REPORT ON PROCEEDINGS BEFORE

COMMITTEE ON LAW AND SAFETY

INQUIRY INTO VIOLENCE AGAINST EMERGENCY SERVICES PERSONNEL

At Macquarie Room, Parliament House, Sydney on Friday, 18 November 2016

The Committee met at 9:00 am

PRESENT

Mr G. Provest (Chair)

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

The CHAIR: Good morning and thank you for attending this public hearing of the Committee on Law and Safety, which is the second hearing in conjunction with the Committee's inquiry into violence against emergency workers. My name is Geoff Provest. I am the Chair of the Committee and the member for Tweed. With me are my Legislative Assembly colleagues Mr Damien Tudehope, the member for Epping, Mr Edmond Atalla, the member for Mount Druitt, and Ms Jenny Leong, the member for Newtown.

This morning the Committee will hear from representatives of the Fire Brigade Employees Union, the Police Association, the Law Society, the Australian Medical Association and the Australian Salaried Medical Officers Federation. In addition, we will also hear the perspective of an intensive care paramedic, Mr Greg Golds. I thank the witnesses for making themselves available today. For the benefit of the gallery I note the Committee has resolved to authorise the media to broadcast sound and video excerpts from its public proceedings. Copies of the guidelines governing the coverage of proceedings are available.

LEIGHTON DRURY, State Secretary, Fire Brigade Employees Union, affirmed and examined

CLAIRE PULLEN, Senior Industrial Officer, Fire Brigade Employees Union, affirmed and examined

The CHAIR: Thank you for appearing before the Committee today. Do you have any questions regarding the procedural information sent to you?

Mr DRURY: No.

Ms PULLEN: No.

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

Mr DRURY: Yes. I thank the Committee for this opportunity to appear and to make a brief statement. I have been a serving firefighter and member of the Fire Brigade Employees Union [FBEU] since 1999. I currently hold the rank of senior firefighter. The majority of my time as a firefighter has been served at Parramatta, Northmead and recently Hornsby fire stations. I have done brief periods and periods of relief throughout the metro area at Silverwater, Blacktown and Castle Hill. During my time as a firefighter it is my observation that assaults on firefighters by members of the public are rare. This may be a result of us spending the bulk of our time engaged in work with a limited scope for interaction with members of the public. In part it may also be because of the union's long-held position that firefighters are not used as an alternative police force. The front cover of one of our journals from 1961 with our long-serving president and later chief officer of the fire brigade Rex Threlfo read "We Won't Be Wallopers".

I suspect the general public knows what our role is and what it is not. We are rarely placed in positions of conflict with members of the public, for example the issuing of fines and infringement notes. Should our role change then this may change as well. Currently we hold positions of significant trust within the community. In my experience our employer is able to adjust our response protocols accordingly where a risk to firefighters is reported. For example, we may turn up without lights and sirens where a threat has been reported and we may have police attend as well. Our communications centre plays an integral role in this work. It is this sort of dynamic risk assessment and response that is appropriate in our industry. Given that the occupation of a worker can rarely be an aggravating factor in sentencing, the union's view is that a focus on prevention at an employer level is a more useful way to prevent assaults.

Ms PULLEN: Nothing from me, thank you.

Mr EDMOND ATALLA: Given your statement that firefighters are generally not the target group for assaults, do you still stand by the submission that your members really do not need any special protection in legislation similar to police and ambulance officers where penalties for assaults on those officers are much greater than penalties for assaults on firefighters?

Ms PULLEN: I think there are two parts to the question. The first one, which we deal with a lot, is in terms of the difference between prevention and punishment. I should be clear that I think there is very little that legislation can do to prevent assaults from the sort of people that on the rare occasion it happens do assault firefighters. My experience from speaking to the very few members who have discussed this with us is they are not members of the public who are making rational considerations about what might happen after that interaction. I think it is important to talk about prevention being something you do before the incident arises rather than what punishment might come up. I want to be clear about the distinction in our mind about that. It may be useful to require recording of assaults against firefighters in the way that the Bureau of Crime Statistics and Research [BOCSAR] does for paramedics and police officers. Anecdotally it is very rare. I am aware of it happening once in my time with the union, which is about 6½ years. That might be useful, but at the same time we do not interact with members of the public in the way that the police and the ambulance do.

Mr EDMOND ATALLA: Did you say you do or do not record assaults? Do you have a formal process for recording them?

Ms PULLEN: The agency does, the employer does require us to report pretty much everything, but there is no separate statistical body in the way that BOCSAR records them for police and ambulance.

Mr EDMOND ATALLA: Given that firefighters are uniformed officers and we are seeing random attacks on people in uniform, do you still believe that people who are out to attack someone in uniform will make the distinction between them and all the other emergency services personnel in uniforms?

Mr DRURY: No, probably not.

Mr EDMOND ATALLA: Given that, do you still believe that you do not need to be included? If the Committee was to recommend that all emergency services personnel require special protections and legislation to cover them, are you still of the belief that firefighters do not need to be included?

Mr DRURY: I would hate to presume what the Committee would put forward as those measures, so that would be hard to say. Going back to your original point if people are mistaking us with the police and somebody else in regards to these random attacks, as Ms Pullen said I do not think further penalties would deter those people from doing that. At our side I think preventing that from occurring is a more appropriate way to head.

Mr EDMOND ATALLA: Should there be a situation where a firey was assaulted and killed, do you believe that there should be mandatory sentencing of the person who assaulted the firey, similar to mandatory sentencing that applies to police officers?

Mr DRURY: I think that is a hard question to answer in one respect. Certainly we have the view that all workers should be protected. Anyone going to the job, either here or the garbage men or the baker, should be able to work in safety with as many protections as everybody else.

Mr EDMOND ATALLA: I am specifically asking this because mandatory sentencing currently only applies to police officers. It does not apply to any other emergency service personnel. If an emergency service officer who is not a police officer was killed in the line of duty then mandatory sentencing does not apply. Should that be extended to emergency service personnel, including fireys?

Ms PULLEN: It is one of the questions that we tried to grapple with in our submission. We looked at where to draw the lines around professions in this kind of matter. I was at a meeting yesterday where the nurses union were in attendance. I noted that some number of nurses have died this year or been seriously injured in aged-care facilities. The example that was given was a resident who was demented who put a statuette in a sock and badly concussed the worker who ended up with a brain bleed and went to hospital. We were talking about this in the context of that nurse would not be covered by the scope of what this inquiry is looking at, but her colleague in the emergency room would be. For some professions it is easy to say, "You are clearly this and you should be covered", but would that also apply to National Parks firefighters? Curtis Cheng, for example, a civilian employee of the police—I am not familiar with the Act in sufficient detail to say whether or not he would be covered by the mandatory sentencing provisions for police.

Mr EDMOND ATALLA: No, he would not.

Ms PULLEN: I think it would warrant further consideration from us before we could say yes, you should definitely include us in any mandatory sentencing regime.

The CHAIR: One scenario would be that firefighters increasingly have become exposed to attending meth labs, for example. Meth labs are notoriously known to have booby traps and a raft of protection measures. If an injury did occur, where do they stand? If you look at aggravation provisions in the Crimes (Sentencing Procedure) Act, a lot of workers are included like taxidrivers and bus drivers. This Committee is looking in depth at where to draw the line. Deep down members of the Committee are very appreciative of our emergency workers and we are looking at how we can assist them in the changing environment. Part of the inquiry is to have a critical look at the procedures, policies and training in place for emergency service workers to ensure that these are adequate to fit the current needs.

Ms JENNY LEONG: You mentioned in your opening remarks something that is clear in your submission, and that is the fact that firefighters do not find themselves subject to this kind of aggression and violence at the same level as other emergency personnel do. What can we take from the way that firefighters are perceived in the community? What work is done behind the scenes, by the union or the employer, that we could learn from for other emergency service personnel? The concern is for health workers and paramedics. Your example of the nurse in the aged-care facility is very specific, but we have heard that there is a lot more violence and aggression towards health workers in emergency departments and paramedics. I would say that they fall into a similar category in that they have the trust of the community and they are seen as being there to assist. You would expect that health workers and paramedics would be treated in a similar matter to firefighters. Ms Pullen, you talked about prevention. What things do you think are done well for firefighters that we could potentially adapt and implement into other emergency service areas?

Ms PULLEN: It does happen at a level even below internal policy with the employer. When we were preparing for our appearance, Mr Drury was able to take me through a number of examples of how individual stations make their decisions around how they respond. I will flick that part to Mr Drury to talk to you about a couple of the examples.

Mr DRURY: When I first joined the job, I went to Parramatta straight out of college. One of the first things I noticed on our teleprinters were streets that were marked over at South Granville way. These were streets where if you turned out for incidents in those areas, you would wait for the police to turn up. That was due to what I deemed at the time was more teenage vandalism than any concerted attack on firefighters. But those sorts of processes are in different areas, and different stations have their own particular ways of dealing with those problems. Some of that is, like I said before, turning up without lights and sirens on. Our communication centre is pretty integral—we have firefighters in there at the moment. They assess those risks for us as we turn out to different events. Going back to your other point, I suppose we are fortunate that we do not attend the same sort of incidents that the police and ambulance do. If we do, it is a stand-off nature. We deal with the cause or the flow-on of what the problem was. Obviously, we very rarely then deal with the actual cause of the issue.

Ms PULLEN: I have been reflecting further on the conversation about the nurse who was injured in aged care and the example Mr Drury has given about making sure the police are attending the sorts of jobs where there has been a risk reported through the communication centre and they have said, "We think you need some help." I think it would be a good question to put to the expert witnesses from the Police Association—I am not sure whether you have spoken to them—

The CHAIR: They are sitting right behind you at this point in time.

Ms PULLEN: —about what the appropriate equivalent of the police is for them. Do they have enough staff to go? Again, this is something that comes up in terms of staffing at hospitals. I am not sure if you are familiar with what a five-person hold is to take someone down.

Ms JENNY LEONG: Yes, we heard about it from the nurses.

Ms PULLEN: But if there are only four staff, how do you do a five-person hold? For us, given that our minimum staffing is required for all aspects of our job—and please correct me if I am wrong, Mr Drury—one of the ways to deal with, for example, someone throwing rocks at the truck is you lock yourself in and if it is a 14-tonne truck you will probably be right until the police arrive. There might be an equivalent to that for other occupations. Certainly for us, the way things work at the moment, almost at station level means that we are able to call on the appropriate resources if we need them.

Ms JENNY LEONG: You mentioned localised risk assessment. Are there other training policies or other procedures looking at where the risk is and how to prevent it that you think are useful and that you could share? Please talk to us about any communication system or technology that you use in the truck or on the firefighter in terms of support technology and equipment to alert firefighters if an incident occurs.

Mr DRURY: We do have a range of different resources that we use. For a long time we have been doing pre-incident planning. They were specific to different premises, but that is broadening into different areas as we go along. Recently we have had an upgrade to our turnout system within our fire trucks. We now run an ADASHI system, which is a computer terminal very similar to the police and ambulance. That is providing current local information. It uploads pre-incident planning [PIPs] and a whole range of information that we can now use going forward. We can see where resources are and how far they are away. Coming back to a question about whether firefighters are put in that position, like I said, we are very fortunate that we do not have to be on the front line as much as what the other services do. The role that we play is a secondary role. I remember the Redfern riots—obviously the police were at the front but we were at the back to put out fires. At the time we may have even rescued some officers who had been struck. We are very much a secondary role in this.

Ms JENNY LEONG: You might find this a strange question without the context, but it has been raised in some of the discussions we had as part of the hearings of this Committee. It is around the risk of future civil unrest with attacks on firefighters and people in uniform as part of a large community uprising. Have you had any indication from your members of signs of that being a concern or a problem in Australia?

Mr DRURY: As a response agency to those sorts of incidents we take those things quite seriously. Certainly at a command level they are preparing and planning for those types of events and we work very closely with the other emergency services, State and Federal, around those incidents. We had resources at the Lindt café siege, obviously sitting in the background in a response role, if needed. There is a lot of planning going into that into the future and that really did change I would say after the 9/11 attacks in New York as one of the scenarios that we could or may likely face. Fire and Rescue spends a lot of time in those areas and planning for them.

Ms PULLEN: It is my experience from speaking to our members about this is that occasionally when the terror threat is upgraded an email will go from the employer to the "all staff" email address that says, "Perhaps reconsider wearing your uniform on the train on the way in, and you might want to be a little bit

mindful when you are going out for lunch." That has been almost inevitably followed by a member taking a selfie on the train with a member of the public who has come up and said, "Oh, you are a firey, isn't that great! Can we grab a snap with you?" Generally speaking people can differentiate between the sort of work that we do and the work that other agencies do and they are able to respond to that appropriately. I think it is appropriate to take a snap on the train.

Ms JENNY LEONG: In your submission you say you would not necessarily be the first responders in city areas, but the Committee has heard that often in regional and rural areas the first responders are not always able to be the appropriate service. Do you have any comments about volunteers in the scope of this inquiry and also in circumstances where your members might be the first responders even if they are not necessarily the most appropriate service?

Ms PULLEN: I think there are now 10 stations in regional New South Wales where our members also perform what is called "community first responder work". That is where an ambulance is more than 40 kilometres or more than 40 minutes away. So they have a very advanced first-aid role when they turn up. They do everything—they help people give birth to babies, they deal with heart attacks and if little Timmy has got a broken thumb they put a splint on and wait for the ambulance. It is quite common for our members to be the first responders in those areas. The converse of that being smaller regional areas, the community knows the members who are turning up. It is not uncommon to have multiple generations of families being in the fire brigade or someone who is the local ambo is also the part-time firefighter.

We think it is appropriate that they are covered and that they are captured by the scope of workers comp, and for this inquiry as well, but there is the trade-off between the anonymity that you have in the city and the knowledge that a local community would have in a regional area, which I think mitigates against some of the concerns. It is not uncommon for our retained firefighters, for example, to be the police. Their full-time job is as a serving police officer and then they are a retained firefighter in what remains of their spare time. As to volunteers, obviously we do not cover them as they are not employees, but they are an important part of our industry and we work very closely with them, particularly in the urban interface areas. I do not see how you could not include them. If the concern is that someone is being assaulted because of the uniform they are wearing or the public service they are performing, how could they not be included?

The CHAIR: The Committee has already spoken to the Rural Fire Service and a wide range of services, including Marine Rescue NSW.

Ms PULLEN: That is good.

Mr DAMIEN TUDEHOPE: Do firefighters carry duress alarms with them when they are attending incidents?

Mr DRURY: What kind of duress alarms?

Mr DAMIEN TUDEHOPE: If they are in difficulty is there a manner in which they can call for assistance?

Mr DRURY: If I am understanding your question correctly, you are referring to a personal device if they are physically threatened?

Mr DAMIEN TUDEHOPE: A personal device, yes.

Mr DRURY: No, we do not. But when we are wearing breathing apparatus it has a distress system that operates—if you are knocked out then it senses you are not moving and goes off—and we carry handheld radios that have a distress beacon on them.

Mr DAMIEN TUDEHOPE: Can you give me a description of handheld radio? What sort is it?

Mr DRURY: From memory it is a Motorola GRM, it works on the GRM network.

Mr DAMIEN TUDEHOPE: Is that state-of-the-art?

Mr DRURY: I do not know where the state-of-the-art is up to at the moment. It does go to government contract so I am not quite sure what the highest level of that technology is, but it is appropriate for what we use.

Ms JENNY LEONG: Putting it another way, you do not get complaints from your members about its functionality?

Mr DRURY: No, it is a pretty good system. They are quite expensive because we take them into dangerous atmospheres and they need to be intrinsically safe. They do have an alarm feature that you can

activate if you are in trouble that goes to our communication centre. I would not necessarily say they would think that was due to an assault, it may be more along the lines of being trapped in a building but they would send help.

Mr DAMIEN TUDEHOPE: It is a manner of attracting attention that someone is in difficulty and they need some help.

Mr DRURY: That is correct.

The CHAIR: Other jurisdictions have specific policies as to threats faced by their emergency workers. Does New South Wales have such a policy? Does head office put out a policy that firefighters must be aware of, for example, in hazardous situations? I have been out to your training facility where there is a lot of emphasis on fires, chemicals, et cetera, but do you have a policy for interaction with the public?

Mr DRURY: In the context of this situation I would say nothing substantial.

The CHAIR: Is the union satisfied that sufficient protections are in place—policies, equipment, et cetera—to ensure the safety of your members?

Ms PULLEN: Rarely will you find us saying no to more training, more skills development or anything in that line. It is certainly a view that the membership and the leadership of the union are as one on, but I think we should be clear that in the context of—I do not want to say the word austerity, but our budget is shrinking substantially over time. It is of concern to us that we may not be able to provide the level of fire protection we currently provide in the context of those cuts. In that context, the idea that you would train people in something that very rarely happens, it would seem to me to be a nice to have, rather than a must have. Frankly, I may be speaking out of turn here, but if someone came to us and said, "There is X number of dollars to provide training for this" I suspect we would say, "Can we have it to keep the fire station open, please?"

Mr DAMIEN TUDEHOPE: Have you heard of signal 55?

Mr DRURY: No.

Mr DAMIEN TUDEHOPE: Then you might want to talk to your colleagues in Melbourne.

Ms JENNY LEONG: Are you going to expand on that or are you just going to leave us hanging?

Mr DAMIEN TUDEHOPE: There is a signal 55 message to the Emergency Services Telecommunications Authority, multi-agency call tasking at a dispatch centre—and you may have addressed this—and they advise other responding personnel, including the Melbourne fire brigade command staff and, if necessary, other agencies such as Victoria Police and Ambulance Victoria. Once the signal 55 is given staff should withdraw to a safe position.

Mr DRURY: We do have something similar. Our communication centre does provide that information when a threat has been recognised—we get that through our ADASHI system. When firefighters are turning out and they recognise a threat then the police are obviously then called or ambulance or whoever is required.

Mr DAMIEN TUDEHOPE: So there must be some sort of protocol in place?

Mr DRURY: Yes, at a communications level, that is right.

Ms JENNY LEONG: I ask one more question as a follow-up which has come up a couple of times around the risks of firefighters going into meth labs or various drug facilities that might be booby-trapped, which is obviously a risk. I wonder whether or not that is something that is a similar risk to someone who is aggressive or violent to front-line emergency service personnel or whether that is a different risk and there are other ways that could be addressed or mitigated. That is the scope being discussed where firefighters might be at risk from that kind of aggression. Your submission seems to be about prevention. What do you think could be done to support firefighters facing that danger?

Ms PULLEN: It is a difficulty I deal with when I am advising our elected officials and I take the legal view that you could anticipate every possible risk and I find firefighters are very sanguine about the level of unpredictability in their work. Over time I have become accustomed to the idea that you just cannot predict.

Mr DAMIEN TUDEHOPE: You cannot legislate for everything?

Ms PULLEN: No, that is exactly right. Working at a station for a period of time; for example, the firefighters at Redfern have a very good sense of when they are going to a meth lab that is going to be booby-trapped and they are able to relay that job and say, "Look, we just didn't go in. We protected the surrounding

houses but that one just went up; that's what we did with that." They get to know their area and have that sort of experience.

Mr DRURY: And we have the standard operating guidelines that deal specifically with those sorts of situations as well. Could that be added to those guidelines? Possibly.

The CHAIR: In the times that I have been out to Alexandria you actually run training courses in meth labs, and so on, for the NSW Police Force?

Mr DRURY: Yes.

The CHAIR: Being involved in different roles, the big thing was the roll-out of the new helmets, the communications systems and hopefully in the future the video. That is a pretty good road to take, is it not? It creates greater safety and a greater command centre. I envisage that in the future video links, drones and things of that nature will come. Is the union fairly proactive in that area of ensuring that our firefighters have the right equipment?

Ms PULLEN: Very. I actually found surprising the level of engagement we have when I transferred over from another union, the level of work that goes in from our end into managing those processes. I sat on one of the committees for the new uniforms. That was an exhaustive process, not just for tender but the development of the specifications about how you sewed the Kevlar in the right way. I have never worn one of the helmets but I understand Mr Drury does.

The CHAIR: I have worn one.

Ms PULLEN: They are very exciting with the mouthpiece and all the different parts.

The CHAIR: I wasn't allowed the black one though.

Ms PULLEN: Only one person gets to wear that.

Mr DRURY: As a union we have a 17 person State committee. I am the elected State Secretary at the moment so I am seconded across into the office but the other 16 are active firefighters out there in the different parts of the organisation so the decisions that they obviously make and that we make directly affect them as well as their colleagues and friends so it is certainly something we take very seriously.

The CHAIR: So you are actively involved in the process of the Kevlar stitching?

Mr DRURY: Yes.

Ms PULLEN: Yes, things you never knew you needed to know.

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

Ms PULLEN: Yes.

Mr DRURY: Yes.

The CHAIR: Once again, thank you. On behalf of the Committee, we thank your members for the valiant way they keep our community safe on a 24/7 basis.

Ms PULLEN: Thank you.

Mr DRURY: Thank you.

(The witnesses withdrew)

SCOTT DAVID WEBER, President, Police Association of New South Wales, sworn and examined

ANGUS SKINNER, Research Manager, Police Association of New South Wales, sworn and examined

OLIVER BEHRENS, Executive Member, Police Association of New South Wales, affirmed and examined

The CHAIR: Thank you for appearing at this hearing. Do you have any questions about the procedural information sent to you?

Mr WEBER: No

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

Mr WEBER: Yes, Mr Chair. As the President of the Police Association of New South Wales I represent 16,500 sworn police officers and also 6,000 retired members who are associates. I represent the legal welfare and industrial rights of police officers across New South Wales. I am a serving police officer. I have been a police officer for 22 years and a sergeant of police and currently I am the President of the Police Associaiton. I have been seconded there for the last six years.

Police officers, along with all emergency service workers, make a great sacrifice to our community. They put themselves in harm's way, frequently suffering physical and psychological injury in order to protect others. We owe it to our emergency service workers to keep them as safe as possible, especially when they are undergoing these dangerous situations. Every year more than 2,000 police officers are assaulted. You have heard from the other emergency services representatives about the alarming rates at which they suffer violence. Also concerning for police officers is that over the last five years the assault rate trend has been stable; in other words over the past five years we have failed to make measurable progress in reducing violence inflicted upon the men and women of the NSW Police Force.

There may be some perception that emergency services workers sign up for this; that when you put on the blue uniform or put on your nurses uniform, ambulance or fire brigades uniform, well, that is just part of the job. Emergency services workers are selfless people. They go out there and put their lives on the line to protect the community but we should not be suffering violence just to help others. This is not what should be tolerated by society at all. This violence has real and lasting consequences for emergency services workers. They feel the pain; they endure bruised eyes, deep cuts and broken bones. They require hospital stays; they need time off work to recover. They suffer permanent disabilities and lasting pain. They may be exposed to communicable diseases. They experience trauma and may suffer post-traumatic stress disorder and devastating psychological injuries. Their health and wellbeing and that of their families suffer due to this service, and this does not even take into account all the near misses that occur every single day on top of these assaults.

This human toll cannot be accepted as part of the job. Police officers experience violence in a variety of circumstances. Our workplace is the entire State of New South Wales. We attend every single job when someone calls for assistance and we respond to calls for assistance from other emergency service workers. Therefore, there is no single solution to everything, as the Committee has previously discussed, but there are a large range of mechanisms that can reduce or mitigate violence and the consequences for police officers when violence occurs. In particular, the Police Association of New South Wales strongly urges the Committee to give consideration to the following measures, which have been outlined in our submission. In circumstances in which police are assaulted there is safety in numbers. Low police to population ratios increase the risk of violence to police officers. Therefore, as a minimum, police numbers should maintain police to population ratios.

We need strategies to reduce alcohol- and drug-related violence, particularly ice. The Committee has already discussed meth labs. We have seen a dramatic reduction in alcohol-related assaults as a result of the Last Drinks campaign, which involved a coalition of police, doctors, nurses and ambulance officers—all emergency service workers—working towards a common strategy. Another useful measure would be the provision of body worn video. There should be safe and dignified strategies for emergency service workers to interact with people with a mental illness. We have some ongoing strategies, like the mental health intervention team, but more needs to be done. There should be mechanisms to test for communicable diseases. As the Committee will hear from my colleague Leading Senior Constable Oliver Behrens, that is critical for peace of mind for the police officer and their family. Station security technology needs to be enhanced. Chair, you touched upon drones. That technology could be used to begin to mitigate risk. Injury management and return to work procedures need to be addressed. Sentencing strategies for people who assault emergency services workers should also be considered. We are happy to elaborate on that.

We note that the New South Wales Government submission raises the issue of prosecutions for work health and safety breaches. While the Police Association supports any proactive action by SafeWork to improve measures, the Police Association urges the Committee not make any recommendation that would weaken WorkSafe's prosecution function. As we all know, police officers are the last line in the State of New South Wales. When everyone else is running away from a situation, we are running in. When emergency service workers across the State of New South Wales need assistance they call police. It is critically important that we maintain and protect not only police officers but all emergency service workers.

The Police Association looks forward to providing any further details on these strategies and any other information that it can assist the Committee with. Leading Senior Constable Oliver Behrens is a serving police officer and one of the executive members of our committee. Executive members are not seconded to the union. They participate in their free time. They are still serving police officers, working out on the street. Oliver is here today to share with the Committee his experience of the violence that occurs. His story is indicative of what thousands of police officers go through every single day while serving the community.

The CHAIR: Thank you. This Committee and all members of Parliament are very appreciative of the commitment and the dedication of your members, above the call of duty, and of the effort that they put in every day for the good people of New South Wales. No-one here would dispute that. Part of this Committee's role is to look at the fairness of the procedures that are in place for all emergency workers. There have been some significant, dramatic and very upsetting cases in recent times. That is where we started in formulating our terms of reference. Leading Senior Constable Behrens, would you like to make an opening statement?

Mr BEHRENS: I am happy to. Thank you very much. If I may, I would like to share a story, by way of example, of an interaction I had around Christmas time last year. My partner and I attended a job at a unit on the tenth floor of a housing commission estate in Surry Hills. Neighbours had called about screaming and yelling coming from the unit. When we got there we heard a significant commotion coming from inside the unit—yelling, screaming, calls for help and smashing sounds. We yelled through the door, to identify who we were, and asked the person inside to open the door. They responded that they were trying to open the door but they could not. At that point we could not wait any longer. My partner and I ripped the metal security door off its hinges and started kicking in the main front door to try to get in because the commotion was ongoing. Before we were able to kick through the door the male occupant of the unit was able to open it and let us in. He ran out and said, "She's got a hammer."

My partner was a junior constable. He stayed with the man because we were not sure who he was. I walked into the unit. It was a relatively small unit. On the far side of the unit was a balcony. The balcony was separated from the unit by a glass window and a glass door. I could see the whole balcony. The woman was on the balcony. The door was closed and she was swinging her hammer ferociously. It was a claw hammer. I tried talking to her, calming her down, but it was clear that she was in some kind of major psychotic state. It was very difficult to get through to her. She was yelling her name, screaming for help and screaming for people to call the police. I was standing right in front of her in full police uniform. I tried several different techniques to calm this lady down. I talked to her about her what her issues were. I suggested I call more senior police to the location to calm her down. A few times I was able to get her to calm down a little bit and I thought I was on the winning path. I checked the door to the balcony. It was locked. There was no key in the door. I asked the guy who my partner was standing with outside whether he had the key. He said, "No. She has it." She had locked herself out on the balcony.

After a few more minutes of talking I thought we had her calmed down. Other resources were on the way, such as police rescue, police negotiators and our supervising officer. She spiked suddenly, as she had been doing repeatedly in waves, but this time she was not swinging the claw hammer. She started climbing the balustrade of the balcony on the tenth floor. I reacted instinctively. I did not think about it. I lunged forward and kicked through the door in a single kick. I grabbed hold of the last two limbs as they disappeared over the balcony, her left arm and her left leg. Fortunately for me, she was a rather small woman of thin build so she was not that heavy that she dragged me over the edge with her. I was able to hold her there long enough for my partner to race in and help me lift her back over the balustrade and pull her back into the unit. She was still clutching the claw hammer, which we had to pull from her hand. She was as agitated as ever. She was yelling and screaming. She was clawing at us with blood-soaked fingernails, scratching my hands and arms and my partner's hands and arms. She was trying to bite us. We moved her to the sofa and tried to pin her down and hold her as best we could. There was not much more that we could do at that time other than securing her with cuffs and keeping her pinned down.

Further police and the ambulance arrived a short time later. The ambulance officers were able to subdue her and she was transported to St Vincent's Hospital. My partner and I escorted the ambulance to St Vincent's Hospital, where they started doing medical checks and blood checks to try to find out what was wrong

with this woman. Despite the fact that they were taking blood from this woman to determine her medical status, the details of her medical status and what communicable diseases she might have—that we now might have—were not able to be relayed to us for privacy reasons. We had to go through what most police officers go through and what the statistics say is in the realm of a thousand incidents for New South Wales police every year: We were potentially contaminated by infectious diseases.

We got our own blood test. We sat down and had a chat with an infectious diseases expert and weighed up our options. In most cases, the option a police officer takes when they think they are at serious risk of an infectious disease—by the way, given the woman's history we had learned from her partner that he had only known her a short time, that she was an illegal drug user, that she had an unstable mental health background, and she was sexually promiscuous in that he knew she was married and she had left her husband to have an affair with him in the past couple of weeks. So all the risk factors were there. Treatment-wise for police in those circumstances when we have had blood-to-blood contamination, the normal option is something called PEP, which is post-exposure prophylaxis, as it was explained to me. I had been in similar circumstances before. My young partner had not and it was more traumatic for him, being his first time.

PEP is quite a serious bit of medication. It is predominantly to reduce the risk of contracting AIDS from blood-to-blood contamination. I understand it is quite expensive and is taken over a 28-day period. For the person taking the drug, that 28-day period is quite a serious commitment in relation to the side effects that that person goes through whilst on the medication. The side effects can include nausea, vomiting, diarrhoea, prolonged headaches and weakness. Police officers, when taking this medication, quite regularly go off on sick leave. Those who still come to work very often are so drowsy and affected by this medication that they are not capable of performing their regular front-line duties and have to be put on to a secondary duty for the period of the month that they are on the medication. The medication, I understand, also has an impact on the patient's liver and kidneys over the long run, especially with repeated doses.

This treatment is often unnecessary in terms of the physical wellbeing of the officer, as well as the monetary cost to the taxpayer in terms of lost production and increased sick leave. It could largely be avoided with a simple blood test of the person of interest in the circumstances. If the officer knows that this person has a particular infectious disease, then that specific disease can be treated rather than the broad-spectrum approach. Alternatively, if they do not have a disease, then an officer might choose not to take any sort of treatment, other than to monitor themselves. In conclusion, I thank the Committee for placing themselves in the shoes of a front-line emergency services worker. It is our job to protect the public and achieving that aim sometimes means placing yourself at risk or in harm's way. I thank you for imagining yourself in my situation on the balcony, when saving a woman's life potentially puts you at risk of a terminal illness and the effects that that has not only on the officer and the organisation but also on the family of the officer who is waiting three months to get the result of prospective blood tests. Thank you very much.

The CHAIR: Thank you for your honesty and for your commitment. It is deeply upsetting to hear you have to go through that procedure and that unknowing. The submission calls for mandatory testing of prescribed infectious diseases for emergency service workers exposed to the transfer of bodily fluids. Is testing police officers for exposure to possible infectious diseases not already a part of established procedures? Would your suggestion apply to every instance where a level of exposure has occurred or only in those cases when that level of risk has been determined to be significant? If so, how would that level of risk be assessed?

Mr WEBER: First, no, it does not occur. It is critically important. Oliver has just highlighted a case. It is obviously extremely upsetting and traumatic, not only for Oliver as an individual and his family, but his colleagues as well. This happens all the time.

The CHAIR: Did you say 1,000?

Mr WEBER: Yes. We get needle-stick injuries. I know this has happened to Oliver and it has happened to me. We have been walking down the street and people just spit in your face. This occurs with all emergency service workers, especially when we go to a motor vehicle accident; we are there trying to save lives. There are those domestic violence situations or people suffering mental illness. There are a lot of issues that can occur where bodily fluid can contaminate a police officer. What we are requesting is that when that bodily fluid attaches itself to a police officer or they are spat on, that we have the power to arrest that person for the purpose of a test. It is about peace of mind, but also knowing instantaneously what is ongoing and what is occurring. There would have to be follow-up tests. There is legislation in numerous States, including Western Australia.

Mr SKINNER: Western Australia, South Australia, Queensland.

Mr WEBER: We do not have to make the legislation. We have to review those three States and look at the statistical data. Angus can highlight more of that. That is where we need to progress. Listening to our

colleagues before, the fire brigade—and I know you have listened to nearly all emergency service workers—this is a common occurrence. We are in a different environment. They touched upon 9/11. It was mostly fire brigade officers who died in that incident. Also, walking down the street in a terrorist environment, if someone is willing to take a life, they will see someone with a blue shirt and hat on and they will not care if it is a police officer or a fire brigade officer, or if they see someone in a white shirt who looks official. If they see any person who looks official, they will target them.

The CHAIR: For how long has that legislation existed in the other States?

Mr SKINNER: They are quite recent. We have given further detail in our submission, but off the top of my head I believe Queensland was the first, which was two or three years ago.

The CHAIR: Have they proved effective for your members? I know you talk to your colleagues.

Mr WEBER: Yes. Recently we had a federal council, the Police Federation of Australia, and we spoke to Queensland and Western Australia about this issue. Yes, it works extremely well. On top of that, instead of Oliver waiting three months, it might be possible for him to wait one or two weeks.

The CHAIR: Yes.

Mr WEBER: It is the streamlining of the process. Also, it has a preventive mechanism as well. So many times—and this has occurred to me—police officers have been spat on in the face and they have said, "Oh, you've got hepatitis now", or, "You've got AIDS now." That is usually the response, "You have AIDS", or they flick blood on you and they say, "You've got AIDS now." They are a few simple words but they can have ramifications for the rest of your life, not only yourself but your colleagues and your family, and your career. So that extra barrier on top of that so we can say, "No, what will occur now is that you will come with me to the hospital and we will take a blood test." Then also, in regards to legislation, a punishment for doing that as well, because it is a disgusting and heinous offence.

Ms JENNY LEONG: I will follow up on that. The chair asked the specific question whether it would apply to every instance and what level of risk would be assessed. Who would make the decision on what risk is there? The other part to that question is who would have access to that information? We have moved slightly to talk about lots of other risks. You moved into terrorism risks and other things. Let us leave that to the side for a minute. Obviously people who are committing terrorist acts have an intention to cause serious harm. Harsher sentencing is a different debate to the idea of mandatory testing. I am interested to know who would make the risk assessment in that situation? Who would have access to that information and would that information also be used for circumstances other than personal treatment?

Mr WEBER: Mr Skinner has reviewed all the information, but I will make a comment before he responds. Terrorism highlights the different nature and environment we operate in. I go back to my original statement that in the past five years assaults against police have been stable. This is where we need more legislation and some preventative tools.

Mr SKINNER: There are a couple of questions to answer. The first related to the specific details of the testing model and also the effectiveness of the different frameworks in other jurisdictions. I can address those in the same response. Queensland, Western Australia and South Australia have all adopted some form of the testing power we are talking about. However, they have taken different approaches to the details, which we believe has had an impact on the effectiveness of those systems. The first differentiating factor is whether the testing power is enlivened by a predicate offence or by the fact of this exposure occurring. Some jurisdictions have adopted a model where a specified offence enlivens the power, and some have adopted one where the fact of exposure, regardless of whether it involved an offence, enlivens the power.

We believe the most effective of those options is the one where it is enlivened by the fact of the exposure because the police officer's concerns in terms of peace of mind or potential treatment plans arise from whether or not it occurs in the context of an offence. I believe it would be the same for health workers. We believe that is the most effective of those two options. I have some knowledge about when that risk is assessed to happen. However, further details would need to be obtained by health professionals. Again, those different jurisdictions have all landed somewhat differently with regard to defining when an incident has occurred. It might be that certain fluid has come into contact with the officer. Some set a threshold where it has come into contact with the officer and the officer has broken skin, meaning it could be transferred, or it is on their face, meaning that the mucus membranes in their eyes or mouth could absorb those fluids. That is one area where the threshold must be set.

In terms of who makes the decision, again there is a number of options. From our point of view, the interest of officers, health workers or any other emergency service officers who would be covered by this is to

get an answer that is as immediate as possible. In that situation they can have peace of mind and stop worrying as soon as possible, or they do not have to endure the month-long scattergun approach that is taken to treating whatever they may have. They can target what they may have. We believe that the most effective option would be the senior officer being the person who determines that the power is enlivened, and it would be set at a particular rank. That is an option that has been adopted by a number of those jurisdictions.

Ms JENNY LEONG: Surely a health risk needs to be assessed by a health professional rather than a senior officer. I am not sure about people's qualifications in this room, but surely the assessment of the risk to someone's health should be done by a health professional.

Mr SKINNER: Yes.

Ms JENNY LEONG: Where does the health professional assessment come into the potential risk in that scenario?

Mr SKINNER: The legislation that has been enacted using these models has defined circumstances that can be assessed factually. Was fluid applied to the officer? Was there a break in their skin? Was it applied to an area that has mucus membranes?

The CHAIR: Like a checklist?

Mr SKINNER: Yes. The senior officer is able to determine that because it is a factual question.

Ms JENNY LEONG: Those health risks are included in the legislation?

Mr SKINNER: Yes, they are part of the process for deciding.

Mr WEBER: Most of the scenarios should be captured. If you are involved in a motor vehicle accident, the driver is already tested for drugs and alcohol. In Oliver's case, the lady was in hospital getting her blood tested already. If someone is walking down the street and they spit on me, I arrest them for assaulting me. There is already some execution of powers occurring. It occurs mostly during the execution of a police function or power, whether it be rescuing someone involved in a motor vehicle accident, dealing with someone with mental health issues and taking them to hospital, or dealing with someone who has just assaulted a member of the public or a police officer. The next step after a police officer has been exposed to bodily fluid is ensuring that a medical professional takes a sample to alleviate the concerns in relation to communicable diseases.

Ms JENNY LEONG: In your view, who would have access to that information?

Mr SKINNER: In the interests of the officers we are representing, the most important thing is that the officer receives a disclosure. I may be speaking prematurely, but I believe that if that were covered off there would not be any other interest that would require that that be disclosed to anyone else.

Ms JENNY LEONG: The intention is not to assist with prosecution or charges; it is very much your position that it should be to assist with the personal treatment of the officer affected?

Mr SKINNER: That is certainly the primary interest we are dealing with.

Mr DAMIEN TUDEHOPE: I want to be clear about that. If there were an assault by a person who did have a communicable disease and you tested that person, you would not upgrade the offence if the person had a communicable disease and spat at you?

Mr SKINNER: If you are prosecuting someone for an offence, perhaps the better procedure to deal with that situation would be to seek that information under a separate power. Our concern is to provide peace of mind or appropriate treatment for the officer. Any way we can make this testing regime more workable—

Mr DAMIEN TUDEHOPE: Further to the member for Newtown's point, you would not use that material for the purposes of upgrading offences?

Mr SKINNER: We have also requested that it be an offence to apply the fluid to the officer in the first place. For that to be an offence, it would not be dependent upon that person having a communicable disease. Depending on the recommendations that do or do not come from this Committee, our answer may change. If you adopted our submission, it would be that there is an offence of applying the fluid to the officer or emergency service worker, and they would be prosecuted for that, regardless of any diseases they may have. The testing power would be solely designed to—

Mr DAMIEN TUDEHOPE: Give some comfort to the person.

Mr SKINNER: Yes.

Mr DAMIEN TUDEHOPE: I want to be clear about this. It goes to the privacy issues about the information obtained as a result of having committed that offence. You would not use that for the purposes of anything other than giving comfort to the police officer involved?

Mr WEBER: Yes, that is correct. We are talking about a power that is going to be used in regard to motor vehicle accident victims.

Mr DAMIEN TUDEHOPE: You already compulsorily test them.

Mr WEBER: Yes, but not for communicable diseases. In Oliver's scenario, he could have contracted a communicable disease. After that we look at the circumstances. Do we need to look at laying charges? Obviously there was the evidence that it occurred, and we would have to follow up. It is a very difficult situation.

Mr DAMIEN TUDEHOPE: Once you have that information—

Mr WEBER: Yes, to clarify it. Ms Leong, I understand your concerns, and you do not want it to be a punitive tool. However, in saying that, if a person walked up to me, injected me and said, "Sergeant Weber, now you have AIDS", we would go down the path of laying charges for offences. If I did contract AIDS, there would have to be a number of background checks. What's Scott's sexual life? Did he have AIDS before? Obviously that would be clarified in regards to the blood testing. They are very difficult scenarios. I think we need a lot more time and information to work through that. Probably that is a question we would have to deal with out of session because there are too many variables there.

Ms JENNY LEONG: I did not get to say thank you, Mr Behrens. I assume I am aware of the building you work in because I imagine it is in my electorate. All of us would agree that police are often put in situations of dealing with people who have serious drug addiction or mental health issues. Police are called to respond but the issue is not necessarily one that a police officer should be dealing with because in fact the person might have serious mental health or drug addiction problems. In terms of your experience in that situation, moving slightly towards a prevention scenario, what do you believe could be done to better resource the broader public service to be able to assist in that situation? Also what could be done to further resource the police to assist in preventing that kind of incident from occurring? We cannot always prevent those incidents but are there things that can be done to try to avoid that situation occurring in the first place? Obviously, it is the preference that we avoid officers ever being in that situation or at least minimise the incidence of those situations.

Mr BEHRENS: They are great questions. I am not sure how effectively I can answer them. Mental health is a significant issue in the community. Certainly around my area where I work it is a large proportion of our workload, despite the fact that it is primarily a health issue and not a law enforcement issue, as you pointed out. I have been doing this job for 18 years. In the beginning there was little to no training in relation to how to deal with mental health and we sort of picked it up as we went along and we got better at it. These days the organisation has done a fair bit of training of personnel in relation to how to deal with mental health.

I know Mr Weber is very passionate about the mental health intervention team, which is a project that has been running for a couple of years now. How do we avoid it or how do we improve the scenario? I do not know how we could avoid it. I certainly do not have the background information, but from the perspective of the bystander mental health in New South Wales appears to be a bit of a revolving door. You schedule someone and later that afternoon you see them walking the streets. I have heard of people being scheduled twice or three times in the same 24 hour period. That certainly does not help.

Mr WEBER: From a policing point of view we do have the mental health intervention team. It is a four-day course. Across the entire State of New South Wales there are officers being trained.

The CHAIR: It is a very good course. I have been to Goulburn and gone through it. It is excellent.

Mr WEBER: Every single officer has the one-day training but then we have specialised training focused on that. In the situation that occurred with Mr Behrens, there is the crisis team. The doctor, unless they had a very close personal relationship, would have called us anyway because she was armed with a hammer. That is a common occurrence. I can understand the concern that a police officer with full arms turning up could possibly aggravate the situation or not put the person at ease of mind. But at the present moment the first thing to deal with is the violent nature and the propensity for violence and then deal with the underlying issues. How can we prevent that? As we said, we go to a lot of mental illness incidents.

Perhaps—and this has been discussed for a period of time—when we are going to a location and we do realise there is someone suffering a mental episode there we have a counsellor linked into our VKG, our radio network, who contacts the house or we have a doctor who speaks to the person and asks what is occurring. They could speak to the family and say, "Hang on a minute. Has Scott taken his medication today?" All those sorts of

things. The doctor can then relay that information to the police that are attending so that we know. Then we can have a conversation with the doctor or psychiatrist on the phone and we can say to the person that we are going to take them to hospital or they are going to go with their family. We can use all those different triage methods. But at the present moment the New South Wales police are the 24/7 universal problem solvers. We deal with this more than we ever have, but we have a lot more training and we are a lot more capable of dealing with it. But, I agree, it is not our primary job to do this.

Mr SKINNER: I think every officer that I have dealt with over the course of negotiations around the mental health intervention team and also mental health transport are all of the view that mental health is not criminal, persons with mental illness are not any less law abiding or any more violent than any other member of the community. The appropriate response to a person with a mental illness who perhaps comes within the criteria of section 22 of the Mental Health Act is a health response. Police officers do not want to be putting persons with a mental illness in the back of a police vehicle, but the unfortunate situation is, as you will hear from us and as you have probably heard from other representatives in this inquiry, every agency says that they do not have the resources and they do not have the numbers to give it proper attention.

What ends up happening is, because of the availability of services, the police officers will be the only ones available to be the first arrivals and then they will have to make a decision about whether they utilise the powers under section 22 of the Mental Health Act. They then have the unfortunate situation where they have to decide do we in effect criminalise mental illness by putting this person in the back of a police vehicle or do we risk our own safety by utilising some other form or transport or waiting with them by the side of the road or at a house or whatever? Because an ambulance service is not available they will end up transporting them often great distances to a declared mental health facility. Then health staff are obviously dissatisfied. Because of the demands on police resources police have the decision to essentially lose a car crew for the evening while they stay with the person in the health facility or they have to hand over. I believe you have heard from representatives from—

The CHAIR: The Health Services Union and the Nurses Association.

Mr SKINNER: Yes. There is a problem where each service keeps handing the person over. The problem will not be fixed until there is sufficient resources in all the involved agencies to have a coordinated response where ideally health staff would attend and it would be them that are providing any treatment or support, transport would occur in a health vehicle and, if needed, because of the circumstances, perhaps police will be required to be there for escort or protection. That is obviously the ideal but at the moment it just cannot occur.

Mr EDMOND ATALLA: Thank you for your submissions and particularly Mr Behrens for sharing that story with us. It highlights the level of exposure of police officers in their day-to-day jobs. We appreciate all that you do for us. Where are we at with introducing legislation relating to the transfer of bodily fluids? Have we started, have we drafted legislation?

Mr WEBER: No.

Mr EDMOND ATALLA: Has it been discussed in your organisation?

Mr WEBER: It has been discussed. It was part of the Police Association pre-election submission. Again we have had numerous discussions. I have raised it with Mr Chair at Tweed Heads and he is extremely supportive. I have raised it with numerous politicians. It is an ongoing conversation piece not only for us with New South Wales Parliament but also with the New South Wales Police. It is a major concern for our members and I think something that this Committee can actually rectify.

Mr EDMOND ATALLA: Are you getting any resistance in relation to privacy?

Mr WEBER: No, no resistance. We just need to look at the way forward and the assistance that we can glean from Western Australia, South Australia and Queensland is that there is already a draft, a template, there. We can look at that. We can look at the issues that have occurred there and work through them. I think it is a necessary thing for emergency services workers in New South Wales.

Mr EDMOND ATALLA: I want to understand the three-month period. You have indicated that if an officer is exposed to a bodily fluid—

Mr WEBER: I think Mr Behrens is the best person to answer that.

Mr EDMOND ATALLA: —you do not get the result for three months.

Mr BEHRENS: It can take up to three months for certain infectious diseases to materialise in the bloodstream. While they test you on the day of the incident, that does not mean you are cleared because you

have to give it a period of up to three months to develop in your bloodstream before you know definitively that you do not have something.

Mr EDMOND ATALLA: Is that regardless of whether you know that the person who transferred the bodily fluid is or is not infected? Are you saying that even if he knew that the person who spat on your officer had AIDS, you would not know whether the officer has contracted the disease for a period of up to three months?

Mr SKINNER: That is correct. The ideal situation where this testing power would operate is that the person whose fluid was applied to the officer is tested and they have nothing. That is the ideal, because then there is no concern. If you test that person and they do have something then the waiting period is still going to occur, because the officer will not be able to be certain for a period, depending on the nature of the disease—for some diseases the period is six months and for some it is three.

Mr WEBER: But it gives you the opportunity to specifically target that infectious disease, because you know what you are dealing with.

Mr EDMOND ATALLA: For example, you can start treatment.

Mr SKINNER: Yes, rather than the scattergun approach of being treated for everything that you might have.

Mr EDMOND ATALLA: In your submission you included seeking non-sworn officers in the definition of emergency services. Please elaborate on what prompted you to include non-sworn officers. Why have you named employees within the forensic services group?

Mr SKINNER: These are duty categories that are potentially exposed to fluids in the course of their duties. It is also the reason why we are suggesting that the testing power relate to emergency services, not just police, because obviously there is a number of duty types across the services that could be exposed. We have seen recently the unsworn staff still have to face really threatening situations, as we have become profoundly aware in the past couple of years. Therefore, regardless of their sworn or unsworn status, they can potentially be exposed to these situations. That is the reason for our inclusion. We believe that the definition should be set at any duty type that could be exposed to those fluids, and that is why forensic services was included. They are at crime scenes dealing with evidence and material that may include fluids.

Mr EDMOND ATALLA: Would you go as far as including the harming of non-sworn officers in mandatory life sentences? For example, had the offender who killed Curtis Cheng, who was a non-sworn employee, himself not been killed and instead had appeared before a court for sentencing, would you have called for a mandatory life sentence?

Mr WEBER: That is definitely a discussion we would have had a different scenario occurred. Again, we would be speaking with the family as we did following the tragic incident with David Rixon. I thank the New South Wales Parliament for making the right decision. That legislation has been utilised twice, not only for David Rixon but also with Bryson Anderson. Our major concern is that if someone is willing to take on a police officer who is in full uniform and therefore a visible deterrent in regards to committing crime and who maintains law and order in our society, what are they going to do to your constituents in Mount Druitt? What are they going to do to your mum, your dad, your brother, your sister, your children? These people are going to commit more offences and they are a high risk. The reason behind it for us is not only a deterrent but also that police officers are the last line of defence, and if someone is attacking that last line of defence then they are attacking the entire society of New South Wales.

Mr EDMOND ATALLA: Would you support mandatory life sentencing for offences against non-sworn officers?

Mr WEBER: We would have to have discussions with Curtis Cheng's family—

Mr EDMOND ATALLA: I am not specifically talking about Curtis Cheng, but a non-sworn officer. If non-sworn employees were included in the definition of emergency services in the Police Act, for example, would you extend the mandatory life sentence for them?

Mr WEBER: We have not had those discussions with the PSA, but we will have discussions about this. Those are discussions we will need to have, but we do not represent those members. We would be willing to sit down and have those conversations, but with this we can't be definitive because we have not had conversations with scene-of-crime officers and officers on the front line who are non-sworn. No, that conversation has not yet been had.

Mr EDMOND ATALLA: So non-sworn employees are not your members?

Mr WEBER: No—sorry, I should have clarified that at the start.

Mr EDMOND ATALLA: I turn to the subject of the transport of people with mental health issues. In my electorate twice in the last 12 months there has been the necessity to transport a person with mental health issues to an institution. I could not get that service done by the New South Wales police unless the person was sectioned, but the person did not show signs of being a threat and therefore the police were reluctant to use section 22, as were the ambulance officers. At the end the person was transported by taxi to an institution. Do you believe that the legislation needs to be strengthened to clarify whose duty it is to transport a person with mental health issues to a health facility if that person is not a threat?

Mr WEBER: There is a current memorandum of understanding. The police are the last resort, as they should be in regards to this. I think we highlighted that earlier. With your constituents in Mount Druitt or anywhere else in New South Wales, firstly, it should be someone that is known to the person—a family member, friend or a doctor. Then it should escalate to the crisis team, then ambulance and then police. It is a last resort that we would put someone in a police vehicle. But this occurs across New South Wales—it may be the tyranny of distance or a lack of other resources. As I am sure some of my counterparts in the emergency services have highlighted, they would say that they just do not have the propensity to deal with all the situations. As a supervisor I have put the person in a taxi and made sure other familiar people were there. In a police vehicle is an absolute last resort, and there has to be significant violence. If the person is violent but can be restrained, we much prefer to put them in an ambulance and have a police officer inside the ambulance. As my colleagues have said, these people are not criminals; they are going through a mental illness episode and we want to make sure that the incident is dealt with as a health issue and they get treated. It is not a law enforcement issue. It is extremely disappointing that the resources were not available for the incidents you mention, but there is a memorandum of understanding. We are quite happy with that memorandum of understanding. Probably what we want is for it to be properly resourced and enforced.

Mr EDMOND ATALLA: Would you support, rather than having a memorandum of understanding, that it becomes clearer in legislation?

Mr SKINNER: In relation to the specific incidents that you raised, your question was about clarifying the legislation. I think we would say that in that situation the legislation should permit Health to do so. But I do not think the legislation should be clarified to allow police to do that because police should not be in effect arresting people if they do not meet the criteria in section 22. In direct answer to your question, I do not think the legislation should be clarified if it relates to police in that scenario but perhaps Health. Again, that can be difficult for them in terms of resources, although it sounds like a Health vehicle was present.

Mr EDMOND ATALLA: In this particular case neither the ambulance nor the police wanted to do the transfer—the ambulance because of resourcing and the police said they were not qualified—

Mr WEBER: Or entitled to.

Mr SKINNER: We are not entitled to take the person.

Mr EDMOND ATALLA: Unless they section them under section 22?

Mr SKINNER: Yes.

Mr EDMOND ATALLA: The police were reluctant to do that because the person did not show any signs of being a threat so it became no-man's-land. This needs to be looked at because it is pretty serious. We have had two situations in 12 months.

Mr WEBER: It is all too common.

Mr DAMIEN TUDEHOPE: How many incidents have there been where police placed in fearful situations have been infected with a communicable disease?

Mr WEBER: That is extremely hard to answer because of privacy.

Mr DAMIEN TUDEHOPE: I do not want you to identify a particular case, but you must have numbers?

Mr WEBER: Some officers will not say anything—and that would be my opinion too because I think it is a very personal thing—and they have not highlighted that.

Mr DAMIEN TUDEHOPE: Are you aware of any circumstances?

Mr WEBER: I know of a few officers but they are very discreet, as they should be. There is also a policy in regards to discrimination—if Scott Weber had HIV/AIDS and worked at a police station I technically

do not have to inform anyone as long as I look after myself and all those sorts of things. We do not have the numbers.

Mr DAMIEN TUDEHOPE: So there are no numbers that you can indicate to the Committee? I appreciate the circumstances where a person would be placed in a position of apprehension, but if a police officer was infected that would be an additional offence, would it not?

Mr WEBER: Yes, it would be. On top of that, we do not have any numbers. To my knowledge NSW Police or any other agency does not hold that data.

Mr SKINNER: I think the closest data that is available to us—the police force does provide in its annual reports the number of workers comp claims that have resulted from certain factors and that does include biological factors. But that obviously does not definitively say the answer to your question; it essentially shows the number of people who made a claim in relation to biological factors.

Mr DAMIEN TUDEHOPE: Are you aware of any case where someone has been charged with infecting a police officer with a communicable disease?

Mr SKINNER: I am not personally right now. We could take that question on notice perhaps.

Mr WEBER: I know of one.

Mr DAMIEN TUDEHOPE: Where someone has been charged?

Mr WEBER: Yes.

Mr DAMIEN TUDEHOPE: In your submission you raise the issue of security at police stations and the upgrade of potential working areas at police stations. Can you elaborate on what you would like to see occur in the upgrade of security at police stations?

Mr WEBER: We just saw a current incident out at a police station at Merrylands that was extremely volatile.

Mr DAMIEN TUDEHOPE: Some police stations have been fired at!

Mr WEBER: That is exactly right—Lakemba is a prime example. At the moment we are going through an upgrade of 200 stations. They are putting up barriers and restrictions, certain duress alarms and updating CCTV. The new police stations that are being built—like the one in your jurisdiction—will have better technology and will be safer by design, but a large amount of money has been invested by the New South Wales Government into doing that. There is a current ongoing program with NSW Police, and it is part of Alert: 2016 as well.

Mr DAMIEN TUDEHOPE: So there is nothing additional that you think we should be doing to improve security at police stations, other than the rollout of more secure interview and reception areas and the like?

Mr WEBER: That is what we are going through now—and I am sure Mr Skinner is getting the new statistical data—with the new station at Mount Druitt and all the upgrades that have occurred. Merrylands is obviously critically important.

Mr DAMIEN TUDEHOPE: Can you tell us about Merrylands?

Mr WEBER: That is where the offender drove the car through the roller door.

Mr SKINNER: In 2015 the Police Association campaigned for a number of security upgrades to stations—the list of that was provided in our submission—which included essentially safety screens, secure forms of entry lighting, CCTV and all that sort of thing. Midway through last year the Government announced an amount of funding to upgrade security at stations but as part of our core duties at the Association we are always undertaking audits and assessing the safety of stations. What was illuminated through that process in the last campaign we made, was that there needs to be ongoing monitoring and auditing, and there needs to be resources to ensure that upgrades are made as the safety and security situations change and as threat levels increase. Also as stations get old and deteriorate there needs to be strategically planned ongoing monitoring and then upgrading to that, and the resources need to be available when those needs arise.

Mr DAMIEN TUDEHOPE: I take it at the moment that process is occurring?

Mr WEBER: It is a process that is occurring.

Mr SKINNER: Yes.

Mr DAMIEN TUDEHOPE: In your submission you also raise police numbers. Clearly police numbers in regional areas are an issue. Do you have any view on one-out call outs in regional areas? Do you have any view on what we should be doing in addressing a potentially dangerous situation where a police officer attends a potentially volatile situation alone?

Mr WEBER: This is probably part of the re-engineering program that has been announced by Police Minister Troy Grant. But before that, when we did our pre-election submission we were saying that police numbers need to keep up with population—which at the present moment would probably be about 247. We have the lowest police to population ratio in the country bar the Australian Capital Territory, but obviously due to their lack of tyranny of distance it translates to a bigger issue in New South Wales. Making sure that we have adequate numbers is critically important. There is a Workforce Optimisation Solutions for Policing [WOSP] program. This is a police allocation model. It has been initiated by NSW Police but it has not been implemented yet because they are waiting for the selection of the two new deputies to take on board the re-engineering process. What we need to do is not only look at a new allocation of police numbers but also to utilise this program in regards to where police officers are critically needed.

We have also been down at the Industrial Relations Commission in the last 1½ years about single unit policing, which is critically important, where we are setting up safer protocols. We have also been down at the Industrial Relations Commission again for random breath testing [RBT] and single RBT. The world has changed, and not for the better. Police are definitely a priority target and a police officer working by him- or herself is a target. We have seen that just recently at the horrific incident out at Parramatta headquarters with Curtis Cheng, which was deliberately targeting a police officer and Curtis was killed. So there are a lot of issues but with single unit policing the stance of the Police Association is to make sure that there is appropriate resourcing for single unit stations or that people working as single units have appropriate backup. There is an escalation in regards to different jobs that we go to and there is a lot of protocol around it, but again it is about having that critical mass and proper resourcing.

Mr DAMIEN TUDEHOPE: We could explore that at some considerable length and I am sure that the Chair is more across this issue than anyone else. I take it in a single call-out circumstance there is a protocol in relation to duress alarms and the sorts of things that police would use to call for assistance?

Mr WEBER: If we call for assistance we have our portable radios and duress alarms. There is GPS in the vehicles and constant monitoring by VKG. Again single-unit policing is a critical issue and we saw the issues in Victoria where single units were not allowed for a fair period of time. As we have discussed before, we do a risk assessment of situations and make sure that we have the proper resources. There are certain situations that single-unit officers should never attend and that is quite clear. Sometimes we just need to make sure—again we were talking about the MOU before—that those policies are adhered to and make sure that NSW Police informs all our armed police officers of what the correct protocols are and where the correct resourcing is. It links into our radio blackspots. There are heaps of issues there.

Ms JENNY LEONG: I have a few questions but I think some of them can be provided as additional information. I am very happy to do that. Given the increases we have seen in drug and alcohol incidents, which you are concerned about, and violence, would the Police Association be supportive of the return of the drug and alcohol unit within the Department of Education? My understanding is that the department was defunded. My concern is about looking at prevention measures and whether that is something the Police Association would be supportive of. I am happy for you to take that on notice if it is something you are not aware of.

Mr WEBER: It is something that we are not aware of and have not answered but we have been strong supporters of Healthy Harold and going in there.

Ms JENNY LEONG: He was visiting the Parliament this week.

Mr WEBER: That is right. We have been strong supporters and I think education is the key. We need to look at those generations; that is why we have police officers at schools. We have not only youth liaison officers but also police officers who go to schools specifically to teach about safety and prevention, which is critically important. It is the same with our domestic violence roles—getting in there in regards to the family unit and making sure that everyone is protected. Yes, we will take that on notice.

Ms JENNY LEONG: As to the protocols for current handover between potentially violent or risky people who are then taken to emergency departments, what are your views on the current protocols around the handovers? Do you think there is space for those to be improved and what would you recommend the Committee looks at to try to improve and provide protection to emergency department staff who are taking handovers from police in those circumstances?

Mr WEBER: I do note the time and we can obviously highlight that with the document we supplied but it is critically important that police officers go to the hospital and in due time the person needs to be assessed by a doctor and medical professional. Again they can decide in regards to the medication and how that person can be dealt with. We do not want a car crew or four police officers waiting in hospital for six or seven hours. In regard to the triage process or seeing the doctor, we need it to be an absolute priority. That is what I was talking about before; conversations need to flow where we can actually streamline through emergency or go straight in when we are doing the schedule—get access and the assess done straightaway and the police can move on. Once, usually, the proper medication has been delivered and they are talking to trained professionals, the situation de-escalates very, very fast.

Ms JENNY LEONG: Can you provide some additional information around the handover protocols currently occurring in that situation? It would be interesting to know that in the broader role of the Committee in protecting people working in emergency departments; it would be great to know from your perspective the current protocols and whether you think there would be ways to improve safety for those emergency department workers.

Mr SKINNER: Just as a short answer to that, it is clear from the submissions on the evidence heard by this inquiry that both agencies involved are dissatisfied with the situation. We get police officers saying, "We're losing whole car crews for whole shifts because they have to wait at the hospital until health resources are available" and on the other side you get submissions from health workers who are saying, "We're getting essentially dumped and people having to leave."

Ms JENNY LEONG: Which is why I would like to get more detail on what you think would improve the process.

Mr SKINNER: Yes, I think probably the short, simple answer to that is an MOU can be all well and good but it has to be resourced to honour it and I think it is clear from the evidence of both police and health that it is an issue.

Ms JENNY LEONG: The final question is basically any evidence that you are able to provide us that actually mandatory sentencing of standard non-parole periods provides a reduction in the incidence of assaults.

Mr WEBER: Okay.

Mr EDMOND ATALLA: My first question is in relation to assaults on police officers going to and from work. Do we collect any statistics on these types of assaults, for instance, police officers on their way to work?

Mr WEBER: I do not think they are broken down but we did have an horrific incident of Samantha Barlow going to work in Kings Cross. You had discussions earlier with the fire brigades union—we do not go to work in uniform. That is not our protocol anymore. We do not travel on the train that way. That is not what we are meant to be doing. Also, we are a lot more aware of our surroundings in regards to the current environment. I am talking about counter-terrorism and terrorism incidents. We do not have the data. The reason I raised Samantha Barlow was that it was absolutely horrific and she was a fantastic police officer. She went back to work but eventually she retired. At the present moment not many come across our table because we are a little bit more aware of our situation and also of being targeted.

Mr EDMOND ATALLA: Is this something you would take back to your members?

Mr WEBER: I am quite happy to have a look and see if we can find some statistical data about it. There are different numerous mechanisms we have taken on board. No longer would I drive to work in uniform or half uniform, catch a train or the bus. It just does not occur anymore.

Mr EDMOND ATALLA: Mr Skinner, I ask about the upgrade of security at police commands. A couple of representations have been made to me and I understand Mount Druitt is one of the stations that has been upgraded with security screens. This may be a comment more than a question. The issue was that the public did not feel safe. I am 100 per cent in support of protecting our police officers but comments made to me were, "Police are protecting themselves. How can we feel safe?" They feel that the environment is becoming very unsafe if police officers are barricading themselves. The public is saying, "What about us? Who is protecting us?"

Mr SKINNER: Yes, the security measures were making them feel threatened.

Mr EDMOND ATALLA: The security measures were making the public feel very much threatened. I am not sure what you can do to draw a balance between keeping police secure and making sure that the public feel protected and safe. The other comment is that those screens have caused people trying to make a discreet

complaint to raise their voice. They have felt very embarrassed by the situation because they could not communicate with the screen being there. Perhaps someone could look at the design of those screens. If someone was raped and wanted to make such complaint, they would not want to yell out so that everyone else standing in the line behind could hear that complaint. Could you take that on board and see how that could be addressed?

Mr WEBER: I think that is probably more to do with protocols and procedures. With that situation you just need to look at the customer care ratings that we get and the massive amount of support from the community. We do that a lot better. There are numerous rooms we can put them and have a private conversation with people. Also, a police station or the Local Court is virtually an epicentre of where criminals go so it is a hotspot, for all intents and purposes. In saying that, you have police officers there, highly trained, highly skilled, in a police environment. I think the members of public are quite safe there. We are trying to stop people jumping over the counter. We saw that scenario in banks, such as Advance Bank. People used to jump over the counter and rob them. The banks had to create a better design. It is a compromise, but in this environment we are quite happy with it and we do not think it is too heavy-handed.

Mr EDMOND ATALLA: That is fine. You have my 100 per cent support on that.

The CHAIR: Would you take this question on notice? Regarding the lists in your submission, would you let the Committee know in writing the response from the police executive? Am I right to assume that you have raised these issues with the proper chain of command?

Mr WEBER: Yes.

The CHAIR: Oliver, on behalf of the Committee I express our deep concern for your wellbeing after the horrific ordeal that you went through. Thank you for the way you have gone beyond the call of duty. I hope that all is well in your future.

Mr BEHRENS: Thank you. It is.

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

Mr WEBER: Yes. We are happy to do that.

The CHAIR: Please pass on to your members the Committee's appreciation for the way they keep our community safe. Thank you.

Mr WEBER: Thank you, Chair. Thank you for your support.

(The witnesses withdrew)

(Short adjournment)

GREGORY DOUGLAS GOLDS, Private individual, affirmed and examined

The CHAIR: Welcome. Thank you for appearing before the Committee today. Do you have any questions regarding the procedural information sent to you?

Mr GOLDS: No, I do not.

The CHAIR: Do you have anything to add about the capacity in which you appear?

Mr GOLDS: Yes. I am an intensive care paramedic with the Ambulance Service of New South Wales and have been for the past 22 years. I represent a group of emergency services personnel that my wife, Kyla, and I formed online via social media. We currently have 7,700 members.

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

Mr GOLDS: Certainly. My wife and I are paramedics. Kyla works for the NSW Ambulance Service as well as the Queensland Ambulance Service. I am a New South Wales ambulance officer. Our concerns were brought to a head when one of our colleagues in Queensland was rather viciously assaulted over a period of eight minutes when he received injuries and a lot of press exposure has come about since that. My wife and I simply decided the following morning—Kyla was working on the Gold Coast that night—that we would like to sit beside this officer. Both of us did not know him personally, but we wanted to sit beside him in court and let him know that he was not alone, because we had had it made known to us that a lot of our colleagues who had been assaulted stand there alone and court is a lonely place to be, especially when you are staring down the barrel of the bad guy.

Then our interest grew when we realised that there were many, many instances where those offenders of those assaults were, through our eyes, slapped on the back of the wrist, sent home, sometimes without record. It is our belief that that is certainly not acceptable, and that is supported certainly by the people that are members of our social media group and most definitely the members of the people that we speak to you about us being victims of assault. When I say "us", our terms of reference is police, fire, ambulance, multi-rescue officers and emergency department officers, be that nurses, doctors, security staff, wards people. All of those people are front-line emergency service officers, as far as we are concerned, and we have seen each one of those become victims of assault and, sadly, go through the court system. That is why we are here. We have seen more often than not the judiciary not come up with what the public consider to be an appropriate sentence for those people.

The CHAIR: Before I turn to the Committee members for questions, primarily your submission focuses on sentencing and punishing the offenders. Do you think there are appropriate safeguards for the current paramedics in respect of duress alarms, procedures or training?

Mr GOLDS: Within New South Wales Ambulance there is no de-escalation techniques that I, as an intensive care paramedic of the New South Wales Ambulance Service, have been instructed in. A lot of that comes from being streetwise and experience of working on the front line with—

The CHAIR: Do you carry a personal duress alarm?

Mr GOLDS: We have a portable radio with a button that is not particularly easy to find when you are being threatened by a big guy, but it is available. Once deployed, that is sent to the operations centre as a flashing alarm, as far as I am aware. From our perspective, once we have deployed that alarm, we hear from the coordination centre, "Is your radio secure?", or words to the effect of our radio number, "Murwillumbah 582, just a welfare check. Are you okay?" To be honest, if you are a lady of that size being threatened by the bad guy, she might not be in a position to push that button. In that case, if there is no response, that would be escalated, as far as I am aware, and it would be escalated to the stage that a police officer would be tasked to that case to make sure that we are okay.

The CHAIR: But there is no training?

Mr GOLDS: Absolutely not. Not that I have received and not that I am aware of.

Ms JENNY LEONG: Can I follow up on that. In respect of the current equipment and your experience, what improvements do you think could be made?

Mr GOLDS: The ability to be instructed officially by people who know, not just experience dictating this is the way it works, because sometimes that is wrong. An educated opinion explaining to not just New South Wales—I do not speak just for New South Wales paramedics; I speak for all of those emergency service

personnel—an educated understanding or instruction how to de-escalate an angry situation would certainly be of benefit, absolutely.

Ms JENNY LEONG: And in terms of the actual equipment?

Mr GOLDS: There is nothing; not that I can see. The people we are representing have suggested things like pepper spray and Tasers. We do not want to be armed. If someone is assaulting me in my office—which is three metres by two and a half metres square—there is nowhere to run. There is a lot of metal in that space, and more often than not we are travelling quickly down a highway. If I deploy mace, everyone gets it. If I use a non-lethal thing like a Taser, if I hit him and I am touching metal, God help me. There is nothing that we would suggest as far as equipment is concerned.

Ms JENNY LEONG: You believe it is about training?

Mr GOLDS: Absolutely. That is what we do. Ninety-nine per cent of the time we are the good guys. People love us because we are there to help. I suggest that if we won Lotto today we would come back next week and keep doing what we do. We do it because we want to make people better.

The CHAIR: Do you get training in dealing with mental health issues?

Mr GOLDS: Yes.

The CHAIR: Is it sufficient? You heard the evidence from the police officers about that being an issue.

Mr GOLDS: It is sufficient for people at my level of training as an intensive care paramedic. We can run the entire gamut of our pharmacological deployment. People who do not have that level of clinical training do not have that option; they need to push a button that will get me to them. We can pharmacologically sedate people. Once they are pharmacologically restrained, we can mechanically restrain them. As my police colleagues suggested earlier, it is not the mental health patients that we are suggesting need a different approach. It is the inherent bad eggs. It is not the people who are mad; it is the ones who are bad.

I have been in discussions with Dominic Morgan, the chief executive officer of NSW Ambulance, and with Allan Loudfoot, one of the senior managers. I have said candidly that NSW Health has invested a great deal of money in NSW Ambulance for advertising that will not work. There are posters in ambulances and in triage rooms in hospitals saying that it is not okay to assault us. The people who are armed, cocked and loaded to hit, spit and kick us, will not sit back in an ambulance, read a sign and change their mind. It is not those people who have their mind changed; it is the good people who would never have done it in the first place. They are the people that advertising appeals to. I do not believe that it has achieved anything. The bad people are not going to change their mind.

We have put it out to our social media group, and they have suggested deterrents in the form of sentencing, and certainly truth in sentencing. We fully support that approach. We see a revolving door of people being found guilty of assaulting a public officer and being released despite the fact that they could do it again. We do not think it is appropriate that the judiciary seems to think that assaults against us are not worthy of genuine incarceration. I am not talking about incarcerating purely because they will be made better, but simply punished for doing the wrong thing.

Mr EDMOND ATALLA: How many intensive care paramedics are there in New South Wales?

Mr GOLDS: The numbers escape me, but there is a limited supply. I believe there are more than 3,000 paramedics in NSW Ambulance, and there are about 400 intensive care officers. However, that is a guess.

Mr EDMOND ATALLA: Are assaults on intensive care paramedics less frequent than assaults on other ambulance officers?

Mr GOLDS: Any answer I gave would be hearsay. The people who are armed and ready to hit us are not looking at our epaulets or our level of clinical training; they simply want to strike out at someone wearing a uniform.

Mr EDMOND ATALLA: I imagine that intensive care patients—

Mr GOLDS: I understand. The people who are more unwell and who require intensive care help?

Mr EDMOND ATALLA: Yes.

Mr GOLDS: Not necessarily, no.

Mr EDMOND ATALLA: I am talking about assaults by other people.

Mr GOLDS: Sicker people?

Mr EDMOND ATALLA: No, family members of intensive care patients.

Mr GOLDS: Not necessarily, no.

Mr EDMOND ATALLA: Do you believe that there is a culture in the NSW Ambulance Service of reporting or not reporting incidents?

Mr GOLDS: More often than not, not reporting.

Mr EDMOND ATALLA: Why?

Mr GOLDS: I do not know. I can only speak for myself. I have been the victim of assaults in the past, but I had never reported them until we commenced this social media drive. I probably would not, purely because I have seen that nothing has happened historically. Nothing has happened to the "bad" guys, for want of a better word. Now, having been made aware that there is not much going on in the world of incarceration or punishment for those people, I have realised that someone has to stand up, so I am speaking up now.

Mr EDMOND ATALLA: And that is what prompted you to start the Facebook page?

Mr GOLDS: Absolutely, yes.

Mr EDMOND ATALLA: I think I read that you have 7,600 members.

Mr GOLDS: Yes.

Mr EDMOND ATALLA: I assume they are people following your Facebook page.

Mr GOLDS: Yes.

Mr Edmond ATALLA: Do you believe there is an increasing trend of emergency services workers calling for what you are advocating?

Mr GOLDS: Yes, absolutely.

Ms JENNY LEONG: Thank you for the work you do. The Committee is hearing about a very concerning trend. Your submission focuses on sentencing. Obviously we would all prefer to prevent these incidents occurring in the first place.

Mr GOLDS: Absolutely, yes.

Ms JENNY LEONG: Given your experiences on the ground, what would you prefer to have put in place to prevent these incidents? You mentioned responsible service of alcohol. I understand from a teenage family member to whom I am close that anyone can get a responsible service of alcohol card in about half a hour using a credit card on the internet. That is obviously not ideal. There are also differences in the way that licensed venues are dealing with these issues. Can you speak about the prevention side from your experience on the front line?

Mr GOLDS: First, there are de-escalation techniques. Any instruction in that would be splendid from our perspective. We should not rely simply on experience. If you or I were to come into some money we could go to the pub and get rolling drunk in any licensed establishment we went to. However, that is against the law. We are not the fun police by any stretch. More often than not it is men who exercise their testosterone fuelled by alcohol. We see a lot of that. If the law exists and it is enforced appropriately, those people would not be able to get drunk and then roll out of those places and assault people with one punch. They cannot look up at us and then think we are the bad guys because they are not drunk and if they are not drunk they are not making those very poor decisions and assaulting us. I do not know how enforcement of those laws takes place currently in New South Wales, but I know that it is not effective and I know that it is not working. Looking at it from that perspective, if we can decrease the number of hooligans that are rolling out of places at closing time or near to closing time and are drunk purely by enforcing a law that is already there then most of our work is already covered. We will not even get called to those people because they are not punching innocent folk and therefore not calling us and not assaulting us when we get there.

Ms JENNY LEONG: Another question is around the role of the intersection between your responsibilities and the police responsibilities. Do you see ways that we could improve the interaction and coordination between those services that would provide additional protection to emergency services workers or would assist further in terms of the handover of those responsibilities or the communication between those areas when situations escalate? Are there areas that you think this Committee could look at to improve those interactions?

Mr GOLDS: Absolutely. Something that we have the ability to do or would like to have the ability to do is to flag previous addresses that have been known to harbour violent patients.

Mr DAMIEN TUDEHOPE: Do you not do that already?

Mr GOLDS: It is a very long, drawn-out process and we have been told via ambulance management that it has been particularly ineffective historically when we have expressed a concern that there is a violent patient.

Ms JENNY LEONG: Do you think it would be worthwhile for the Committee to look into that flagging process in a bit more detail to see whether there could be improvements?

Mr GOLDS: Yes, and if those areas that are flagged are acknowledged then certainly we are not to respond without police presence. Sometimes ambulance officers are pressured into attending locations that are considered to be violent, certainly those that have people with mental health issues. If we are forced or promoted by our communications team to attend those scenes without police there are a lot of people who have not got the experience or the ability to stand up to the communications team and who would continue to attend those scenes. That is not on.

Ms JENNY LEONG: You mentioned concerns around the signage and said that the people who are going to read the signs are not the people who would necessarily cause the harm. I guess if people are not going to engage with a sign the likelihood of them understanding the details of the sentencing provisions is also unlikely. I am interested to know why you come to the conclusion that we need harsher sentencing when your concern is that people are not even paying attention to a sign?

Mr GOLDS: At the moment word on the street says that if John beats up a paramedic then he is going to get off. But if that word on the street is spread to his friends or to John that he has not been just slapped on the wrist but is now incarcerated as a punishment for what he has done that puts much of a serious inflection on to what his intent is actually going to be rather than simply sitting there reading that it is an offence. It does not say what happens to those people on any of those stickers that are on ambulances. People can be made aware that if you do this you are going to be punished and punished appropriately. As people in Western Australia and the Northern Territory have found out, once their mandatory sentencing was in place within 12 months there was a decrease of I believe 33 per cent in assaults against public officers.

Ms JENNY LEONG: Is that information somewhere in your submission?

Mr GOLDS: Yes, it is. If that is the case and it has data going back, I am not sure of the semantics of how it worked but I know that if those numbers are there and it did decrease assaults against us by 33 per cent then that is something that certainly should be looked at.

Mr DAMIEN TUDEHOPE: It is an aggravating offence, is it not, to assault an emergency worker for the purposes of the Crimes (Sentencing Procedure) Act?

Mr GOLDS: I am not sure.

Mr DAMIEN TUDEHOPE: It is fundamental to your position that sentencing is inadequate.

Mr GOLDS: Absolutely.

Mr DAMIEN TUDEHOPE: You are not aware that there is already an aggravating offence for assaulting an emergency worker?

Mr GOLDS: Sorry, I do not know about the term "aggravating offence".

Mr DAMIEN TUDEHOPE: It is a further matter that courts are required to take into account when sentencing.

Mr GOLDS: Then yes, absolutely.

Mr DAMIEN TUDEHOPE: Why is that not sufficient for the purposes of dealing with the deterrence that you are talking about?

Mr GOLDS: Because it does not seem to happen in reality. In the courtrooms people who are found guilty of those offences against emergency services personnel are not deemed by the judiciary to be worthy of what we consider to be appropriate punishment.

Mr DAMIEN TUDEHOPE: Are you saying that anecdotally?

Mr GOLDS: Anecdotally.

Mr DAMIEN TUDEHOPE: There are no specific trends that you can identify?

Mr GOLDS: Absolutely not. I am just going on what public opinion is.

Mr DAMIEN TUDEHOPE: You say that there is a groundswell of public opinion out there which says that if you attack an emergency services worker you will be dealt with leniently?

Mr GOLDS: Absolutely. Yes.

Mr DAMIEN TUDEHOPE: You think mandatory sentencing is the solution to that?

Mr GOLDS: Yes.

Mr DAMIEN TUDEHOPE: When someone attacks an emergency worker is it your position that they are often affected by either alcohol or an illicit substance?

Mr GOLDS: Sometimes, yes. Yes, certainly.

Mr DAMIEN TUDEHOPE: Would you agree with me that that sometimes can also mitigate against their responsibility?

Mr GOLDS: That is certainly a grey area. Having sat in courtrooms we have certainly been encouraged by magistrates who have said that they understand that the person was under the influence of prescription medication but that is no excuse. Then those people have indeed been charged and appropriately sentenced.

Mr DAMIEN TUDEHOPE: But it is a factor which a court would be required to take into account when determining their level of responsibility?

Mr GOLDS: Most certainly, yes.

Mr DAMIEN TUDEHOPE: Similarly, people who potentially have mental health issues—

Mr GOLDS: That is a different thing altogether, but most certainly.

Mr DAMIEN TUDEHOPE: You would not want them dealt with that way?

Mr GOLDS: No.

Mr DAMIEN TUDEHOPE: A mandatory sentence is exactly that, is not it?

Mr GOLDS: Yes, but with exception.

Mr DAMIEN TUDEHOPE: There would be an exceptions regime?

Mr GOLDS: Absolutely.

Mr DAMIEN TUDEHOPE: What would that be?

Mr GOLDS: A sliding scale of their sentencing. If those emergency services personnel have been assaulted then without question there is a minimum sentence, a minimum period of incarceration, instead of having those people simply slapped on the wrist and gone. Certainly the level of seriousness of that assault would mean an increase in their sentence that is handed down by the judiciary. Most certainly though if people are under a mental health order or if they have a mental health disorder then those people, as my police colleagues said earlier, are not the bad guys. It is not those people who we are wanting to—

Mr DAMIEN TUDEHOPE: I have no issue with that, but I will just explore this with you: Would you agree with me that there is a huge variety of people who may for whatever reason do something which is construed as an assault on a paramedic or an emergency services worker?

Mr GOLDS: Yes.

Mr DAMIEN TUDEHOPE: There are a whole range of reasons why they might do it?

Mr GOLDS: Yes.

Mr DAMIEN TUDEHOPE: Would you also agree with me that magistrates ought to be able to take that into account on an individual basis?

Mr GOLDS: In a perfect world I would love that to be the case and that is the case currently but it does not seem to be employed appropriately.

Mr DAMIEN TUDEHOPE: Fundamental to the way that the legal system works is that when someone faces a court, and there is a variety of different reasons that it may have happened, then all those

factors have to be taken into account. The problem with your regime is that you remove that from the magistrate's discretion.

Mr GOLDS: Absolutely. I have also considered that whilst viewing the mandatory sentencing that is already in place for people who kill police officers. Those people may have been affected by substances, but if they have done the wrong thing and killed those police officers, regardless of the effect of inebriation then they need to be incarcerated. It is their punishment, not just a rehabilitation scheme. We look at people who are drunk drivers. They are inebriated, under the influence, but they are still doing the wrong thing. They are charged and hopefully sentenced appropriately.

Mr DAMIEN TUDEHOPE: An appropriate sentence might be that you would, in those circumstances, require them to do some alcohol management course. Would you agree with that?

Mr GOLDS: In conjunction with the punishment, most certainly.

Mr DAMIEN TUDEHOPE: It may be a better outcome for society if we address the alcohol offending or the drug offending rather than locking them up.

Mr GOLDS: Absolutely, but rehabilitation is certainly a perspective of it. But what we are calling for is for those people to be punished for their ability to go down the road for a cup of coffee and live their daily lives. That must be withdrawn from them because they have assaulted my wife and myself. That is it.

Mr DAMIEN TUDEHOPE: I understand. I think there is an issue around attacking people who voluntarily give their time to attend emergency situations, and that those persons should not be exposed to assaults and the like. A lot of the evidence we have heard has been about how to deal with the underlying conditions that cause a person to thrash out and potentially assault an emergency service worker.

Mr GOLDS: One of those things might very well be to address whether the people who have assaulted us have assaulted us previously.

Mr DAMIEN TUDEHOPE: That is an interesting observation, if someone has had a prior offence for having done it.

Mr GOLDS: They might not even have been registered as having a prior offence, but they can be violent people historically and not had anything acted upon.

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

Mr GOLDS: Yes.

(The witness withdrew)

PENELOPE MARY MUSGRAVE, Member, Law Society of NSW, affirmed and examined

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

Ms MUSGRAVE: No.

The CHAIR: In what capacity are you appearing before the Committee?

Ms MUSGRAVE: I am a solicitor and a member of the Criminal Law committee of the Law Society.

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

Ms MUSGRAVE: No, I understand the Committee has the written submission of the Law Society.

Mr EDMOND ATALLA: I note in the submission that the Society is content with the current sentencing regime. Please elaborate on that.

Ms MUSGRAVE: I think the answer is quite simple in the sense that there is a complex sentencing regime that can be used in relation to these assaults. Mr Tudehope has already identified the aggravating circumstances under 21A. The regime as it exists at the moment has a flexibility to respond appropriately to assaults against emergency service workers. Having reviewed some of the other submissions online, there is one other thing I would add, which is that you have to be quite alive to the risk involved in putting up a legislative solution that may detract from work that could more properly be done in prevention, education and the like. Really what we want to do is minimise the impact or minimise the number of assaults. Criminal law is a fairly blunt tool in that regard, and that is why there is the reference to the effectiveness of general deterrence in this area, particularly when you are dealing with often vulnerable groups in emergency situations. General deterrence probably has even less impact in the back of an ambulance.

Mr EDMOND ATALLA: Other witnesses have alluded to sentencing imposed in Local Courts, with a maximum of two years or five years for repeat offences, as inadequate. There is the view that sentences should be increased. What is the society's view on the fact that Local Courts deal with, as I understand it, about 90 per cent of cases?

Ms MUSGRAVE: I should note that the Law Society has not considered that discrete question, but I can draw on my knowledge to assist you in your consideration of it. The Director of Public Prosecutions' [DPP] submission talks about the fact that the bulk of these matters are kept with the police in the Local Court. The police have a process whereby they refer matters to the DPP to consider whether or not it should be heard on indictment, and that can happen. You can lift it out of the Local Court into the District Court. When you asked that question it resonated with me because a similar situation did arise following an assault on a bus driver some years ago, and the question was raised: Why was that dealt with in the Local Court rather than the District Court? There is a Sentencing Council report on that specific issue that went through the court files, looked at how courts were responding and applying the principles they should apply to offences involving violence and whether or not the two-year jurisdictional maximum was sufficient to address that form of violence. The report found—and this is from memory, but the report is published and online; this is just from my fairly imperfect memory—there were a couple of matters that jutted up against the two-year maximum, but the vast majority were being dealt with appropriately. Recommendations were made about improving the level of communication between the police and the DPP to make sure that appropriate matters were referred. That report would be three or four years old.

Mr DAMIEN TUDEHOPE: It was 2013, I think.

Ms MUSGRAVE: So it is three years old.

The CHAIR: In fairness, the Chief Magistrate has indicated his preference to lift it to five.

Ms MUSGRAVE: That would be consistent with the submission made by the Sentencing Council back in 2013.

The CHAIR: The DPP did not have any objection to that either.

Mr DAMIEN TUDEHOPE: I think it was a workload issue. He thought that they should have the flexibility of being able to deal with matters expeditiously.

The CHAIR: Mr Tudehope did not turn up to that briefing.

Ms MUSGRAVE: I probably cannot speak on behalf of the Law Society on that specific issue—a broader issue, shall we say.

Ms JENNY LEONG: My broad question is in relation to the issues around sentencing—harsher sentencing, stricter sentencing and standard non-parole periods. This Committee has received a number of submissions, as you would have seen, that have been made public. We have also heard some really disturbing stories about front-line emergency service workers and the violence they are subjected to. Obviously, people have a desire to change the law to try to stop these things from happening, and stricter sentencing and standard non-parole periods are seen as a way to address the seriousness of this issue. Can you comment as to why the Law Society does not believe that is the answer? Can you also give any examples of evidence of why those changes do not have the impact that perhaps the people who have suffered these violent incidents might want to be seen?

Ms MUSGRAVE: There are a few questions there. I am just thinking how best to start. Can I answer first the question about public perception and the degree of concern that is out there in the community?

Ms JENNY LEONG: Yes.

Ms MUSGRAVE: I must say that is something that had some impact and resonated with me when I read through the submissions. One of the challenges that is faced when the bulk of matters are dealt with in the Local Court is that you have less access to the sentencing remarks, which decreases the understanding of why the court imposed the sentence that it did. That problem is compounded in this area because the circumstance of aggravation under section 21A is not going to be captured in any sentencing system. So you can draw down on specific offences, you cannot draw down on whether section 21A was applied—there is simply no field out there to do that. You have then got to drill down about what aspect of section 21A was applied—whether it was a breach of trust or the use of a weapon or it involved someone in public office. That is the beauty of the Sentencing Council report from some years ago but they did have to go and do a file review effectively—there was not a computer system.

It is an issue of more general concern but it does apply across the board. I do feel that there is an understandable level of public concern but it can to a degree arise from a lack of understanding and appreciation of how the court looked at not only the circumstances of the offence but also the subjective circumstances of the offender. Until you get that enriched understanding, there will be a degree of frustration with what people see as a result, particularly when you are facing a sentence of two years jurisdictional maximum and someone gets an alternative sentence. Increasing understanding of why that sentence was imposed would be truly useful.

The CHAIR: The Chief Magistrate made that comment as well.

Ms MUSGRAVE: It does apply across the board. It is an issue in a whole lot of areas.

Mr DAMIEN TUDEHOPE: Do you have any specific recommendations as to how the Committee might look to address that?

Ms MUSGRAVE: These are purely from my personal understanding of the systems. If you were going to apply it systemically long term there would need to be a significant investment made. There is work around alternatives where you might do an examination over a period of time and you could ask magistrates to record something on the bench sheets or police prosecutors to, or you could require a specific written reference to the section 21A considerations that got extracted and filed. You would need to engage with the Judicial Commission—

The CHAIR: We have had discussions with them.

Ms MUSGRAVE: You could think of it as a short-term study as opposed to a long-term answer, although I think a long-term answer would be fantastic, and that would be helpful. Just on the point of standard non-parole periods that I have not touched on. There is a whole lot of considerations that go into whether matters should have a standard non-parole period applied to them. There is some complexity with imposing a standard non-parole period for an offence against an emergency services worker because that is an aspect of aggravation under section 21A. So you are almost saying there is a standard non-parole period for assault if the person is an emergency services worker and these circumstances apply. The better way of doing that is getting a body of understanding and published reasons about the appropriate way of looking at that circumstance of aggravation under section 21A. Really what a standard non-parole period does is to say, "Here is a guide." There are other ways of having a guide—appellate authority is equally a guide.

Mr DAMIEN TUDEHOPE: The best review system is appeals.

Ms MUSGRAVE: That is exactly right. The Committee got a submission from the Director of Public Prosecutions. That talks about the number of appeals and where they would have considered whether or not it was appropriate, given the objective and the subjective circumstances of the offender, to take it up. If I have not answered any of your question please tell me.

Ms JENNY LEONG: Thank you, that was very helpful.

Mr EDMOND ATALLA: Currently the penalties for assaulting a police officer are dealt with under the Police Act—

Ms MUSGRAVE: Yes.

Mr EDMOND ATALLA: —and all other emergency services are dealt with under the Crimes Act.

Ms MUSGRAVE: Specific offences for police officers are also in the Crimes Act.

Mr EDMOND ATALLA: From my understanding they generally use the Police Act because it has a higher sentencing regime than the Crimes Act, is that not correct?

Ms MUSGRAVE: There are some specific offences involving police officers that are in the Crimes Act which have really high penalties.

Mr EDMOND ATALLA: Given that basically emergency workers are dealt with by various Acts, do you support all emergency service workers, including police, being consolidated into one Act—the Crimes Act—so that everyone is dealt with equally within the definition of an emergency worker?

Ms MUSGRAVE: I keep on going back to general principles, and I think they apply equally here. You will find that in the New South Wales criminal law you will often have two tiers of responses. You will have a specific response in a specific Act and it might be regulatory or it might be a low-level offence in, say, I do not know what the specific piece of legislation is—it is something like in the Rural Fire Act where there will be some specific offences. That should be your first port of call, and part of the decision about your response is: Is this offending so serious that it has the indicia of criminality that needs to be taken up into the Crimes Act where the more serious offences lie? That is theoretically how you should look at the structure of offences in New South Wales. And the beauty of that is that you have got the separate rural fire, ambulance, whatever things and they are able to respond to the particular fact situations that they are involved in—for example, the Rural Fire Brigade might have powers of investigation to look at why a fire has happened or can you stop a firie going in to chop trees down or something, because they have got different dynamics.

I think it is often useful to take a step back and say, "Okay, what offences are working across the separate pieces of legislation?" It is good to have some commonality in terms of enforcement powers, regulatory responses, offence provisions and say, "The baseline in New South Wales is that we have X provision for this." Having a separate Act just for emergency services with a broader definition I think has problems. This is a fairly simplistic answer but I think it rings true. I fully appreciate the dynamic that emergency services workers are involved in, it must be an extremely volatile situation, but you have other areas of employment that are vulnerable for other reasons. You will immediately get a broken down offence or employment-specific system of legislation—you will have emergency service workers, teachers, people in remote communities, different things everywhere. The beauty of the Crimes Act is that it says, "Here is one offence that really fits every member of society" with these parameters that allow a magistrate to go into it and say, "What was operating here? I have got the scope to respond appropriately. I will hear everything that is happening and I will then sentence you within the bucket." That is a terrible analogy. The preference would be to keep the serious offences as general offences in the Crimes Act and in the specific Acts you have the lower level of regulation that responds to the specific needs of that community.

Mr EDMOND ATALLA: The specific wording in some of those fire and emergency services Acts is hinder or obstruct, isn't it?

Ms MUSGRAVE: Yes.

Mr EDMOND ATALLA: They use that for assault cases as well?

Ms MUSGRAVE: Yes.

Mr EDMOND ATALLA: Why would they do that and not refer to the Crimes Act?

Ms MUSGRAVE: I do not know the answer to that. I think it may come down to what their policy is, what their communication is like with the police, whether they feel that they have referred matters and they have not been taken up, whether they have in-house regulators that they find they have a better relationship with. It

would be an interesting question to drill down on because that may show you why things are not being referred to the police to investigate for offences under the Crimes Act.

Mr DAMIEN TUDEHOPE: I agree with all that.

The CHAIR: During your submission you ask for further investigation. Can you expand on that?

Ms MUSGRAVE: I am familiar with the submission but what were you asking for further investigation of?

The CHAIR: On risk mitigation strategies to protect?

Ms MUSGRAVE: It comes back to the point I initially made, which is that if you respond with increased penalties, or something like that, you run the risk of detracting from a solution that might be more effective. I sat through the last witnesses and Ms Leong was talking about equipment in vans and protocol policies, more work health and safety risk management strategies that would aid in preventing or minimising that volatile situation. Crimes Act offences are only responding after something bad has happened. I reiterate the point I made that the offences have very limited utility in this aspect and in this specific environment even less.

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

Ms MUSGRAVE: Of course, yes.

The CHAIR: On behalf of the Committee, thank you very much. I found, and I am sure other Committee members found, your evidence very informative and enlightening.

Ms MUSGRAVE: Thank you for hearing me.

(The witness withdrew)

ALAN PHAM, Chair, State Medical Officers Group, New South Wales, affirmed and examined

TONY SARA, President, Australian Salaried Medical Officers Federation, sworn and examined

KATE PORGES, Member, Australian Medical Association Council, affirmed and examined

The CHAIR: Thank you for appearing before the Committee today. Before we proceed do you have any questions regarding the procedural information sent to you?

Dr SARA: No, thank you.

Dr PORGES: No, thanks.

The CHAIR: In what capacity do you appear before the Committee?

Dr PHAM: I am a burns registrar working at the Children's Hospital, Westmead. I am appearing today on behalf of the Australian Salaried Medical Officers Federation [ASMOF] as the Chair of the State Medical Officers Group, representing junior doctors.

Dr SARA: I am the President of ASMOF. We represent about 2,100 staff specialists. About 70 per cent of the staff specialists who work for New South Wales hospitals. We represent about 2,200 which is junior doctors, which is about 45 to 50 per cent of the salaried workforce in that category in New South Wales public hospitals.

Dr PORGES: I am an emergency physician and area director of emergency services for the Central Coast Local Health District. I work at both Gosford and Wyong emergency departments. I am also on the New South Wales Australian Medical Association [AMA] Council, so I am here as an AMA representative too.

The CHAIR: Would each of you like to make a brief opening statement before members ask questions?

Dr SARA: Thank you, sir. We have divided the workload up between us. As the AMA and ASMOF have been doing for some years, we have made a joint submission to the inquiry as we perceive that adds weight to our individual submissions because between us we represent the profession in New South Wales in the public hospital system. ASMOF represents the staff specialists and the junior doctors and the AMA represents the visiting medical officers [VMOs]. From time to time we do joint submissions to make the point that this is what the profession wants to say, so we have divided the work up. In terms of the opening, I was going to say that we have done a joint submission in this case. We have divided up our speaking points among us and I will hand over to my colleague Dr Porges to start off.

Dr PORGES: As an opening submission, we all are aware that violence against doctors and in fact all staff in healthcare facilities is a growing concern and is increasing in prevalence. According to research, healthcare workers are more likely to be attacked at their workplace than prison officers or police officers and the health industry is, amazingly, ranked as the most violent workplaces in the country and hospital emergency departments, where I work, are particularly high risk. About 90 per cent of all doctors who work in emergency departments report that they have had some violence in their workplace. It has become the norm, and we expect it, and I think we develop a warped sense of humour that just takes it as a day-to-day expectation. It deflects the attention from the fact that it is still violence and a violent workplace and we must certainly work towards decreasing the vulnerability of those healthcare workers in our healthcare facilities.

Dr SARA: As we have already outlined, the AMA (NSW) and ASMOF (NSW) have been involved in the NSW Ministry Taskforce on Violence in Emergency Departments. We support the work undertaken through that process, and particularly note the focus on organisational and hospital leadership, which have been ignored for decades. We endorse the NSW Health 12 point action plan. We were part of the workshop that developed that—certainly I was; I can't remember who was there from the AMA. We would also endorse the Victorian Health 10 point plan that is contained in the appendices.

In terms of the submission, we go through a various set of headings, which are reporting, legislation, organisational, policies and procedures, workplace design, security, education and training and we divided those headings up between us as well. In terms of reporting, we submit that hospital staff must be encouraged by hospital management to report incidents of occupational violence whenever they occur and should be supported in any efforts to prosecute the perpetrators of such violence when it is appropriate.

Obviously if people are mentally unwell or affected by drugs and alcohol then prosecution is clearly not relevant, but there are people with personality disorders or people acting out behaviours in emergency departments. We would submit that prosecution should be considered in those cases. What this means is that we need to support workers to report claims of violence by removing institutional barriers to that reporting by covert penalties, minimising unnecessary, superfluous or redundant documentation, ensuring the reports are recorded, audited and taken seriously.

Where appropriate, staff should also be offered police intervention and legal support. The reluctance to report violent and aggressive behaviour stems from the amount of time it takes to complete the necessary forms, an inaccessible and poorly understood reporting mechanism and the perception—which verges on reality in many cases—that there is no real benefit from reporting incidents. Hospital management has not really had an interest in this for a very long time. There are some indications that the non-reporting of a violent incident is due to concerns about the perpetrator's condition. We have covered that. If someone is clearly mentally unwell or severely affected by drugs or alcohol then reporting it as an incident for the purposes of prosecution is clearly not appropriate. Nevertheless, the incident should still be reported, to make the workplace safer. As Dr Porges has already indicated, the normalisation of occupational violence is something that we as a health system need to address. It should not be seen as just part of the job. Without accurate reporting of incidents of violence it is very difficult to quantify and understand the extent of the problem. In order to assess progress in strategies to reduce the violence, again, we need to have monitored reporting systems in place so that we can make things better over time.

The next category we want to touch on is legislation. We support enhanced penalties for those who are violent towards emergency staff. The penalties should be in line with those for assaults on police officers, as per section 58 and section 60 of the Crimes Act 1900. At the very least, the penalties should be more severe than for common assault. We submit that this will reinforce the message that violence towards such workers acting in accordance with their professional duties is not just unacceptable but a particularly grave form of assault that requires more severe penalties.

The next aspect we wish to address is organisational. The work health and safety legislation makes it very clear that the ultimate responsibility for a violent organisational climate rests with the employer. As a union we have not, to this point in time, thought about that, but we perceive that the health system must acknowledge its responsibility, as the employer, for work health and safety issues. The Acts are fairly clear. It is the employer's responsibility to do all that is reasonably possible to prevent such incidents occurring. In that vein, we would support the development of a comprehensive aggression management program to integrate strategies to manage violence in organisations, and a commitment to environmental design, staff training and team response. Those strategies must address the needs of patients and staff, the education of patients and staff, and ward and waiting room design. There needs to be support from management to respond to reports of violence, including enhanced security staff presence and processes.

The next issue we bring to the Committee's attention is policies and procedures. There needs to be zero tolerance for any violence against staff in a hospital. Hospital administration must clearly lead that process. As well, hospital management must ensure that internal policies addressing occupational violence are developed and rigorously implemented as a priority. The strategies and policies must be fully supported and promoted by senior managers. That is one of the key issues. We need to change the culture of the managers. The managers are not the staff who experience the assault. It is the front-line workers, the doctors—the Kate Porges and the Alan Phams—and nurses and managers of departments who face it. It is not the people who sit various layers up. They are not personally subjected to such violence. It is not something that affects them, so they are less inclined to do anything about it. The next topic is workplace design. The principles of crime prevention through environmental design should be mandatory in designing, refurbishing, renovating or retrofitting workplaces to prevent and minimise violence. Dr Porges has some points to add on this matter.

Dr PORGES: The previous witness said that prevention is better than legislation and sentencing. I agree with that. Prevention is better than watching the violence occur. Workplace design is very important in that regard. If a chair is bolted to the ground it cannot be thrown at a member of staff. We recommend the implementation of crime prevention through environmental design. That should include regular hospital security audits, decent illumination, surveillance cameras, a restriction on access to different areas, and metal detectors. A supportive, calm environment is important. An overcrowded emergency department that is understaffed will lead to increasing agitation in patients who already have a mental health disorder or illness or are drug affected.

All emergency departments should have a safe assessment area that has secure walls, is soundproof and lockable and has a camera surveillance system, a mattress on the floor and nothing that can be thrown. Likewise, security is very important. A security system cannot be one size fits all. It depends on the size of the emergency department, the size of the facility. There must be security staff present. The security staff must meet some

standard of training before being employed and that training should be ongoing. There should be some monitoring of the training and of their fitness to continue to do those duties. They have to be supported in protecting staff and be given reasonable restraint powers to protect themselves, protect staff, and they have to understand very clearly their roles and responsibilities.

Dr PHAM: As Dr Sara mentioned, my colleagues and I, the interns, residents and registrars, those doctors who are fresh out of medical school and their first four or five years, form the bulk of the medical staff who deal with these patients on a day-to-day basis. We submit that the education and training about how to prevent and respond to aggression and violence should begin as early as possible. It needs to continue throughout a health worker's career, from the moment they enter the workforce through to when they become a consultant.

The CHAIR: Are you saying it is not there now? There is no training.

Dr PORGES: Correct.

Dr SARA: Correct.

Dr PHAM: It is definitely not there in a medical school context. It is slowly being implemented in a workplace context.

The CHAIR: When you get to a hospital, there is no policy or procedure and you are given no training? As a young intern you walk in the door—

Dr PHAM: Correct. You learn on the job. You ask your registrar and your consultants, and if you are lucky enough—

The CHAIR: So there is no training, full stop.

Dr PORGES: No. An understanding of aggression and how to deal with violent patients is part of the Australasian College for Emergency Medicine training of senior registrars. It is an expectation. I am an examiner for that college, and we do scenarios where they have to talk down a violent patient. There is nothing for more junior doctors.

Dr PHAM: In line with that, hospitals have standardised codes to indicate the potential risks of violence. A code grey indicates a violent emergency. A code black can be activated in the event of an armed threat. However, these codes are not standardised between hospitals. The responses to the codes are not well known to all the emergency department and security staff. They do not have adequate training in how to manage these episodes when the codes are used. We believe that staff need to be educated. They need to undergo appropriate training, in a team-based setting as well as at an individual level. They need to learn communication and de-escalation strategies. The training needs to be appropriate to the group, as well as to their geographical location. Do they work in a major hospital that has access to security staff, where they can work together as a team to de-escalate a situation, or do they work in a small country town hospital where there is one doctor and one nurse and they need to know how to de-escalate a situation by themselves in the middle of the night?

Dr SARA: A three-day training course may be appropriate for a security officer, but it would not be necessary for a junior doctor. They might need half a day. The training needs to be focused on the staff members concerned, on what they need to know.

The CHAIR: You would be aware that on Monday we had submissions from the Health Services Union, the nurses association, and there was a fair amount of debate about security guards whether they should be the bouncer from the local pub, or should they have some medical training. When we are looking at various mitigating factors in respect of sentencing, technically this Committee started off looking at emergency workers, so that did not include the security guards in the hospitals, but is he or she going to be at the front line? I am gobsmacked about the fact that there is no training for the interns. Do you bring it up? I thought the platform in every hospital, and excuse my ignorance, is that your medical council, which is made up of clinicians, would meet with the administrators, and as a young intern that would be their avenue, or through your organisation.

Dr SARA: It has been brought to the attention of hospital management for decades.

The CHAIR: It is longstanding.

Dr SARA: Longstanding lack of interest.

The CHAIR: You mentioned there is a cultural—

Dr SARA: Yes. What we hope happens as a result of this inquiry is that the culture and the policy and processes are changed in our hospitals. If I can go back to the point you raised about the security staff, it is not a

bouncer from the local security firm or the local pub. They are an integral part of the hospital team. They need to learn the culture of the hospital and they need to learn the culture of health. They need to be ambassadors for the hospital for most of their job. People get lost in hospitals; they are very large places. So they need to be diplomats and guides. As well they need to form part of a team with doctors and nurses to handle and de-escalate aggressive and violent patients, and only as a last resort will their skills in unarmed restraint come into force. The difficulty with bouncers and private security guards is that they are interested in being rugged he-men and taking people down. That is not the culture that we want in health. At the end of the day, for an inpatient or person who is a patient in an emergency department, the defining authority in that department rests with the doctor. We want security staff to understand that and form part of the team so that they are part of the de-escalation process, and if the doctor says, "They are psychotic. They are never going to listen. We need to give them some drugs into a vein or a muscle", then the security staff will assist with that. But uncontrolled security staff is nearly as bad as having none.

Dr PORGES: I would completely support that. Having been in many situations where I am using security and police and six foot three nurses and other people to restrain someone, you also often have to be talking down security guards who are trying to be the he-man. It is very flattering. They do not like the fact that a patient has called me all sorts of names, but that is okay. It is like, "No, that is fine. You do not have to restrain them more. Let us get on and try to de-escalate this." That is a very important point.

Dr SARA: That brings us, I guess, to a summary of our submission and our views. Healthcare facilities are seeing an increase in violence. Facility management has been very slow to respond over decades. The Australian Medical Association and the Australian Salaried Medical Officers Federation strongly support the NSW Health 12 point plan and the Victorian Health 10 point plan. Our view would be that the plan in New South Wales needs to be driven to completion in a timely fashion and maintained on an ongoing basis. We do not want to have to come back in two, three, four, or five years time and have the same issues being raised. We perceive that the plans should be done soon. So it is a whole range of factors. It is reporting, the legislation, the facility design, security, education and training. The plan covers all those points and if that is driven to completion by the Ministry, we will be very pleased.

Ms JENNY LEONG: Thank you very much for your submission and your contribution. It is helpful to have articulated a lot of the prevention measures, because obviously the preference is that we prevent these situations from occurring. We have heard from a number of different people who have come before the Committee. There is a need for localised solutions. You talked a bit about that. If this Committee were to make recommendations about how changes could be made, do those localised solutions already exist somewhere? For example, have there been endless submissions to various hospitals about management processes? Do you have previous submissions that have been written on how the basics of that should work? We are not recommending that a review be done. Rather, these are the things that have been called for that could prevent these violent attacks occurring, and can you point us to those?

Dr SARA: There are various responses to your question. The first one that I would draw the Committee's attention to is what has happened in Blacktown Hospital over the past three years. There were increasing episodes of violence. The nurses association raised those episodes in the media again and again. They made repeated submissions to the hospital management and the district management and got nowhere. Eventually, after a particularly bad incident and another press release, Minister Jillian Skinner was forced to say to the districts, "Sorry, this has to stop." District management has not wanted or perceived that it was not able because of resource restraints to be able to do something local to resolve those issues.

I am a trained medical manager. I have a Fellowship of the Royal Australasian College of Medical Administrators. I have been a medical manager for 25 years. My day job is a manager in the health system. The way to make this work, in my humble opinion, is the 12 point plan, some policy directives in due course, and change the culture of managers by inserting the plan and its sequelae into the service agreement between the Minister and the districts, and some policy directives in due course. Drive the managers to drive the changes. The solutions will be local. The change in design and build and fitting of emergency departments will be local. There has been a consultancy undertaken on the design of 20 emergency departments. The districts need to do that themselves. They need to report back to the Ministry that we have done an analysis of our emergency departments—their design, their security alarms, their entry and exit points, and so on—so the Ministry has a clear role in this, and then drive the districts to do it. The districts then need to drive that at each facility, each emergency department, each clinic.

Drug and alcohol clinics at Langton have this issue as well, so it is not just hospitals. It needs to be a system-wide approach, driven from the top down, engaging the local staff in every emergency department, every facility where violence has occurred or could occur so that the entire structure system process is resolved. It cannot be one size fits all, to answer that part of your question. It has to be clearly articulated by the secretary,

the Minister, all the way down to the head of the emergency department, the director of nursing—everyone: This is what we are going to do. Recalcitrance and a lack of action or process will be severely dealt with.

Ms JENNY LEONG: Are you aware of the app that the Nurses and Midwives Association has introduced, which allows the reporting of incidents that occur?

Dr SARA: No, we are not.

Ms JENNY LEONG: They make mention of it in their submission. Do you have similar ways of collecting reports of incidents that occur with your members? Also, do you have any recommendations about how the reporting of incidents could be made easier for your members so that it better allows risk assessments to be done and improvements to be made to safety and security?

Dr SARA: We have not had the opportunity to think along those lines. We are not perhaps as well resourced as the nurses association. We do not have the 90,000 members that they have. I would think that such an app would be a very good way for a nurse to make a report to the nurses association. They can aggregate those reports and then they are in a position to drive hospital management to implement the changes, the building works, the duress alarms, whatever is required in that place. I do not know that we are in a position to do that, but we would certainly be very willing to talk to the nurses association and see what their views would be. In most emergency departments there are doctors and nurses, so if the nurses were strongly encouraged to make such reports, then we would certainly support that. It is likely to be less onerous to make a report on an app to the nurses association than it is to go into the Advanced Incident Management System. That system is extremely user-unfriendly. It is opaque. As a manager, I had to be one step up the chain in using it. We understand that a replacement incident management system is being trialled as we speak. Hopefully it is far easier and more user friendly. We stated in our submission that unless we monitor incidents and there is free and frank reporting and transparency, we will never get on top of this.

Dr PORGES: I do not think we have a clear concept of how widespread this is because there is so little reporting.

Ms JENNY LEONG: The NSW Police Association said that there is a culture of encouraging near misses to be reported so that they can respond in advance. When we are struggling to hear about incidents being reported within the health system rather than near misses, we are very much behind—

Dr PORGES: That is the IMS system. It is a combination. You say that this patient is mentally ill and we will tolerate it. There is that sense of normalising it. The IMS system being too clunky and never getting any feedback or outcomes means that people have stopped reporting or have never reported.

Dr PHAM: To illustrate the point, the IMS system—which is the institutional system for reporting violent incidents—involves entering information online. It is easily accessible from any work computer, but it takes on average about 35 minutes to 40 minutes to fill out.

Ms JENNY LEONG: For one incident?

Dr PHAM: Yes, that is correct. There is a combination of free text and drop-down boxes.

The CHAIR: And you do not get any feedback? That was the complaint.

Dr PHAM: Correct. When the form is submitted you get a number that you can record. Then it disappears. To find out what has happened, you have to pass a request up the chain of command. Even then it must go to a committee that reviews it. As far as the outcome is concerned—

Ms JENNY LEONG: There is no feedback?

Dr PORGES: No.

Dr PHAM: Correct.

Ms JENNY LEONG: Dr Pham, given your experience do you think people are reporting incidents using the IMS?

Dr PHAM: Only in very extreme circumstances. For example, there have been a couple of incidents at Sydney Children's Hospital over the past 12 months where parents have made threats of armed violence—saying they would come back with a weapon and kill someone. Those incidents were notified. However, the day-to-day being punched, kicked, spat on, and threats of non-weapon-related violence are not reported.

Mr EDMOND ATALLA: The NSW Nurses and Midwives Association submission contains some very concerning statements about nurses not reporting incidents; there is a culture of saying that it is just part of the job. They feel that if they report incidents they will be out of place because that is what comes with the job.

If a nurse or a doctor is assaulted, that is just part of it. That is definitely not acceptable. I understand that doctors are under extreme pressure, particularly in emergency departments. As soon as they finish with one patient they must rush to the next one. When the incident reporting form takes 40 minutes to complete they obviously will not do it. What would you recommend to make it easier for a doctor or a nurse to make a report? We have heard about the app, but when I asked about whether it was working the NSW Nurses and Midwives Association representatives could not answer. The Committee is not sure that that is the solution. Do you have any thoughts?

Dr SARA: As we said in our submission, we would strongly encourage our members, both junior and senior, to report incidents. We will need to withhold judgement as to whether the new IMS will be easy and suitable. We will certainly be liaising with our colleagues at the NSW Nurses and Midwives Association about its app. We will strongly encourage our members to report incidents in the expectation that the 12 point plan will be implemented. As a result, these incidents will be monitored and changes will be made. If our members perceived that it did not matter whether they reported because nothing would change, why would they bother? We will strongly encourage our members to report incidents and we will continue to push the ministry to implement the 12 point plan and change the game completely.

Mr EDMOND ATALLA: If a person were specifically employed to take reports—that is, so that the doctors did not have to take the time to fill out the long form; they would be able to lodge verbal reports—would that make reporting easier?

Dr SARA: I am not sure; it would depend on the number of incidents at a particular site. If there were an incident every one or two days, employing a grade 2 clerk at $45,000 a year to deal with 50 sites would not be the best expenditure of taxpayers' funds. It would make a lot more sense if it were added to the duty statement of a clinical support officer in an emergency department in terms of expenditure of taxpayers' funds. It would depend on the site. Many large emergency departments have clinical support officers. Adding that to their duty statement would be a worthwhile initiative, and we would support it. However, again, it comes back to what the new system will look like. If it takes a young doctor 10 minutes to log an incident, we would strongly encourage them to do so because we will ensure that the ministry drives the process. We will drive the process at the local level as well. If we hear about a number of incidents happening at a local site, we will be making representations to the management of that district. If the worst comes to the worst, we will go public, as the NSW Nurses and Midwives Association did in respect of Blacktown Hospital. We intend to be more proactive as well given that it appears that the culture will change.

Mr EDMOND ATALLA: Would you support making reporting mandatory?

Dr PORGES: I would not. I do not report episodes of violence; it is a definitional thing as well. There are so many pressures on emergency departments. Everyone is obsessed with the electronic transfer of prescriptions [ETP], transfer of care [ToC] and a number of other measures that keep us very busy. You are lucky to do pee before 3.30 p.m., and we eat lunch at about 4 p.m. We are not sitting there doing nothing. If there is someone with terrible crushing chest pain in front of you and someone has just swung at you, you sadly put the swing behind you to look after the patient. It is mandatory for me to care for patients.

Mr EDMOND ATALLA: Do you believe that the majority of assaults on doctors and nurses in health facilities are drug and alcohol related?

Dr PORGES: I would say that 75 per cent or 80 per cent would be drug and alcohol related. Mental illness would be the other large portion. A smaller portion would be delirium/dementia related. We have a lot of little old ladies from nursing homes who can get a good swing up when they want to. You try to duck. It is a terrible illness for a woman who is confused and scared in an emergency department.

Mr EDMOND ATALLA: Does the health system look at preventative measures, and does it follow up people to ensure there is a cure?

Dr SARA: That is generally a part of the process. If someone has delirium, confusion or dementia that becomes part of the care process and you do what is feasible in terms of your role in that institution. But if someone is severely demented there of course is no cure and they may come back in a week's time or whenever. In terms of the bigger picture process there is the 12 point plan and thought has been given to the processes, the policies, the duress alarms and the entry and exit points. As Dr Porges has indicated, there are going to be people who have issues with mental health and drugs and alcohol, but there is a small percentage of personality disordered people. The shooting at Nepean I guess fell into that sort of category. It is a matter of reducing, minimising and mitigating the risks as far as possible and changing the culture at the facilities and the policies and processes to assist that.

Mr EDMOND ATALLA: Where are we at with implementing the 12 point plan?

Dr SARA: I do not know that I want to comment. I do not want Elizabeth Koff to ring me tomorrow and say, "How dare you say that?" I do not think we know.

Mr DAMIEN TUDEHOPE: We will ask.

Dr PORGES: I would suggest it is very early.

Mr DAMIEN TUDEHOPE: Just to be clear, your position is this: If in fact this 12 point plan is implemented you would say it would create a significant improvement in the security of emergency workers in hospitals?

Dr SARA: Yes, because it is everything. It is organisational, the facilities, the training and the security. It is a comprehensive plan.

Mr DAMIEN TUDEHOPE: And the audit of the environment and all those things which this Committee is inquiring into really have been put into this 12 point action plan, certainly in relation to the workplace environment of emergency departments and hospitals?

Dr SARA: Yes. There is an aspect of the 12 point plan that we have not touched on.

Mr DAMIEN TUDEHOPE: Who compiled this, by the way? How was this plan arrived at? Did you have any input into it?

Dr SARA: Yes, I went along as the president of the union. There were experts in drug and alcohol. There were experts in nursing, experts in emergency departments and representatives from the Health Services Union. I do not have the document with me but a large number of people attended.

Mr DAMIEN TUDEHOPE: At any rate, the people who made submissions to this plan were from a broad cross-section—

Dr SARA: It was a workshop. We sat around for an entire day at North Sydney and we had presentations from experts in emergency departments and experts in drug and alcohol. We workshopped it and we came up with those 12 points. Karen Crawshaw led the process. We wrote it all down. She said, "Give me 10 minutes." She rang up Minister Skinner and went through the plan and the Minister said, "Good. Tick." There was a press release done. We were very comfortable with the process. We were comfortable with the outcome of the process and the plan but, clearly, driving it to completion is something we do not do very well in the public sector and we do it even less well in Health.

There was one aspect I just wanted to raise which is an intersectoral issue and that is guns in emergency departments. There is a memorandum of understanding [MOU] between Health and the police that they will put their guns in a gun safe on entry to the department. It is up to the discretion of the individual police officer. One aspect of the 12 point plan is that Health revisit the MOU with the police service. We would maintain that 95 times out of 100 a police officer should put his gun in the gun safe when he comes into an emergency department. It would be extremely unusual—it would require an American-style emergency department incident as we see on the television with guys with weapons in the emergency department to require a police officer to need his pistol. That is a part of the 12 point plan and it will require liaison and consultation with the police service. We believe that also is a part of the plan that needs to be driven to some sort of outcome.

Mr DAMIEN TUDEHOPE: This is dated 8 February this year. You have been given no update since then?

Dr SARA: There is a meeting next week. I am on the working party and it is led by Karen Crawshaw, who is a very competent woman. I have a great deal of respect for her. There is an updating next week. There is a document that was done by security consultants as to the design of emergency departments. That is a public document, I think. The districts were required to do their own audits of all the others. There are so many different facets. There is the security, there is the design, there is the duress alarms, there is the policies and the processes, there is the AIMS and there is the MOU with the police. As long as the Minister and the secretary continue to make this a high priority and drive it then we are comfortable that in the next six to 12 months we should get a large number of those items resolved. It will require the secretary to say to the chief executives of the districts that this is not negotiable and to put it into the service level agreement between the Minister and the districts, because if it is not in that agreement it will not happen.

Mr EDMOND ATALLA: Other than Minister Skinner endorsing the 12 point plan, are you aware of any directive from the Minister to the hospital hierarchy to implement it?

Dr SARA: I am personally not but I am not high enough up the pecking order in my district to have seen that.

Dr PORGES: Certainly in our area health service there have been some directives. One thing I would comment on in relation to those directives is again the importance of localising solutions. It does concern me at least in our local health district that there is a three-day violence prevention program. It has been ordained that all senior emergency doctors and nurses who could be the senior doctor or nurse in the department 24/7 do the same three-day course as security officers. My comment would be that if you teach someone how to throw a football they will want to throw a football. For me, a middle aged 5 foot 4 woman, I do not want to throw a football.

Mr EDMOND ATALLA: In the 12 point plan a number of hospitals have been identified for a security audit.

Dr PORGES: That has occurred. That has been done.

Mr EDMOND ATALLA: My question is how was that list compiled? Not all the hospitals are listed here, so why were these particular hospitals chosen?

Dr SARA: They are hospitals that we in the Health system knew from anecdote and from experience were sites where there had been enough incidents above the white noise and the average. We, the unions, agreed with it. These are sites that needed an external audit, not a locally run audit which may very well paper over or turn a Nelsonian eye to something. The list came from the ministry, which has access to the AIMS reports. They had spoken to other people. We spoke to our members. This was a list that we endorsed as being sites that needed to have an external audit that we could have some faith in.

Mr EDMOND ATALLA: Was there scope for the audit, for what you were expecting to be done?

Dr SARA: Yes, we saw the terms of reference before they were done. We signed off on that.

Mr EDMOND ATALLA: Were you happy with those?

Dr SARA: Yes. We did not bring a copy of the document.

Dr PORGES: I am sure you would be able to get a copy of the document. The findings were not unreasonable and the list of hospitals struck me as a being a broad range of hospital emergency departments of various sizes from tertiary to regional, rural and very remote.

The CHAIR: Thank you for appearing before the Committee. We found your evidence very informative and precise. There is obviously a lot more work to be done here. 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 further questions?

Dr PORGES: No problem.

Dr SARA: Yes.

Dr PHAM: Yes.

The CHAIR: Thank you and keep up the good work out there in the community. That concludes our public hearing. I place on record my thanks to all the witnesses who appeared, Committee members, staff and Hansard for their assistance.

(The witnesses withdrew)

The Committee adjourned at 12.38 p.m.