in contact with management, that they have reported it and that they are being provided with assistance. It is one method of trying to push forward.

One of the big problems that we are trying to overcome is this lack of reporting and lack of oversight of just how big the problem is. It is very hard to get statistics out of the Ministry of Health. It says it is because it has trouble getting statistics out of the local health districts and there is this whole culture of, "Don't tell them too much; they might make an issue about it." Hiding it is not going to help. There needs to be really open disclosure about the incidents that are occurring and what we are going to do about them.

Ms JENNY LEONG: I have a follow-up question. Does the app also ask your members to report near misses or incidents where there actually was not an incident? We heard earlier from the NSW Police, and it sounds like it has a lot of resourcing and funding to roll out a number of prevention programs. I wonder in relation to that whether or not this app captures near misses, what the scope is for this app to be used or adapted for people to be able to report and whether that requires the complexity of some of the other mechanisms that you referred to.

Mr GIBBS: Yes, it has. We have had some near misses reported on it. Saying that, it is just a tick and flick to say different things about where it actually occurred. Did it occur in aged care, ED, mental health? Was it in a public or a private facility? Was there an injury or damage? It then gives a space at the bottom for a descriptor. It also asks: Have you reported it on your system? It also asks: Do you want follow-up? They do not have to have this follow-up, but the thought process in designing it was to build some statistics of where things did happen, especially in the aged care sector, because we never hear about anything in the aged care sector.

Mr DAMIEN TUDEHOPE: What is the record of prosecutions in relation to attacks on healthcare workers?

Mr HOLMES: I am unable to answer that question. I do not know.

Mr DAMIEN TUDEHOPE: If you are going to make a case in respect of the prevalence of this, are there no instances that you can point to in relation to prosecutions of people who have attacked healthcare workers?

Mr HOLMES: I do not believe that there are none. Once it becomes a police prosecution matter it is not necessarily something in which we are completely involved. There are inadequate numbers of them because of the difficulty that the police say they have in prosecuting patients.

Mr DAMIEN TUDEHOPE: The Committee is interested in the manner in which the courts are dealing with healthcare workers. Can you not point to any inadequacy in relation to that?

Mr HOLMES: I am not able to tell you the number of cases.

Mr DAMIEN TUDEHOPE: You can take the question on notice.

Mr HOLMES: I do not think we have access to that information. I think the prosecutions are so few that they do not come across our line of sight.

Mr DAMIEN TUDEHOPE: Why are there so few?

Mr HOLMES: Because of the difficulty in obtaining the evidence. The police are obviously well aware that if a person is a patient then there are limitations on what they can do depending on their illness, particularly if the patient has been scheduled. Of course, to prosecute, the police must have witnesses. How much support can be given to them to go through the process is another factor that needs to be examined.

Mr DAMIEN TUDEHOPE: Ms Compton, I am very sympathetic to what you have been through. In fact, you have made a statement to the police.

Ms COMPTON: Yes, I did. I was not encouraged by anyone, especially the police, to make that statement. That made me so angry. I understood why they said that; it was because that is the law. However, I do not accept that that should remain the law. That is my personal opinion. That is why I wanted to make a police statement; I wanted words on paper because I was so angry. I felt that that would help me as part of my healing process. I wanted to make the statement, even if I was bashing my head against a brick wall. Someone had to do something, so I made a statement.

Mr DAMIEN TUDEHOPE: That was the right thing to do. Were the police telling you that they could not use that statement?

Ms COMPTON: I knew that the public prosecutor would in all probability not go ahead. I am very nervous. Normally I do not have trouble finding words. I knew the prosecutor would probably not proceed with any criminal action against this gentleman, even when he was no longer scheduled. I know that the police approached the person concerned and recommended that he get legal counsel, which he did. I secretly hoped that that would frighten him because he was probably not expecting to be told to obtain legal advice. He sought legal advice, and I guess the Director of Public Prosecutions weighed up the probabilities and decided that there were not enough points to proceed with any action against him because he was on a schedule. Unfortunately, I think the law is solid regarding someone who is scheduled. However, the police did go back and ask him why he attacked the nurse. He said he did it because he was having a mental breakdown.

Mr DAMIEN TUDEHOPE: Mr Holmes, if the police had commenced a prosecution, Legal Aid, or whoever was representing him, would have had to make an application under the Mental Health Act. Is that your understanding?

Mr HOLMES: I am not a lawyer, so I will take your word for it.

Mr DAMIEN TUDEHOPE: If they had made an application under that Act, it may have been a condition imposed by the magistrate that the person would re-present at the hospital. I am concerned about

dealing with this issue of re-presenting. What is the solution to people who have been involved in circumstances such as those related by Ms Compton from being discharged and then re-presenting?

Mr HOLMES: An appropriate management plan should be put in place for that person if they re-present. Their medical records should be flagged so that if that person—

The CHAIR: Does that not happen now?

Mr DAMIEN TUDEHOPE: Are they not triaged like that?

Ms COMPTON: I believe that the patient's medical file was tagged and that an alert is effective on him. However, we are a hospital, not the law.

Mr GIBBS: In many cases, the alert is placed on the paper record, not the electronic record. The paper record does not come until the patient is admitted.

Mr HOLMES: There needs to be a procedure to ensure that if that person re-presents they are properly supervised and escorted through the system.

Mr DAMIEN TUDEHOPE: Or referred to another facility?

Mr HOLMES: If there is another one to which they can be referred; that depends upon the location. It is hard to transfer a patient if he or she is in a rural facility. It is very expensive and extraordinarily difficult to coordinate ambulance officers, police officers and so forth to transfer a patient in rural areas.

Mr DAMIEN TUDEHOPE: I would like to summarise your position. You are saying that you would like an audit undertaken of security in hospitals to establish what measures should be implemented in mental health and emergency departments.

The CHAIR: And aged care facilities.

Mr DAMIEN TUDEHOPE: Within our healthcare system.

Mr HOLMES: The breadth of the Auditor General's capacity would be to look at not only what is happening but also whether health and other emergency services are adhering to their complete range of responsibilities under work health and safety legislation. I think the Victorian model was very helpful in terms of identifying the range of shortfalls. It came up with solutions to the problem by working with management and work health and safety professionals to ensure that change was happening and that it could be audited and reviewed. There are often spurts of activity, focus and funding, and then it can fall away.

Mr DAMIEN TUDEHOPE: The first position is to undertake an audit to establish what you need. The second step would be to establish whether there is a compliance process with the work health and safety regime that would be the subject of what the auditor said was necessary?

Mr HOLMES: I believe that is a summary of what the Auditor-General's recommendation could be; that is, that they undertake that role.

Ms JENNY LEONG: The discussion has focused on the specific incident and emergency departments. We have also been discussing the links with mental health areas. The Committee has heard from the Health Services Union that there have been violent incidents in other areas, including maternity wards and aged care facilities. Does the audit need to encompass the entire hospital system, or should it focus only on emergency departments and mental health facilities?

Mr HOLMES: I am conscious of this Committee focusing on emergency workers. Our submission raises the fact this is a problem across the health system. It is such a broad issue that if you isolate it to emergency departments you will not pick up where violence is occurring. It is not occurring only in emergency departments. It is not even restricted to emergency departments and mental health facilities; it can occur anywhere.

We have heard instances of violence occurring at the doors of the operating theatre at Nepean Hospital when a patient had decided to pre-medicate themselves, but when they got to the check-in at the operating theatre the effects of their personal pre-medication took effect and they became extremely violent and held a nurse at bay, using the equipment that was available. It can occur anywhere. That is why to do this properly you need to look at the whole of the circumstances where health workers are involved. I would say that other emergency workers work in various places.

One of the other areas our members are at risk is in community health care. They are going into people's homes and they are at risk there. Of course they have to make a judgement call about how they proceed into people's homes and they do not always know what is behind the door. There are no easy solutions. If there

was an easy solution we would have been able to point to it and campaign and try to convince the Government to do it. It is an issue that given the prevalence—overall, the statistics of crime are supposedly coming down, which is welcome.

Mr DAMIEN TUDEHOPE: You would agree with me that to install a security guard in operating theatres on a 24/7 basis is unreasonable?

Mr HOLMES: Yes, and that has to be on the risk basis. But my use of that example is to show you that this issue is wide and there needs to be a proper response. That operating theatre had to be redesigned so that the nurse could not be held captive in that particular area.

Mr DAMIEN TUDEHOPE: That is often the reason we redesign triage units and the like, so as to ensure that when people are entering emergency sections the nurses and staff are protected. I accept that.

The CHAIR: Thank you all. Ms Compton, I really appreciate your coming to give the Committee insight into the issues that you have faced and how it has affected you.

Ms COMPTON: Thank you for inviting me.

The CHAIR: Mr Holmes and Mr Gibbs, thank you for appearing before the Committee today. The Committee may wish to send you additional questions in writing, the replies to which will form part of your evidence and will be made public. Would you be happy to provide a written reply to any further questions?

Mr HOLMES: Yes.

Mr GIBBS: Yes.

The CHAIR: Thank you, and thank you to your members who keep our greater community safe and well.

(The witnesses withdrew)

RODERICK BISHOP, NSW Fellow of the Australasian College for Emergency Medicine, Australasian College for Emergency Medicine, affirmed and examined

The CHAIR: Thank you for appearing before the Committee today to give evidence. Before we proceed, do you have any questions concerning the procedural information sent to you relating to witnesses and the hearing process?

Dr BISHOP: No, I do not think so.

The CHAIR: Dr Bishop, would you like to make a brief opening statement before we commence with questions?

Dr BISHOP: You should have the submission that the College has given you.

The CHAIR: Yes.

Dr BISHOP: I also draw to your attention some reference documents in that. There is a joint international labour organisation, International Council of Nurses, and a World Health Organization framework guideline document—I have copies of those documents if you do not have them—which I think gives a pretty good overview of a lot of the issues. There was a similar inquiry to this one in Victoria in 2011 and a subsequent auditor's report that I think Mr Holmes referred to. There is also the New South Wales policy directive on zero tolerance. It has a much longer name than that. Those documents cover quite a lot of the issues and support a lot of what I am about to say. If you look at the submission of the College, it first covers the contributing factors and you have heard some of those from the previous witnesses. I stress particularly that drug and alcohol and mental health issues are certainly present, but a lot of this comes from the stress and anxiety that patients and their relatives are under when they are being cared for by emergency services, pre-hospital and in the hospital. They have a flight or fight response because they are stressed. For some of them, their only way of managing that stress is through violence. It is a sad reflection, I guess, on the way they handle things, but that is an issue.

The other thing is crowding and waiting times are clearly contributing factors, and there is good evidence of that from around the world. Finally, they mention the handover from police and I will talk more about that. The recommendations that we have put in, one is obviously access to security personnel is key. You have heard a lot about that. Particularly in the smaller facilities, it is a challenging issue for them because of the numbers of people you need to control a behaviour-disturbed person. The only thing I would suggest is clarity about the legal framework under which security work. I know my own security officers are not quite clear where they stand in terms of constraint and detainment for people who are not under the Mental Health Act. Emergency department [ED] design is an issue and obviously having enough space to limit crowding is important. Having appropriate assessment areas for people who are behaviourally disturbed is talked about in the Victorian inquiry. To some extent, it is linked to the problems of EDs being gazetted when they were not designed for that function. I will come back to that.

Education and training is important for the staff, for security obviously but also for managers to understand their responsibilities. I will also bring in the public. In a way, there has been a loss of respect for healthcare professionals. We are not seen as we used to be. I do not know whether that is our fault, but it is certainly reality. People do not respect us as they used to and, therefore, behave in a way towards us that is often inappropriate, such as verbal abuse but also physical abuse. I would probably consider the role for public education around that. We need to rethink how those potentially violent patients are handled. A lot of them are brought to us by the police. The submission of the College suggests a working party to get through some of those issues. Where should they be taken? How are they handed over?

One of the things that came out with the incident at Nepean with the shooting is around the handover between police and emergency department staff. We have very good procedures for handover with Ambulance because they are part of Health, but we have not established good handover processes for patients brought in by the police. If they are to be brought to a health facility, that facility needs to be designed to handle them and there needs to be clear processes by which they are assessed in a timely manner and then moved on to an appropriate location. That process of assessment should not be slow. Slow process waiting times when people are already disturbed can often aggravate their behaviour and lead to violence.

We have heard about under-reporting from the previous witnesses. That is ubiquitous and was commented on in the Victorian Auditor-General's report. Why is this the case? It is complex. Our current reporting system is rather cumbersome and, as noted, we get no feedback. So there is not a lot of incentive to report. The other issue is, ironically, that violence is so frequent that it is not an incident; it is just part of the daily activity. When something unusual happens we will think to report it but when we are dealing with

something on a daily basis we do not think to put it into the system. The system could be made simpler, and more support could be given for that reporting process. It is clearly under-reported. There is plenty of evidence for that, not only in New South Wales but elsewhere as well.

Finally, I will touch on the legal environment, which is part of the terms of reference. I am not a lawyer but the College has looked at that legislation and considered more specific wording around who the legal articles refer to—not just ambulance officers. In the New South Wales policy document it clearly identifies that the law specifies ambulance officers, but it could also look to specify other health workers. The other area of the law—I am returning to the issue of security—is a legal framework by which we detain people or restrain people who are not under the Mental Health Act.

It is quite clear that we have a legal responsibility under the Mental Health Act to detain people who are at risk of self-harm or harming others, but when they are not under that Act—if they are just drug affected—there is no "Duty of Care Act". What is our responsibility and what is the legal framework by which security officers work in that space? Those are the main points in our submission and our supporting documents. Together they outline all the issues and some of the recommendations. I am happy to take questions and comments.

Ms JENNY LEONG: Thank you for outlining those. It is really helpful for the Committee to have a number of areas where we can be looking at prevention. Could you expand on your comments on changes to the Mental Health Act? The challenge is around dealing with people with mental health issues in a whole lot of these first response situations and also within emergency departments. Do you think there are additional services and additional supports that could be put in place beyond those measures to provide support across those different responses and within emergency departments? Is additional training needed? What do you see as the resourcing needed to address that?

Dr BISHOP: The Minister is rolling out a violence education program. The challenge of getting everybody through that is huge, not just financially but in getting staff off the floor. That is a big plus. It is important to say—I think it was touched on before—that security is one answer, but you can never have enough security officers. You often need more, so the staff need to be trained to be able to identify the risk factors and then physically handle an incident.

I cannot really speak for the pre-hospital setting. It is very challenging because of the limited number of personnel available. That is often why the police are called to assist. They bring numbers with them and a certain physical force. But bringing those people to emergency departments has been problematic. We were never really designed for some of that work. We were probably not properly trained for it, when it came to us.

That is gradually changing. In the Victorian inquiry there were recommendations about having specific behavioural assessment units or specifically designed units that can manage these people. We need to think through where these dangerous people are taken—so that the facility is built for them, and the staff in them are trained and can cope with that workload. The gazetting of a lot of EDs which were not set up physically to handle that situation—the staff were probably not adequately trained and did not have the support—has been problematic as the incidence of this sort of behaviour has increased. These incidents are often driven by drug—

Mr DAMIEN TUDEHOPE: Are you suggesting specialist EDs?

Dr BISHOP: Not necessarily specialist EDs, but EDs that are built to cope with that, as we build new ones. We already have certain EDs that are gazetted. Not all EDs are gazetted, so not all EDs are subject to having patients brought to them by the police under the law. But in the departments which are gazetted—my hospital is one of them; quite a few of the major hospitals are—we need to think about the design of the facilities and the way we manage those patients. Those patients should not be in with all the other patients. That is one of the problems. They are now brought into a big, open ED like mine, and all the other patients are exposed to them.

Also, it is for their own privacy. Some of these people are affected by drugs or mental health. In a way, they are being seen behaving badly, which they could subsequently find embarrassing. These people are not necessarily bad people; they can often regret what they have done. Having some way of containing and separating those within new designs would be helpful, as would specific training, which is underway. There needs to be a combined approach between emergency positions, mental health workers and drug and alcohol workers. There are often situations where there are comorbid conditions across all three. The patients need medical care, some drug or alcohol follow-up or counselling, and they often need mental health care. A lot of these patients have a comorbid condition.

Ms JENNY LEONG: In relation to the handover from paramedics to EDs, or from police to EDs, what are your thoughts on what could improve that handover process? Are there examples you could point to

where things have worked well? Have there been recommendations about improving the handover that have not been acted on? Are there other jurisdictions where there are better ways of tackling that handover?

Dr BISHOP: I am not sure about other jurisdictions. The point I made before is that we work pretty closely with the ambulance people. I guess that is because they are part of the same organisation. We have a fairly protocolised approach to handover. The ambulance service has developed an mnemonic that they go through—IMIST-AMBO—that goes through all the key issues. It is a very structured handover.

We have not developed that with the police. We often do not know a lot about the real circumstances under which the person was detained. How much force was required? Some people in police custody arc up but others get very quiet. When they present to the emergency department they can seem quite settled but when the police go away their behaviour re-escalates. So we need to have a better understanding of what happened, the triggers, the environment, just like the ambulance people give us a run-down of what was going on at the scene, the treatment given and the history.

So perhaps there should be a better structured handover. It needs to clearly involve the security. If the patient is a threat—presumably if the police have been involved the person is a threat; that is why the police have been called—security needs to be involved in the handover because they are now taking on the responsibility for the security of the patient. The police obviously have lots of other work to do; they do not want to hang around emergency departments looking after patients. Security staff are essentially taking over from the police. That handover is critical.

Mr DAMIEN TUDEHOPE: What is your view in terms of the legal framework which would surround security personnel?

Dr BISHOP: I think it is unclear. That is a problem. The security staff certainly feel that what they can and cannot do is unclear.

Mr DAMIEN TUDEHOPE: Whether they can restrain someone and whether they can use reasonable force?

Dr BISHOP: Exactly. At times we just move under the Mental Health Act. We say, "We have put that person under the Mental Health Act because they are behaving in an abnormal way."

Mr DAMIEN TUDEHOPE: To put them under the Mental Health Act just requires someone like you to schedule them?

Dr BISHOP: Exactly. I would argue that that is probably not an appropriate use of the Mental Health Act for a lot of these patients, but it is a legal mechanism we have. The security staff say, "We are not going to do anything until you schedule them." That is pretty common. I do not know whether people are comfortable with that. I guess that is up to the wider community to think about. If someone is put under the Mental Health Act it certainly has an impact on that individual. It can have consequences for them if it was inappropriate. I do not see that as a good solution. Clearly, if they have a mental health disorder, that is an appropriate framework under which to use restraint, but if they do not—if they are just intoxicated and had an argument with their girlfriend and are just behaving badly—is that really an appropriate use of the Mental Health Act to detain them? A lot of detention is for their protection but it is also for our protection and for protection of the facility because they can do a lot of damage.

Mr DAMIEN TUDEHOPE: Is it the case that the large increase in violent incidences is drug-related?

Dr BISHOP: That is hard to get figures on, but the use of amphetamine-based drugs has certainly changed the behaviour of these people. I liken it to—alcohol certainly fuels violence but they generally settle down whereas people who are on amphetamines, ice and whatever, they are just on another planet. They are just really irrational and require huge amounts of sedation to control them. In my long practice, that has been a major change, this misuse. Certainly Nepean is a place where we see a lot of it. It is one of the epicentres of the issue. But the people I feel really sorry for are the people in the rural environments where we are seeing a lot of ice use and they have very limited resources with which to handle these people who are very violent and very difficult to contain.

Mr EDMOND ATALLA: I just want to focus back on security.

Dr BISHOP: Yes.

Mr EDMOND ATALLA: In your submission you indicate that emergency departments lack sufficient access to security personnel, and this is an issue in the metropolitan area but it is also a more significant problem in regional areas. How do you see this issue being addressed? What recommendations would you make to see that those issues are addressed—the lack of security at the emergency departments?

Dr BISHOP: Going back to the New South Wales policy, risk assessment is the first step. We cannot have, as you identified in the previous session, security officers on every ward, everywhere. That clearly is never going to work, so it is I guess trying to assess the risk at different locations. The smaller the emergency department [ED], I guess the less likelihood of something happening; but when it does happen, it is much more difficult to manage.

Mr EDMOND ATALLA: Why are these risk assessments not done, or are they done but not implemented?

Dr BISHOP: Probably not done formally in many of the hospitals in emergency departments.

Mr EDMOND ATALLA: Do you not see that this is a weakness in the system that needs to be addressed?

Dr BISHOP: If you look again at the thing that came out of the Victorian auditor's report, it is that a lot of these processes and policies are in place but they are just not followed through. That is probably not through any wilful neglect; it is just that people are busy. As a departmental manager, I have millions of things to be considered and some of them just do not get to the top. The prevalence of violence towards healthcare professionals for most managers like me, as both a clinician and as a manager, really has come to the fore. I think we are now very much aware of it, but making sure that all the policies and procedures are in place takes time and commitment. Perhaps we just have not all done that yet.

Mr EDMOND ATALLA: Other witnesses have mentioned closed-circuit television [CCTV] cameras sometimes installed but not monitored and only looked at if there is an incident. There is no proactive approach in addressing issues before they escalate to an incident. Do you support what the others have said in relation to that?

Dr BISHOP: The challenge, again, is that you need to have someone sitting in front of the camera. That is another person who could be doing something else. They could be out attending to other security issues. That is how it is, I know, in our hospital; I am sure it is common in many when you have a certain number of staff and you dedicate one person to sit and watch a camera. It is a challenge within a limited resource and we are all dealing with an environment with limited resources and thinking about where best to put the resource. I certainly think in high-risk EDs, and I would rate mine as one as well as many other similar ones around the city, having 24-hour security within the department would be essential because we see violence, really, on every shift. On every shift we will have patients brought in who are disturbed, aggressive, and potentially violent.

The risk assessment would say that you need security there whereas places with much less frequent episodes, you would have to work out what the best way is to use those resources. The advantage of CCTV, even if it is not watched real time, is that it certainly helps in looking at what actually happened and in helping to understand what happened. Obviously, if there is criminal involvement, the police can use that as part of their evidence. But it has certainly helped hospitals look—with our own incident, with the shooting—at what happened and understand what happened so that we can change some of the things we do and learn from that. I know it did not prevent that incident, but we have learned a lot from how that was handled and some of the things that we have done to change. It is of value. I would really encourage that. It is a reasonably cheap and useful device to have in most places, I would think, even if it is not watched 24 hours a day.

Mr EDMOND ATALLA: There is a move to relocate methadone clinics and those types of facilities into hospital grounds. Do you think hospitals that have such facilities within their grounds may experience higher incidences of violence, or is there no relationship there?

Dr BISHOP: I would not know the data on that. You are talking anecdotally there. I think you would want to really do a proper study to see whether that is the case. Methadone is often a different group of people.

The CHAIR: In the Tweed hospital, the methadone program is quite removed from the ED. It is right over at the back. It is nowhere near.

Mr DAMIEN TUDEHOPE: It might be located on the same site but it is well away.

The CHAIR: Yes. It is very secret.

Ms JENNY LEONG: I have one last question and that is just that you referred to other contributing factors to the idea of a high-stress environment, especially around EDs, especially around crowding and waiting times. You also referred to the loss of respect that we are seeing, and which I agree is a very disturbing trend, around healthcare professionals in those circumstances. Could you mention or refer to studies or reports that talk about that? It is a useful thing for the Committee to be able to refer to. You mentioned in passing that there are specific studies that have looked into the contributing factors around waiting times.

Dr BISHOP: There is some work around waiting times. Respect is a much more difficult thing to research. I could not be sure that there is a specific research around that. I think in the College's submission there is some reference to waiting times, but I would have to check that. If it is not referenced in there, I can probably get you some data.

Ms JENNY LEONG: That would be appreciated, thank you.

The CHAIR: I have just one final question. In your submission you suggest that the ED should be able to issue restraining orders against repeat offenders—patients or their relatives who have committed repeated acts of violence against ED staff while receiving treatment—such persons could return only if medically unwell. Are you aware of any other jurisdictions that are doing that? Would there be a threshold of "medically unwell"? Have you considered the potentially adverse effects—for example, that people who are subject to restraining orders would not present, if needed?

Dr BISHOP: This is a very challenging area, as I think you have heard.

The CHAIR: We raised the issue before with other groups.

Dr BISHOP: Yes. Obviously, you have a responsibility to look after the health care of that individual. In my hospital, we have had a circumstance of this. It is more than 10 years ago when a nurse was stabbed and the woman involved did go to prison. Subsequently, when she came out, a restraining order was placed on her to prevent her coming back. In a metropolitan area, clearly they have options of going to other facilities; but, of course, all you are doing is then putting that risk onto another facility. In a rural area, it is obviously even more difficult. I have not got an easy answer to this. I do not think anybody has because it is conflict between our desire to keep our staff safe and avoid people coming back who have caused trouble and our clear responsibility to provide health care when it is needed. Many of these people do have chronic health needs that are required to be treated. Flagging is certainly, I think, one key strategy.

The CHAIR: And that happens now?

Dr BISHOP: That happens now. One of the troubles at the moment is the computer systems are not really fabulous in the way that they are flagged, but it certainly exists. Most of us, I know in my hospital, have a list of people who are flagged and that is regularly reviewed and kept current. That is one option. Taking out an apprehended violence order [AVO] or preventing someone from coming back to hospital is a really challenging area. I think you would need to think long and hard about how you approach that.

The CHAIR: That subject came up earlier today.

Dr BISHOP: One thing we have done in other areas where we have recurrent attenders—and I guess this is a bit like that—is trying to meet with the individual involved to go through the issues. We have done that with one particular individual.

Mr EDMOND ATALLA: Individual as in medical staff?

Dr BISHOP: No, as in the person involved in the violence. Again, that is fraught with difficulties. We have had one success with that, but we do that with other groups of patients. If they are rational people—and some of these people are rational, but they just have had a bad day—then there is some element we can do with them. If they are there as part of a mental health condition, that is obviously more challenging. But that should be part of their management anyway. If it is drug or alcohol related then obviously it is important to have drug and alcohol involvement and offer counselling and support for that, particularly through their family, because often the family sees the problem and wants help but cannot get it. To ban people is really challenging.

The CHAIR: I can imagine all the issues involved in that. Even in my local hospital 10 years ago, when I started this career, we did not really have safe rooms per se like the safe rooms of today that are totally lockable.

Dr BISHOP: Even those have problems because we are dealing with people who are not like a prisoner you can put in a cell. Often they have a medical problem, so you need to have interaction with them in a way that you would not have with a person in a cell.

Mr DAMIEN TUDEHOPE: One of the things you have called for is a national database.

Dr BISHOP: Yes, some way of identifying these people. Again, there are privacy issues, but as a health practitioner I rarely see patients who object to having their medical history available to any doctor who needs to see it, yet we put barriers in the way. It is not unreasonable for healthcare workers to have access to information about a person they are about to treat that might be relevant to how they treat them. That would include any history of violence towards healthcare professionals.

The CHAIR: Can they prevent a treating doctor from seeing their health records?

Dr BISHOP: It is just that they are not easily available. I cannot easily look at health records at St George Hospital from Nepean Hospital. I can look at records from within my own local health district [LHD], but I cannot look at records across the LHDs and certainly not across States.

Mr DAMIEN TUDEHOPE: There is provision to make health records portable, is there not?

Dr BISHOP: There is, but again that leads to privacy issues. People concerned about privacy make it challenging, even though most of us would be more than happy to have our health record available to whoever needs it. On the other side, health professionals have a right to know whether the person they are about to see has a violent history.

The CHAIR: It could be crucial to their treatment, could it not?

Dr BISHOP: And the way they approach the patient—how they talk to them, what staff they have around when they are doing that interview and also what expectation they may have of the patient agreeing to any treatment. One of the challenges we have with violent patients is that they are often not amenable to the treatment you want to provide and they are not compliant with it, so you may need to rethink your treatment strategies for those patients.

Mr DAMIEN TUDEHOPE: In one sense, part of the education process involves potentially educating the hospital staff and emergency workers on the importance of reporting. I know it might be perceived as time spent doing something you would rather not do at all when you could be doing other important stuff, but it is almost a component of the duty of care to other workers and potentially other hospitals.

Dr BISHOP: Absolutely. That is very true, but you have heard before the incident monitoring system is a bit cumbersome. You get no feedback, and that has been recognised by NSW Health, which I think is trying to address it. It is just a slow process, often with no obvious benefit to the person putting in information. I think your point is very valid, that they do have a responsibility to their co-workers in the system to report these incidents so that other staff would have an opportunity to see any reports, if that information were available. You would have to carefully monitor that information, because someone could have a bad day and lash out in the stress of an environment, and not be a normally violent person. Then they would carry a record that they are aggressive or violent, often unfairly. There are clearly really bad people who are doing this all the time, but there are some individuals for whom it is a one-off. Often later, whether they are drug affected, drunk or really stressed, they regret what they did.

Mr DAMIEN TUDEHOPE: But we are not giving this the status of a criminal record; we are giving it the status of a medical record, because this was something that occurred during the course of treatment.

Dr BISHOP: Sure, but it still may influence how other people deal with them. It is a challenging area. You are labelling someone. We are very careful and we want to see a pattern of behaviour before we will flag them. Just a one-off incident may not be enough for us to flag them on our system.

The CHAIR: How many patients a year do you see through your emergency department at Nepean?

Dr BISHOP: Nepean sees 68,000, so about 190 a day. Around about 10 to 15 of those will be behaviour disturbed on any given day, with mental health issues. Typically one or two a day will need sedation or restraint.

The CHAIR: How many injuries do your healthcare workers suffer?

Dr BISHOP: That is very hard to quantify. Not only the physical injuries but the thing that came to me after the shooting was the psychological injuries that the people on that shift have suffered and continue to suffer. Recently we had a staff member who went off sick after a patient just verbally abused her and all of the incident from January came back. We had to give her some more time off. They are carrying that psychological stress as much as any physical injury. Serious physical injuries are relatively rare, but minor injuries—like being hit in the face or verbally abused and then needing to wrestle a patient to the ground—are constant everyday things.

The CHAIR: Thank you for your very informative testimony.

Dr BISHOP: Thank you for your time. It is a very important issue to us all, and I am pleased you are looking into it.

The CHAIR: The Committee may wish to send you some additional questions in writing, the replies to which will form part of your evidence and will be made public. Would you be happy to provide a written reply to any further questions?

Dr BISHOP: Yes. I am appearing, as you know, on behalf of the College. If you write to me, I may well seek some input from the College officers, if that is all right.

The CHAIR: Yes, not a problem.

Dr BISHOP: Do you have copies of the documents referenced in our submission? I can give you all of them, because I think they contain a lot of wisdom and summarise a lot of the issues.

The CHAIR: We do not have them.

Dr BISHOP: I can give you copies of what I have.

(The witness withdrew)

GARY WILSON, Secretary, Australian Paramedics Association (NSW), sworn and examined

The CHAIR: Welcome. Thank you for appearing before the Committee today to give evidence. Do you have any questions concerning the information sent to you relating to witnesses and hearing procedures?

Mr WILSON: No, I do not.

The CHAIR: Would you like to make a brief opening statement before we commence questions?

Mr WILSON: Recognising the time, I will keep my opening statement—

The CHAIR: Please do not feel intimidated. It is an important subject.

Mr WILSON: It is not so much intimidation; I would prefer to leave you with as much question time as possible because I think that is probably more informative for the Committee. Thank you for the opportunity to represent the views of front-line paramedics and support staff who face the real possibility of violence in the workplace every day. APA is an apolitical organisation run by serving paramedics to look after the interests of paramedics, support staff and the general public that we serve. While we addressed a number of aspects in our submission that impact directly on violence in our workplace, the majority of these have two common factors: resources and infrastructure. While changes in other areas such as legislation may lead to improvements, it is our view that without significant changes in our infrastructure and resources it is unlikely that any significant practical improvements can be made. Our members both present and past are living with the effects of violence and, while we may never be able to be free of all violence, we can stop it from becoming normalised and minimise the impact as much as possible.

Mr EDMOND ATALLA: In your submission you make mention of the adequacy of the measures related to current policies and procedures. Of interest was the current duress procedures. You indicated that these are not adequate. Can you elaborate on that and on what can be done to improve that resource?

Mr WILSON: I would prefer to do that in camera with specifics as far as the duress procedures and their limitations go. In general, I would say that our duress procedures and systems have not significantly changed in the 15 years that I have been in the job and they have fallen far behind other jurisdictions.

The CHAIR: We can arrange an in-camera hearing when the Deputy Chair returns, because there is no-one in the public gallery.

Mr WILSON: And the gentleman who was there is related to my organisation anyway.

Mr EDMOND ATALLA: I will reference some other issues. In relation to training, do you believe that there is adequate training in place for paramedics to deal with violent situations? If not, how could that be improved?

Mr WILSON: I have to acknowledge that NSW Ambulance is taking steps toward that and I give it due credit. However, at this time, no, we do not believe that there is adequate training. We believe there are a number of training options that are available to be considered, ranging from threat perception and management to defensive training to allow us to extricate ourselves. Our members have not given any indication that they believe that offensive training is required. Their focus is solely on extrication and removing themselves from that situation.

Mr EDMOND ATALLA: Do you feel there is a culture of a willingness to report incidences, or is it similar to the nurses? We have heard from earlier witnesses that there is a culture of not reporting. Can you elaborate?

Mr WILSON: A survey we did of our members recently showed that 71 per cent of those who responded indicated that they had been physically assaulted in some form. The average number of assaults per respondent was five, but 32 per cent of those who responded said they have never reported any physical abuse. Indeed, 72 per cent of people reported that they never bothered to report verbal abuse. This culture of underreporting or not reporting at all is well entrenched. The systems that we have in place do not support reporting; the resources we have in place do not allow us the opportunity to do so. Staff are far too busy to spend the time reporting these incidents when there are patients who need to be treated.

Mr EDMOND ATALLA: What needs to be done to improve that?

Mr WILSON: Again, there are multiple factors that need to be addressed to effectively address this issue. The first thing is we need the resources to allow staff the downtime to report the incidents as they happen. At this point in time our staff are running from case to case and just do not have the opportunity. The systems

that are there to do the reporting are old, outdated and not tailored to meet our needs. As part of Health, we have to use a whole-of-Health system, not one that is tailored towards emergency services and our environment, which is unique.

Ms JENNY LEONG: You have pointed to some examples of what we can do to improve things. In regard to prevention and, I guess, immediate action to be taken, because we are busy talking about initiatives impacting on your members right now, tonight and tomorrow, what do you think is the most urgent area that needs reform and improvement to protect your members from violent attacks that might occur?

Mr WILSON: The problem we have is that a lot of the areas we need to improve are infrastructure, and they are not an overnight solution. To implement a solution that fits our needs is going to take some time, but if we do not start that now it will never happen. Some of the things we can do in the short term are simply to put on more staff and make more staff available, not just in Ambulance but in Police as well. We have had reports from our members that police have been unable to attend when called due to their own workloads. We have issues where police have been unable to attend because of our vehicle location systems: they do not know where we are. These are the issues that we need to address straightaway but, unfortunately, they are not an overnight solution. Our organisation believes we need at least 500 new paramedics, and that does not include the support staff that goes with it. Our brothers and sisters in the control rooms are so overwhelmed with the work at times that there have been reports of radios where they have just said, "Look, everyone's busy. We can't get to you." This resourcing is really a significant problem for us. It has been something that has been building for years, ever since I have been in the job—and I have been in the job 15 years. Resourcing has been an increasing problem and unless something is done about it, the problems are not going to go away—they will only get worse.

Ms JENNY LEONG: I would be interested to talk more about the duress systems if the Committee wants to go in camera, but other than that, I have no further questions.

Mr EDMOND ATALLA: Alternatively, we could get a confidential written submission.

The CHAIR: We will finish the public hearing and move to an in-camera hearing if the Committee is happy with that.

Mr DAMIEN TUDEHOPE: I have a couple of questions first. Why do you recommend that the ambulance services be separated from the Department of Health?

Mr WILSON: This is a view that has been the case for most paramedics for a long time.

Mr DAMIEN TUDEHOPE: Why?

Mr WILSON: We see our links with the Department of Health and the way we share some common functions, but those common functions have slowly diminished. With the removal of the non-emergency transport services from Ambulance, we are now an emergency service only in everything but organisation. One of the problems we have had historically is that we have been used to prop up a system that in itself is under-resourced, and there is a problem with competing priorities. While you have one master and two competing requirements, someone is always going to lose out and unfortunately paramedics often believe that that is us.

Mr DAMIEN TUDEHOPE: But would you agree with me that you are health professionals?

Mr WILSON: We are, in the same way that I believe police are professionals in the law enforcement area. I do not see that being health professionals prevents us from being a professional emergency medical service.

Mr DAMIEN TUDEHOPE: But you would prefer that you were part of and recognised as part of the health system.

Mr WILSON: No. I would prefer us to be an independent emergency medical service.

Mr DAMIEN TUDEHOPE: I would like to explore this.

Ms JENNY LEONG: Just one point: We did hear a positive earlier in relation to the handover of paramedics to emergency departments and that it worked a lot more smoothly because of the fact that there was an overarching connection with NSW Health as opposed to the challenges we had with the handover from police to the State emergency departments, even though they are also part of a New South Wales government service. I wonder whether you could comment on that in relation to your position.

Mr WILSON: The IMIST-AMBO handover was developed by a paramedic. There is nothing in the way that it was developed to stop a similar system from being developed for police. The development of a professional handover is not reliant upon a close relationship between the two organisations. There is no reason

the NSW Police Force cannot use a similar system that is developed and agreed between the two organisations—in fact, I would encourage it.

Ms JENNY LEONG: I take your point that there is no reason for that, and from where I sit I wonder why the same handover protocol could not be used for both, but what we have seen is that a handover protocol was developed because of the fact that paramedics sat within Health and it was not developed for the police. Unless you have another reason for it, it seems that there are other arguments relating to the connection between them. In regard to benefits that have been identified by other areas I wonder whether you see any risks of your members not sitting within Health.

Mr WILSON: The problem, as I have said, that we have with sitting within health is purely one of competing priorities. As for the number of LHDs, we have always felt an outsider and as such we have always felt as though we have been resourced accordingly, and that has not sat well with a lot of our members. We understand that resourcing is tight and we understand that the police and the fire brigade have similar issues, but where we sit means that there is an increase in those competing priorities within the health framework. We see other places where the emergency medical services are separate, such as the Australian Capital Territory. Until recently, we have had issues with transfer of care times—again, since I joined the job 15 years ago, transfer of care has been an issue. It has only been in the last 12 months that those figures have significantly improved. These have not been issues in other jurisdictions that have had emergency services separated from the healthcare services. In those jurisdictions, I do not think anyone would argue that the health services provided have suffered.

The CHAIR: That concludes our public hearing today. I place on record my thanks to all the witnesses who have appeared here today. We will resume this public meeting on Friday 18 November at 9.00 a.m. in the Macquarie Room.

(The witness withdrew)

(The Committee adjourned at 16:52.)