IN CAMERA PROCEEDINGS BEFORE

GENERAL PURPOSE STANDING COMMITTEE No. 2

INQUIRY INTO THE MANAGEMENT AND OPERATIONS OF THE NEW SOUTH WALES AMBULANCE SERVICE

At Sydney on Tuesday 22 July 2008

The Committee met in camera at 11.15 a.m.

PRESENT

The Hon. R. M. Parker (Chair)

The Hon. C. M. Robertson
The Hon. A. Catanzariti
The Hon. G. J. Donnelly
The Hon. M. A. Ficarra
Ms L. Rhiannon

CHAIR: Welcome to the second part of the inquiry, which is an in-camera hearing. My name is Robyn Parker and I am the Chair of the Committee. Before we start I want to make some comments about the inquiry. Our terms of reference specifically look at the management and operation of the Ambulance Service. I need you to reflect on the terms of reference by using your experience on how to improve the Ambulance Service rather than looking at individual complaints. We do not aim to solve individual problems but, rather, look at the broader picture, as your submission has. It is not about making adverse reflections on others so I ask you to minimise mention of individual colleagues or managers unless it is absolutely essential.

The Committee has resolved to have your evidence in camera. At the end of the hearing I will give you an opportunity to say whether you want your evidence made public, partially public or whether you want to wait and read the transcript before making that decision. If it is not public or partially public, then we are not able to use that evidence as part of our inquiry, although from reading your submission you have a great deal to offer the inquiry, so I will give you that option later.

WITNESS F, Citizen, sworn and examined:

WITNESS F: Although I am appearing before the Committee as an individual citizen, I make particular mention of my employment background, qualifications and experience and also that over the last eight years or so I have been researching the area of ambulance paramedic stress, so I feel that is quite relevant to the terms of the inquiry.

CHAIR: Thank you for the time and effort you put into your terrific submission because it goes to the heart of a number of issues. We wanted to ask you specific questions in terms of your experience because we aim to make recommendations that have meat attached to them rather than just sweeping general statements. At the beginning you stated that there is a particularly poor management structure and you spoke about the militaristic nature of the management structure. Can you give us more information as to how that plays out?

WITNESS F: If I think back to when I first joined the service back in [redacted], it was extremely regimented and hierarchical. You used to have to follow a chain of command if you were an officer on the road in order to pass information or communicate with someone higher up; you would have to go through a chain of command. You were not allowed, for example, to jump the chain of command and speak to a more superior officer without going through the people between yourself and that superior officer.

It is a very autocratic approach. The whole management style appears to me to be one of a top-down approach in managing the staff. The managers are very much a control command style of management. Part of that comes out of the fact that a lot of managers have shifted from a road role, in which case you need to take control and command in incidents for example out on the road, but unfortunately that then carries through into management. It is a very militaristic style of leadership.

I have talked to colleagues at [redacted] who deal in areas of health [redacted] and they have actually reflected, just in general conversation, that it reminds them a little of the management style example in the health system back in the 1960s and 70s. I was talking to them about my interest in the submission and I said, "How on earth would

you change things like this" and they said that nursing went through a similar process many years ago and they had a similar style of management, uniforms, matrons, hierarchy and bureaucracy—we do have nurses here, so you will know what I am talking about—so part of that shift, although management in the health system now is not perfect by any means, it has moved forward into this century, while the Ambulance Service has remained in the last century, back in the 1960s and 1950s, with that old-fashioned style of management.

Part of the reason why nursing moved forward and the Health Department and other areas moved forward was, and I will advocate for, the shift to tertiary education and better education of the managers. That has all rolled through into their management style; they will be better educated and have a more broad spectrum coverage in relation to management issues, interpersonal issues, how to deal with staff, interpersonal relations and a much more broader range of skills with people.

CHAIR: A lot of your submission relates to actual training in terms of taking on management roles but also training to deal with service provision. I note you talk about the psychometric testing as well—

WITNESS F: Yes, I have a lot of concerns.

CHAIR: —as being, in your view, the wrong kind of testing; that it is forensic rather than forensic based.

WITNESS F: Yes. Do Committee members understand my argument there? There seems to be a bias towards a forensic view or an abnormal mental health view. If you look at selection processes in employment in general—I will give you a comparison. If I had a brain tumour, I would go to a neurologist or a neurosurgeon. If I had a brain tumour I would not go to an ear, nose and throat surgeon. I cannot understand why they use a forensic psychology based assessment test for entry into the Ambulance Service when there are very well-acknowledged and recognised organisational-based assessment tests.

I have had anecdotal evidence from [redacted] who have applied for entry and come back to me saying, "That psychometric test was really strange. For three hours we sat there responding to all these very strange, bizarre questions like, 'Have you ever taken drugs? Have you ever taken illicit drugs? Did you have a single parent? Were you ever abused as a child?'" They have answered those questions. They have then turned up to the interview and in the interview they will sit there and then be confronted by a panel member saying, "Why is it that you took illicit drugs when you were 10?" and they will say, "I didn't take illicit drugs when I was 10" and they will say, "Oh, it was a trick question." It was almost like they were playing games with them out of responses from the psychometric tests. I wonder whether, through that psychometric test and the selection process, they pick people who are very compliant and pick a homogenous group of people who somehow fit this picture of what they think becomes a good ambulance officer.

CHAIR: You have mentioned in terms of stress and burnout a number of things like insufficient rest time, high workload, lack of administrative support?

WITNESS F: Yes.

CHAIR: Malfunctioning equipment and a range of things, but you have also gone into debriefing and stress management?

WITNESS F: Yes.

CHAIR: In your view does the Ambulance Service suffer more than other health services with some of these issues?

WITNESS F: It is well acknowledged that for ambulance officers across the world, no matter where they work, there are extremely high levels of post-traumatic stress and burnout. Post-traumatic stress levels vary across different studies across the world and some of the populations are slightly different; there might be firefighter-paramedic combinations and things like that, but the consensus is that it is usually quite a higher rate. Broad figures might be between 11 and perhaps as high as 26 or 30 per cent rates of post-traumatic stress.

There are also research papers that describe rates of burnout as astonishing, so the rates of burnout are even higher, I believe. My deep concern is that there is this view of the stress of the ambulance officer being the blood, guts and trauma. That is not the case. It can be the case, but I strongly believe that some of the diagnoses and research studies that are making claim to officers having post-traumatic stress, the actual signs and symptoms that those tests are picking up—even with diagnostic test from the psychological side or whatever—the tests are actually not picking up what is purely post-traumatic stress but in fact burnout that is occurring or perhaps organisational-based stress.

It might be an individual case that breaks the camel's back for the officer. They may go out to a critical incident such as SIDS or a traumatic case, but that is the straw that breaks the camel's back. It is the rest of the bale of hay that they have been carrying around that has been the issue and a lot of the issues, I do not believe, are necessarily critical-incident based or blood, guts or trauma. We self-select into that occupation. We go into it knowing that we will go to cardiac arrests, SIDS cases and blood, guts and gore, and the research also supports that a lot of officers actually adapt and cope. Roughly at an incident, one-third will cope well and not be adversely affected, one-third will have mild effects and one-third at a major incident will actually be quite adversely affected. So we have mechanisms to cope but I believe a lot of the stress is organisation-based and cumulative. It is burnout and compassion fatigue is a major issue.

CHAIR: The level of suicide in the Ambulance Service has been raised with us. Do you have experience of that? Do you know of numbers of suicides or attempted suicides and, if so, how much of that relates to the sorts of factors you have talked about? Is it something you are familiar with?

WITNESS F: Discussing suicides mentioned in research, you do find suicide mentioned intermittently with stress amongst officers having an effect. I know there has been recent research that showed that after 11 September there was a much higher incidence of suicide among officers in New York. Although the research paper appeared to attribute that to the critical traumatic incident, the officers made large mention of a "lack of organisational support" post that event. My question then would be: what has triggered the increase in suicide in that population? Is it the actual terrorist event that they attended or is it the lack of support on the part of the organisation? My research and a lot of the research tends to support that it is not the actual stress management solution or the technique that is used to support the

officer that is important, it is the offer of support that is important to them. That is a bigger factor. In terms of actual suicides within this organisation [redacted]

[redacted] an officer has commented to me about their concerns about suicide rates in New South Wales Ambulance in recent years. The comment from that person was that they hear of an unusual death of an on-road staff member perhaps once every six months. I know of one incident that the Committee knows of in Cowra. I know of an incident in 1997 with a female officer, and another male officer a few months later. These were all very violent suicides—[redacted] They were making big statements. There are unusual attempts at suicide by females. It is unusual because females are more likely to overdose. These are quite violent attempts at suicide. My deep concern, as I have said in my submission, is that I believe there needs to be a look at not only the rate of completed suicide but the rate of attempted suicide, because I believe for every suicide that an ambulance officer has completed there are probably—if I could hazard a guess—maybe two, three or four others who have attempted it.

I have been in that situation personally during a workers comp period. [redacted] I know of other people on workers comp that have been in the same boat. I also know of a specific incident of an officer who is now out of the job—they were medically discharged. This comes back to the issue of post-traumatic stress versus organisational-based stress. This officer had been on the road for several years. There was a minor complaint against that officer. I do not believe the officer actually did anything out of order. [redacted]

The officer then received a complaint because [redacted] had changed their mind and put in a complaint. There was an investigation procedure that went on for a ridiculous amount of time—nine or 10 months—and it was unresolved. A committee of one investigated. It dragged on an on and that officer subsequently attempted suicide two or three times [redacted] It is ridiculous what is occurring with officers. They are treated as guilty until proven innocent rather than the other way around. I believe the process by which they deal with complaints is not uniform across all officers. Often it comes down to whether the manager or the person investigating has a vested interest in the outcome of the inquiry or whether they like the officer who has had the complaint against them or not. If it is someone they like or are a buddy with they will look after them and quieten it down. If it is someone they do not like they will set out to destroy their career. It can be bas bad as that.

Coming back to this officer who had the complaint, [redacted] ended up developing full-blown post-traumatic stress, but the triggering event, the straw that broke the camel's back, was a complaint and the mishandling of that complaint process by management. [redacted] subsequently was diagnosed by [redacted] as one of the worst cases of post-traumatic stress development they had ever seen. [redacted] is now out of the job. [redacted] had trouble with workers comp and left the job. [redacted] is still alive now, thank goodness. I know of other similar incidents with complaints. I do believe from my research background that I cannot say it is

just an organisational factor or a complaint factor. Often with serious cases of stress such as suicide there is a home factor and a work factor in combination. If there is an issue at home or some trouble at home you can escape to work. If you have a problem or an issue at work you can escape to the home. But when you have problems in both domains it impacts on people and they turn to serious consequences such as suicide.

The Hon. CHRISTINE ROBERTSON: Is that fairly common?

WITNESS F: The suicide?

The Hon. CHRISTINE ROBERTSON: No, the issue of conflict in both sectors.

WITNESS F: I can only tell you from my personal experience that I believe that is a big factor. It is under-researched worldwide. They talk in general terms about the home-work interface and issues across the broad spectrum of occupational stress studies, but there is maybe only one study in the world in the last 25 years relating to ambulance officers that mentions its importance, but we have not got anywhere.

The Hon. CHRISTINE ROBERTSON: No-one has looked at it.

The Hon. MARIE FICARRA: Occupational stress is probably going to be likely to have an impact on how you handle your home environment and your relationships. It is often a case of which comes first, the chicken or the egg.

WITNESS F: The managers will probably say, "Oh, he's got family issues." You cannot just write things off. Or "He's got a drug abuse problem, naughty boy. Let's discipline him." Well, what caused the drug abuse problem? I could even go so far as to say that maybe some of the managerial decisions have been made because managers have been placed under stress and are making stupid decisions or mishandling their staff. Perhaps they have got personal issues or they are having stress placed on them from higher up in the organisation. Who knows?

Ms LEE RHIANNON: There is an occupational health and safety regulation that requires an employer, such as the Ambulance Service, to consult with staff of the service about any harassment or bullying. I was wondering whether you ever had experience of that in how those regulations played out.

WITNESS F: In terms of monitoring or feedback?

Ms LEE RHIANNON: In terms of whether the Ambulance Service actually acted on that regulation that requires them to consult their staff about how these problems are handled.

WITNESS F: The only consultations I know of have been perhaps culture surveys that they carry out every now and then. I honestly do not believe a culture survey is going to uncover the underlying stresses.

Ms LEE RHIANNON: What is a culture survey?

WITNESS F: A culture survey looks at broad attitude, your belief in the organisation, how you act in the organisation, and policy and the aims and goals of the organisation in

fulfilling its responsibilities. I believe we need to be looking at things such as quality of work-life surveys that target where there is home/work imbalance and where unfair work demands or stress demands are placed on officers. It is a different thing altogether. If you want to wave a magic wand, that is a tool through which you could actually find out what is going on for the staff in the organisation and find out where the specific stress issues are and how they could be addressed.

Ms LEE RHIANNON: It sounds like you never came across the consultation that is required under this aspect of the occupational health and safety regulation.

WITNESS F: I can speak to that in relation to my role as a peer support officer.

Ms LEE RHIANNON: Yes, I would be interested.

WITNESS F: I am speaking with three hats on here: My first hat is as an ambulance officer on the road; the second is as a peer support officer. Do you understand the role of a peer support officer and what they are in the organisation?

CHAIR: Not fully.

WITNESS F: We apply for the position of peer support officer on a voluntary basis. Generally speaking you are an on-road ambulance officer and basically you are a peer to other employees and an initial contact person for support and defusing. If officers are sent out to a traumatic or critical incident, for example a SIDS case, a multiple fatality or a major incident, a peer support officer, if the system works correctly—I will put a big disclaimer on that—would be contacted by the organisation under occupational health and safety requirements and that officer would go out to the scene or follow up and make contact with the officers who attended at that event to check how they are going, touch base, manage their psychological welfare and give initial assistance and psychological support. There are huge flaws in the system in that in my experience as a peer support officer—I will give you an example. An officer went out to [redacted] a murder.

I heard about the case; I went to make contact with the officer that attended that case and I was ordered by management not to. There was another incident where I was ringing staff proactively because my notification system was not coordination or a manager ringing me to say, "Hey, these officers went out to this terrible event and they are really traumatised", my notification system was when I was on my days off at home I would watch the local news that night, see the six officers at this case and go, "Oh my god, why didn't I get a phone call?" because I am the only peer support officer in the area and I was not notified. I would then ring the officers and make contact myself, to which case I would hear them say, "Thank god you've rung me. I've been waiting for you to ring me for the last 36 hours."

There was another life-threatening event. Two officers were involved in a life-threatening event where they were at risk and could have died at a certain incident. A district officer took it upon himself to not contact me—no training in peer support or psychological debriefing or anything; no psychology or counselling qualifications whatsoever—that manager took it upon himself to drive out to the station, to sit and have a cup of tea with the two officers and check that they were okay: "Are you all right, boys?" "Yeah, we're right". As if they are going to admit to a manager that they did have a problem. That is another issue. The manager left the scene, drove back to the office, and a couple of hours later he rang me

and said, "By the way, [redacted], so and so and so and so were involved in this incident. I went and had a cuppa with them. They are all really quite okay. You don't need to contact them, they're fine—hunky-dory. I just thought I'd let you know."

I applaud him for having the can to even want to bother with them—that is a big improvement on what they do—but I sat and thought, hang on a second, that should be ringing alarm bells. So I picked up the phone book, made contact with the officers, and it was like, "Thank god you've rung us". They were falling to pieces. The manager had decided that he had the qualifications and in fact rang and told me, "You don't need to contact them".

There was another incident with a higher-up manager. He actually cautioned me against being proactive in making outcalls to officers. He said, "You do not ring the officers, you sit back and do nothing and you wait for them to ring you, okay?" The norm: lack of communication; lack of notification. There are flagging processes allegedly within the coordination centres where high-stress, red-flag cases are supposed to be a notification to peer support but they do not occur. There are other issues with the peer support mechanism and that still goes on to this day; there are issues of lack of training and support for the peer support officers that still exist now. [redacted]

The initial training is a token two-day training. They feel that they are unprepared for the role. I felt better prepared because of my background qualifications before I went into the job, but I felt really sorry for some of the current peer support officers who do this out of the goodness of their hearts; they get no remuneration, they get no support for what they are doing. It is a token two-day training and then they are thrown out there at the deep end to support the staff, and they are left by managers who say, "Oh well, we are solving this. Let's tick a box and put this lovely little program together". It is good on paper but it is lip service: it does not work. It is pretty appalling. If the peer support program was run better it would work better, but it is only one solution to a part of the problem.

The Hon. MARIE FICARRA: Were you seen as a stirrer, because you are fairly strong, outspoken and confident?

WITNESS F: I am. I am still seen at [redacted] as a stirrer. My mother is a stirrer. A few of you would know my mother. I am assertive; I stand up for people's rights; I am an ethical person; I am here because I could have sat back after eight years of research—I still do my data analysis; I have been looking at the world-wide literature. The reason I am doing my PhD study is that I went through the prac of being an ambulance officer; I was treated appallingly. I have a little peaked interest in it because of my psychology background of stress in ambulance officers. I had read a little bit of literature when I did my initial peer support training about post-traumatic stress and critical incident stress and Mitchell's models of debriefing; I thought this is really great to do something to help the staff.

Then, when I enrolled in the Masters and PhD research I am doing I started to look at the world-wide literature and sit back and observe the people around me and I thought, "Hang on a sec, they've got it wrong. It is not just post-traumatic stress it is all these other forms of stress that we need to address, and this organisation isn't addressing it." Whilstever the organisation does not support its staff how can it have this ethic that it goes out and looks at the health and welfare of members of the public even on a daily basis when it cannot care for the welfare or the health of its own staff?

The Hon. CHRISTINE ROBERTSON: We have heard some evidence that attempts to equate the implementation of clinical governance with harassment and bullying. Have you got any comment on that issue?

WITNESS F: Can you elaborate?

The Hon. CHRISTINE ROBERTSON: The clinical governance processes that are being implemented over the last five years.

WITNESS F: Like a specific example?

The Hon. CHRISTINE ROBERTSON: Measuring the clinical expertise of the persons and what they do and how. Clinical governance is about ensuring that the clinical processes that are appropriate are implemented.

WITNESS F: And tying it to stress?

The Hon. CHRISTINE ROBERTSON: To bullying and harassment.

WITNESS F: I have heard comment by—I do not want to identify them—people in the job. I will give you an example. There is an officer on road who makes a mistake clinically—he makes an error—and errors are always made, unfortunately, in other stressful situations, and in medicine as well. An officer makes a mistake and has been picked up for that mistake at a clinical audit or something like that, they are then, for example, put on a CEP program—a clinical educational program to rehabilitate them because they have made a mistake. I have heard comment from officers saying that they have actually had managers come to them and want to target that particular officer because they do not like them and want to get rid of them out of their area and they say, "You need to give them a bad report so that we can get them out of the job—get them sacked". So managers sometimes are using that clinical audit process or clinical educational process to try to use that as a tool to get rid of individuals they do not like.

The Hon. CHRISTINE ROBERTSON: Another totally different issue: How does the paramilitary type situation structure and the issues that that creates match with the current demand from the ambulance service and the ambulance officers themselves for a commissioner rather than a manager?

WITNESS F: It is hard to tell what the solution is. I am concerned. I have looked at some of the submissions that were placed online and I do have a concern that the Committee may have heard submissions and evidence from on-road ambulance officers, not just union members but others, that are perhaps pushing for, for example, a shift away from health to, for example, emergency services or they are more orientated to a more military style of command. But that is because the officers on road are actually viewing the job and what it is in the future from the perspective of what it has been for the last 10, 20 years, and it is not that. Rather than a paramilitary emergency service role it has become more of a health care role, and internationally we fit the configuration of more a health care role, in which case that military style of command does not fit any more.

I get concerned that some of the officers have made suggestions to you, but this is the difference where I am pushing for education too: in the tertiary sector we are looking at

training the students that come into our program to become the paramedics of the future. What we train them to be now has to fit what they are going to be in three years time, in five years time, in 10 years time, and some of the on-road officers that may be giving you evidence have not got that holistic view of what is going on in the future.

The Hon. CHRISTINE ROBERTSON: Another issue in relation to the psychological testing process, many of the submissions we have received indicate a fairly high level across the spectrum—it is very difficult when you are just getting bits of paper—of psychological instability. How can that be addressed?

WITNESS F: I think the aims of the psychometric test may be well founded, but the other issue too is one of a bit of secrecy about that test. We just hear vague comments, complaints, about what the actual currently used psychometric test is about. As I said, all I know is that it came from—

The Hon. CHRISTINE ROBERTSON: What it is for.

WITNESS F: Yes. But my question would be yes, we need to screen out problem children and potentially problem children but there are quite stable, respected, valid, reliable tests that are operated across organisations all around the world that will probably still pick out those people. You always get people slip through the cracks, but the current psychometric test I am very deeply concerned is throwing the baby out with the bathwater. I am concerned that that psychometric test—I cannot get a clear answer from the ambulance service human resource managers—part of it may be aimed at getting compliant people; picking a homogenous group—

The Hon. CHRISTINE ROBERTSON: Yes, I remember what you said earlier.

WITNESS F: But also trying to screen out perhaps, for example, personalities who may be more prone to post traumatic stress disorder. I honestly believe the very same personal characteristics and qualities of officers that make them damn bloody fine health practitioners are the same attributes that will make them a little more vulnerable to post traumatic stress and the solution is not to screen those good officers out in the first place or you are throwing the baby out with the bathwater. You need to screen out the problem children who have got psychological issues—you can do that with other better tests—but you do not throw out the baby with the bathwater; what we need to do is employ those people into the job who are going to be great practitioners, good in supporting the public, but we have to actually support them in how to best manage and deal with the stress that they are going to face in the job. We need to support them.

But we are wiping out some of our better candidates, the excuse being we need to weed out people with psychological problems. I know there are some issues with people who have got a psychological disturbance who actually get employed. I suspect that those people would cheat any psychometric tests that you invent—some of them.

The Hon. MARIE FICARRA: Is that psychometric test used by any other ambulance service? It is a forensic medicine test in Victoria.

WITNESS F: I cannot give you clearer information because of the secrecy surrounding the test: they do not want to give you a copy of it or show you what it is about

even if you say to them, "I am querying whether it is valid". There was a rumour that it was originally used by the New South Wales Fire Brigade and perhaps another interstate organisation, and then when they discovered it was unreliable and invalid there were questions over it and they threw it out. It is only a rumour.

The Hon. MARIE FICARRA: It was developed in Victoria for the Department of Forensic Medicine, was it?

WITNESS F: I was told by the previous human resource manager that it was devised by the Victorian Institute of Forensic Medicine.

CHAIR: We might clear that up with the Department of Health.

The Hon. GREG DONNELLY: Have you worked for any other ambulance services in any other Australian jurisdictions?

WITNESS F: No.

The Hon. GREG DONNELLY: Have you worked for any ambulance services outside of Australia?

WITNESS F: No.

The Hon. GREG DONNELLY: In terms of your knowledge about ambulance jurisdictions elsewhere in Australia that you have not worked for, do you have a detailed knowledge about any of those particular jurisdictions?

WITNESS F: In what capacity? I probably do know a little bit about their stress management processes and a general overview of that.

The Hon. GREG DONNELLY: I am just trying to establish a comparative analysis here. Have you studied in detail these other jurisdictions in Australia about how they operate dealing with stress matters?

WITNESS F: Some of them I am a little aware of their programs. For example, Ambulance Victoria and the metropolitan ambulance service there have now combined to become one service. They have got a coordinated committee that looks at stress management processes across all of their emergency services.

The Hon. GREG DONNELLY: What about looking at similarly the stress management systems or procedures that might apply to ambulance services outside of Australia? Have you studied those?

WITNESS F: Recently I started looking into the UK and national health services there, but they appear to perhaps have had similar issues to what your committee is looking at now—stress, concerns about recruitment and retention of staff, occupational health and safety issues, bullying and also I think another issue was violence towards staff. They have actually implemented quite a rigorous program around 2004, 2005 in the UK across the whole health sector, but particularly looking at improving the quality of working life in ambulance officers there.

The Hon. GREG DONNELLY: With regard to the various issues facing the New South Wales Ambulance Service which have been canvassed in your submission and the other submissions you have read, are these issues experienced to some degree in ambulance services elsewhere in Australia and overseas?

WITNESS F: My educated hunch based on what I have read and research is that if you take 50 issues, I can find you the research across the last 30 years and I can grab [redacted] Ambulance Service, for example. I will probably find, over the last 20 years, perhaps 20 out of 30 issues that have occurred across that time span. I might pull out [redacted] Ambulance Service and find a similar thing.

The thing I found interesting is that if I look at the worldwide literature and I have given an overview of other things that cause stress in my document, that is based on negative impacting factors found across the worldwide literature specifically for ambulance services across the world. If you bundle together that 30 years of negative impact on staff, it almost describes the New South Wales Ambulance Service—some aspects of the New South Wales Ambulance Service. There are some managers who do a much better job, but then there are the bad managers who negatively impact the staff as a broad-sweeping picture. I find it sad that 30 years of combined research across the world of negative impacting factors on staff seems to have applied at some point in the New South Wales Ambulance Service.

The Hon. GREG DONNELLY: This is your considered assessment; do not let me put words in your mouth. Your educated, considered assessment is that, in terms of the New South Wales Ambulance Service and the issues we are canvassing, it is the worst in the world?

WITNESS F: I could not say that.

The Hon. GREG DONNELLY: I think you just did. I am trying to get you to clarify what you are saying.

WITNESS F: I am just saying that out of 50 factors that contribute to stress, I feel that if I go to another organisation it might only be a mix of these 30 factors that occur, or it might be a mix of 25 factors in this organisation.

The Hon. GREG DONNELLY: But in New South Wales, it is 50 out of 50?

WITNESS F: I think it is higher than the other services. But I would not want to say that they are the worst in the world.

The Hon. GREG DONNELLY: This is not a line of questioning to trick you. I am simply trying to get an assessment of where New South Wales stands compared with other jurisdictions in Australia and overseas. We are trying to assess the position in New South Wales. To use your phrase, we do not want to throw the baby out with the bathwater. We need to work out what is working and what is not, so we can focus on what is not working.

WITNESS F: To address the last part of your question, I would say the area in which you could look to improve the situation—and that is my goal—is to look at their policies and procedures, and doing an audit as to where the stress lies, how it is affecting officers, and to

what degree it is affecting health and wellbeing, and then to set up some guidelines and parameters for the managers to follow—benchmarking. Not just things such as stress leave and workers compensation leave, but daily leave taken, or a mental health day that officers take because they are so stressed that they cannot bear it any more, they have to take a sickie or whatever.

For example, with regard to some of the complaints that come from members of the public, I suspect that if an officer is burnt out or stressed they will attend an incident and they may be a little sharp or abrupt to a member of the public, and then the member of the public, who is under stress anyway because their relative is sick, will put in a complaint. Everything is interconnected. A complaint will come in from a member of the public, and unfortunately the Ambulance Service then tends to slap the person on the wrist and say, "Naughty person. You will be disciplined for being rude to that member of the public", rather than looking at the underlying process or cause. I think the key to a lot of issues within the organisation—a lot of it ties to the effects of stress, the sources of stress, and one will then feed on the other.

CHAIR: Thank you for your submission and your presentation today; it is very useful to us. I do not know whether you are in a position, having given evidence, to make a decision about whether you are happy to have any of your evidence published or kept partially confidential, or whether you would prefer to wait until you have read your transcript.

WITNESS F: I would probably be happy to look at the transcript.

(The witness withdrew)