IN CAMERA PROCEEDINGS BEFORE[1]

# GENERAL PURPOSE STANDING COMMITTEE No. 2

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

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**At Sydney on Tuesday 22 July 2008**

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**The Committee met in camera at 11.15 a.m.**

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**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

[1] Published by resolution of the Committee, Monday 28 July 2008.

Ambulance Officer stationed at , sworn and examined;

**CHAIR:** The Committee's inquiry seeks to look into the New South Wales Ambulance Service. In particular, our terms of reference relate to bullying, harassment, and management issues, including occupational health and safety. Although individual cases may be raised, we do not aim to resolve individual issues as much as look at recommendations that are general and assist the service overall. We ask witnesses to refrain from adverse references to individuals and to base their evidence on the Committee's terms of reference.

The committee has resolved to hear your evidence in camera, which means it is confidential. However, I will give you the opportunity at the end of your evidence to take one of a couple of courses of action in relation to your presentation today. You could choose to allow us to publish the information, or to publish it partially, de-identified, or you may wish to keep the information completely confidential, or alternatively you may choose to have a look at the transcript and then give us your view. We appreciate your submission, the comments you have made, and the time you have taken to assist us with our process. Do you wish to make an opening statement?

**WITNESS J:** Yes. The principal elements in my submission relate to the way I perceive management to treat on-road staff, the way I see management organising resources on the road, and my concerns about metropolitan fatigue that ambulance officers are feeling. The management attitude could be improved so easily just by management treating officers on the road with a bit more respect. As I have noted in my submission, on taking sick leave, for example, a representative from management will ring and say to the other officers at the station,
I find that an appalling way to approach sick leave. I also find appalling the fact that the management did not have another car was due to the fact that there was not anybody to do overtime on that particular night. A Friday night at is pretty busy; you will be up all night, you will not really get a chance to rest. So you can hardly blame people for not wanting to do overtime. But I really do not think that a manager needs to take that line with the person involved or with the staff at the station.

The inspectors have said point-blank to on-road staff that they are not here to be friendly. That does not engender a relationship of trust, nor does it engender a cooperative relationship.

We had a memo from management regarding off-stretcher compliance. The memo said that the Department of Health and management expect 100 per cent off-stretcher compliance 100 per cent of the time, which is obviously a key performance indicator. It was requested that officers at station maintain that compliance. If you turn the page on

that memo, our compliance was 99█ per cent already. If you have offloaded a patient at hospital, you have given your hand-over, and you are now free to press the off-stretcher button. However, if your patient then vomits and the nurse is not there, if the family is crying and wants more information, if the triage nurse asks you for more information—there are any number of things that can delay you just that extra minute in going out to the car to press the off-stretcher button. So, what I suggest is that 99█ per cent is pretty reasonable and that the managers could say, "Hey guys, you are doing a really good job here. If you can get that extra 0█ per cent, we will be pretty happy." But I think 100 per cent compliance 100 per cent of the time is not necessarily that realistic. I think it just demonstrates an attitude from management that 100 per cent compliance 100 per cent of the time, all the time, might not be achievable.

At Blacktown we used to be part of the western Sydney sector; we are now part of the northern Sydney sector. In my opinion, that transfer in March last year was associated with the decline in morale, because managers are not really treating us with common courtesy. They do not spend time; they do not get to know us. Both my inspectors would know my name, but that is pretty much all they would know about me. They would not know that I am █████ and that I have things that I bring to my position as an ambulance officer. Nor would they know anything about my personal circumstances. They just do not make any effort. I do not expect that they should say to me, "█████, sit down and tell me all about yourself", but I expect that they should be open in their communication and that they should at least try to develop a relationship with the officers they are responsible for, so that when those officers have issues they feel able to speak to the inspectors.

The management does not seem able to fill vacancies in regards to sick leave, annual leave and secondments and people are just not being released to take their long service leave because there is no-one to take their place. I feel there is a real shortage of staff on the road and that is causing an increasing fatigue amongst ambulance officers. Not only has the workload gone up but there is no way of getting off road for short periods because they cannot release you from rosters. It was interesting to note in the Department of Health submission that calls to ambulance had gone up 16 per cent last year. There is no real recognition by management of that, nor are there any extra resources. At █████ we are very, very busy. We rarely get lunch; we rarely get sleep. Maybe on a Tuesday or Wednesday night you get some sleep. If calls to ambulance have gone up 16 per cent the very least management could to do is actually tell us that and say, "The only reason we have got a 97 to 98 per cent satisfaction rating with our patient group is because you guys are out there on the road doing it every single day." There is no recognition of that by management. It would not be that hard for management to improve the relationship that they have with officers on the road just by employing some simple courtesies and taking a little bit of time to get to know people. I find it really disrespectful and I find it quite disheartening that I am really just treated as a number. So long as I turn up and get in the car that is really all they care about. Yet they expect me to go out on the road and perform in a professional and caring manner. I think I should stop there, otherwise I will keep on going.

**CHAIR:** Thank you for those comments. I am sure I speak on behalf of the rest of the Committee that our aim is to make sure we support good practice and end up with a structure that supports our very trusted and valued ambulance officers. In relation to your comments about drugs—I will get to the bullying and harassment issues later—you said there are drug cupboards or safes for S8 drugs. What is the protocol for issuing and dispensing that medication?

**WITNESS J:** Pretty much all of the drugs have a register, except for, say, glucose gel which is an oral medication to correct hypoglycaemia and is given to a conscious patient. It is pretty much just a sugar solution. You sign out each drug to replace a drug that you have used from your kit or your vehicle. Some drugs have to be signed out particularly with the patient's name and the case number. I would apply that pretty much to the scheduled drugs.

**The Hon. CHRISTINE ROBERTSON:** Are they signed out by one person or two?

**WITNESS J:** Morphine, midazolam and fentanyl are signed out by two people. All of the other drugs, which include things like naloxone to reverse opiate overdose, Ventolin, atrovent for asthma, benzylpenicillin for meningococcal septicaemia, they are all fit to be signed out by one officer. I might add that in the North sector, in zone one of the North sector where I am fentanyl, midazolam and morphine are in a safe in a separate cupboard, which is where the intensive care drugs are stored. Then there is a separate cupboard for all the general duties drugs.

**The Hon. CHRISTINE ROBERTSON:** So they are stored separately?

**WITNESS J:** They are not always stored separately but at [redacted] they are. There is always morphine, fentanyl and midazolam in a safe. The other intensive care drugs may be in the cupboard where the safe is, not in the safe.

**The Hon. CHRISTINE ROBERTSON:** So it is separate.

**WITNESS J:** Yes.

**CHAIR:** Is a reconciliation done to check whether those drugs were actually used when the officers were out?

**WITNESS J:** In terms of checking back to case sheets?

**CHAIR:** Yes.

**WITNESS J:** Not that I am aware of. There are certainly audits of stock done by inspectors. If I use three salbutamol and some midazolam for someone who is having a seizure, no-one I have ever seen has come and read my case slip to confirm that I had written it up on my case slip.

**CHAIR:** So it is possible for an ambulance officer to abuse the system?

**WITNESS J:** I have never seen any formal mechanism by which case sheets have been checked against drugs signed out.

**CHAIR:** You say in your submission that you are aware of three or four stations that have had their drug safes emptied recently and a theft of S8 drugs. How do you know that has happened? Is it anecdotal or do you know for sure?

**WITNESS J:** It has been talked about in general on the road. It is also talked about by inspectors and station officers who are managers of stations. So I have no reason to doubt it.

**The Hon. CHRISTINE ROBERTSON:** Who has the keys?

**WITNESS J:** The station I am referring to I have not been to, so I do not really know.

**The Hon. CHRISTINE ROBERTSON:** What is the process at stations to access the key for S8 drugs?

**WITNESS J:**

**The Hon. CHRISTINE ROBERTSON:** Everyone has a key?

**WITNESS J:** Generally there is access to the key because what happens is I might be from station and I might get sent to to do a job. I might be a level 5 paramedic and morphine might be one of my drugs. I use my morphine and I need some more. So I go to to restock and I need access to their safe. Drugs are accessible to any ambulance officer who can get into a station, if they know where to look, I guess.

**The Hon. CHRISTINE ROBERTSON:** Is there a person in the stations all the time?

**WITNESS J:** No. At there is rarely anybody in the station.

**CHAIR:** We have asked the department about the practice. It will be interesting to compare your comments with what they say. In relation to occupational health and safety and bullying and harassment issues you say there is a lack of support from management. We have had many witnesses say and a great deal of evidence presented that people are driven to suicide in some instances. Has that been your experience?

**WITNESS J:** Personally I do not feel that I have been subjected to bullying or harassment, certainly not intentional. Perhaps intimidation in the way that managers conduct themselves that does not necessarily invite one to be very open with them. However, I think in metropolitan areas you have a lot of movement of staff and you have a lot of probationers coming through and so the opportunity for behaviours to be entrenched is less prevalent, I guess. Whereas, having read some of the rural submissions—and I did not get sent to a rural location—it seems to me with the entrenchment of management and the entrenchment of long-term serving members at rural locations that is reasonably an obvious conclusion because of what people are saying in their submissions. I have only ever worked at . They are very busy stations and you are never on station. So you are only ever working with your immediate partner. You are out at eight o'clock and back after six. So there is not the opportunity. That is why my issues are really all to do with management and the way management treats us en masse. If you have an issue with your immediate partner, if you consider your partner to be a problem, I guess your first port of call would be your station officer and you would try and get off that roster.

**CHAIR:** As to coping with stress that is related to the job, we are told that debriefing and support are available. Is it easily accessible?

**WITNESS J:** It is available. It is certainly available—the peer support officers, the chaplains and the independent counselling service. I think the issue in this area is: Does management encourage you to use it? I was talking to an [redacted] because I am [redacted]. He said, "Whenever I had an MVA in Newcastle, if it was big I called the peer support officer, asked them to call the officers and I took the officers off road." That absolutely does not happen in Sydney. If you go to a big job, a SIDS death, a paediatric arrest, a near drowning or a job where you have a patient who is alive and then they are not alive and there is really nothing you can do, I would consider that to be a very traumatic job because despite my best endeavours I did not save that person's life. I would expect and want some sort of debriefing from that. I personally would say, "I am sorry but I am not going to be able to respond until I have had an opportunity to speak to somebody." But really what happens is that the radio coordinator will say, "[redacted], are you ready for another one? Can you press your button?" Unless you have the courage to say, "Can you ask the inspector to ring me?", it does not happen. On paper I think they look fantastic. They have got it there, but do they actually encourage the implementation of that? I do not think they do. The people that I know who have called the independent counselling service have had benefit from it but it has been at their own instigation, not at the instigation of the management.

**The Hon. CHRISTINE ROBERTSON:** If the controller said, "Are you ready to take on another case?", how many ambulance officers would respond?

**WITNESS J:** I would say a high proportion.

**The Hon. CHRISTINE ROBERTSON:** Do you reckon?

**WITNESS J:** I do. You get a little bit blasé in some regards. If you go to a cardiac arrest where the person has not been able to be saved, you do just sort of carry on. But if you are affected by a job in any way you should be able to say that you need that.

**The Hon. CHRISTINE ROBERTSON:** I understand what you are saying.

**WITNESS J:** I think the culture is that people just pick up and carry on and that there is not much leeway to feel or to experience those feelings while you are there and doing it. In [redacted] years I have had one debrief and that was mostly because it was a very big MVA and the police inspector called off lots of resources that should not have been called off and so it was much worse than it needed to be. That was debriefed because it was an error on the part of one person.

**The Hon. MARIE FICARRA:** In the North region do you know of any officer who following a traumatic incident or having been unable to save a patient said they were not ready to take on another job? If so, what happened?

**WITNESS J:** I do not know, I have not heard anyone say that on the radio—although you do not always know what the other cars are going to. If you do not hear them call on their job you really do not know what they have gone to. I do know of an [redacted] crew who had a debrief with an inspector after a SIDS death, which was good. Having said that, at that time

while the inspector was doing that, two code 9 accidents went down, which inspectors are supposed to go to, [redacted]. They got an inspector on call from [redacted] to go to that one. I went to a rollover with five people in it. There was no inspector because they were all busy and there were no ambulances either actually. I had one ambulance available to come to me from Liverpool. It took forever to get more ambulances to that car rollover with five people in it.

**The Hon. CHRISTINE ROBERTSON:** So the logistics of the support are difficult?

**WITNESS J:** I do not think they are usually. That was three jobs requiring an inspector all at the one time. That is unlikely, I guess. The big issue for me as a [redacted] officer performing the role of inspector, I did not even ask for an inspector because I knew that there was not one. I wanted three more ambulances, lights and sirens, because purely on mechanism they all had to go to hospital, purely on the type of accident they had they all had to go to hospital. I asked for three cars; they had one to send me, and it was coming from Liverpool to Granville. What I am saying there is that—I have digressed a little bit—there are not enough ambulances on the road when you ask for backup to major events. I have heard of a crew being backed up on a SIDS death.

**The Hon. MARIE FICARRA:** But you would have to think twice about actually requesting it.

**WITNESS J:** If I have not, to be honest, been pulled apart by a job. Early on in my probation—I had a lot of difficulty with crying parents and I found that quite hard to deal with. I was quite okay to deal with the child, but put me in the front of the car, driving with a crying parent, and I had trouble not crying all the way to the hospital myself because I had such empathy for what they were going through. But, you know, I had a debrief about that with my partner at the time, and, you know, over the years I am getting much better at dealing with crying parents.

**The Hon. MARIE FICARRA:** Being a woman with a family, and given that we have not got enough ambulance officers, we have not got enough vehicles and we have not got enough crews, how do you feel about the ambulance career? Is it attractive out there to new recruits, particularly women?

**WITNESS J:** It is very attractive when you go into the job because you have all of the notions of doing a wonderful job and providing lots of important work. But really, after [redacted], the reality of doing 48 hours in four days, four days on and four days off, with a [redacted]

**The Hon. MARIE FICARRA:** That would be very tiring.

**WITNESS J:** I am not really going to last in that job. I did fill in the retirement survey because I am lucky enough to be over 40. It was couched in terms of, "If you had the opportunity to extend your working life beyond your retirement age with all of these flexible work opportunities, part time, temporary/full time, temporary/part time," blah, blah, "would you pursue it?" I went tick, tick, tick—yes, I would love to do all of those flexible work arrangements, but I cannot access that until I am in my retirement age bracket, and my comments were, "I have no idea how you expect me to last to retirement age." I said that because 48 hours is our minimum. You rarely finish on time, so you are usually doing

anywhere between 60 and 100—I am talking minutes—one and two hours of overtime, so you are usually doing about a 60-hour week, and if you add travel to that, it is impossible, really. I am not going to be able to stay in my job because of my commitments.

**The Hon. MARIE FICARRA:** Burn-out?

**WITNESS J:** Yes.

**Ms LEE RHIANNON:** My question partly follows on from that. Firstly, thank you for sending this in. It was useful and I was interested in what you had to say about shift work. With more women in the work force, and hopefully more men being attentive to their families, what are your thoughts about shift work? It seems so unsustainable as you describe it. How could it change—work for the service and work for the workers?

**WITNESS J:** For the Ambulance Service, they have two shifts a day—the day shift and the night shift—so we are doing 10-hour days, 14-hour nights. To institute a third shift, which I think is the only way to make our lives sane, means having another level of staff. I cannot see them having the resources to employ or actually physically being able to employ that many staff.

**Ms LEE RHIANNON:** Because of a lack of money?

**WITNESS J:** Because they are a 24-hour service. Lack of money is one thing, but it seems to me—not that I am an expert on the recruitment process—that, you know, I have seen class and class and class; every eight weeks, 50 more probationers. But, to be honest, they seem to disappear into a black hole because I do not know where they are. Ideally I do not want to work 14-hour nights and 10-hour days because they turn into 12-hour days and 15-hour nights. I do not want to work 12-hour days and 12-hour nights, which is the service's answer to WorkCover's requirement that they get rid of the 14-hour night shift because the 12-hour day is going to turn into a 13 or 14-hour day. By four o'clock on a day shift when you are finishing at six in a metropolitan station that is busy, you are pretty much had it.

As a point to illustrate that, I had a very small motor vehicle accident in an ambulance at half past five in the middle of peak hour in the dark on Woodville Road because I had a momentary lapse of concentration and also because I thought I knew where the place was. For the first time in a long time I had not looked up the address in the street directory. Anyway, expenses on ambulance accidents have gone up from $68,000 to $140,000, What I say is that I had that accident because I was exhausted on that day.

Calls to ambulance have gone up 16 per cent in one year, according to the Health department's submission. There are no extra people, there are no extra ambulances, and there is a bigger picture here that is never reflected by management to the officers on the road. Getting back to your question about the shift structure, ambulance officers would fight 8-hours shifts left, right and centre because I think that the only reason the income is reasonable is because of the hours that you work and the unscheduled overtime that you do. So they would not want to see a drop in net income if they were to go to 8-hour shifts and maybe less overtime because there might be some mechanism for overlap. But personally, as a mother

and as a [redacted], that would be my solution. In fact, part time would be my solution, just to do maybe two shifts a week.

**Ms LEE RHIANNON:** There is no part time offered at the moment?

**WITNESS J:** Part time is generally reserved for women returning from maternity leave. At [redacted], I am really not considering that as an option as a way into part-time work, in all seriousness. I have seen two people being given part-time work in three years: one of those people was a woman, and she called in sick for night shift every night shift for a year before she was given part-time work. She did not do herself any favours with management, but she got part-time work. The other person was a male whose [redacted]. I possibly have grounds, [redacted] if I am not given access to part-time work, then I will not be staying in the job.

**The Hon. GREG DONNELLY:** I am sorry for being out of the room: I had a matter that I had to deal with. I apologise for being absent for a short period. With respect to the configuration of the rosters, the 10-hour day and the 14-hour nights, at the end of how many days is there a break? Is there a 5-day break in there somewhere?

**WITNESS J:** You could just about ask every ambulance station in Sydney what their roster pattern is, and you might find that it is different. The general standard in metropolitan Sydney is two 10-hour day shifts followed by two 14-hour night shifts. Some ambulance stations, like [redacted], have two 10-hour days, one 12-hour afternoon shift, which goes from midday to midnight, and then one 14-hour night shift. Interestingly, the Department of Health noted in its submission to this inquiry that it is using the offer of an afternoon shift as a fatigue-mitigating strategy. But the stations that are getting day, day, afternoon, night are not the busy stations because they cannot be without one car from midnight to 6.00 a.m. That is what it means: you have two cars at the station. You cannot do without that car.

**The Hon. GREG DONNELLY:** But whether it is 10-10-12-14 or 10-10-14-14, what is the length of the days off before you commence the next shift?

**WITNESS J:** You have four days off, and the five-day roster. The five days off that you are talking about is a 10-line roster. Eight-line rosters have four on and four off. Ten-line rosters have four on and five off. Some stations have a 10-line roster.

**The Hon. GREG DONNELLY:** I am not arguing—I agree with this—but rather I am posing this question: To have a roster that has four consecutive days for five consecutive days off after working a period is a pretty attractive roster for a number of people.

**WITNESS J:** Oh, absolutely, there is no doubt about that. There would be lots of opposition to even changing from a 14-hour night. People do love it.

**The Hon. GREG DONNELLY:** Yes. There is the issue, notwithstanding the fact that there is the grind of working through these days, once you get the break, it is a pretty attractive break. There is a tension operating.

**WITNESS J:** Yes, there is a tension. I would say that I am in the minority, without a doubt.

**The Hon. GREG DONNELLY:** Secondly, with respect to part-time work, would you be aware that one of the concerns that the union may have in regard to part-time work being introduced through the award, say, into the Ambulance Service is the reduction or diminution of full-time work?

**WITNESS J:** I can understand how industrially a union would think that that is an issue, absolutely. The casualisation of the part-time nature of work is an issue. However, we are dominated by full-time workers—absolutely dominated—and I think a little bit of flexibility for a proportion is not a bad thing because really the Ambulance Service espouses the Department of Health principles of family friendly, but they do not follow up with it in their practice.

**The Hon. CHRISTINE ROBERTSON:** Clinical trainers being on the road with paramedics: your proposal discusses that. Am I right?

**WITNESS J:** I mention that.

**The Hon. CHRISTINE ROBERTSON:** Yes. Could you just go through a little bit about how that could be implemented successfully? Earlier I asked the HSU, I think, and they certainly really had not thought that through.

**WITNESS J:** Clinical training officers are a fantastic group of people in that they are not being critical of what they see, and they are there to help you gain confidence and skills, and to guide you in your clinical development. The issue with CTOs, the clinical training officers, is that part of their role is to administer the certificate to practice. To maintain your certificate to practice, you have to accumulate points. The issue with the ambulance officers is that all that points accumulation predominantly happens in your own time, outside of work hours. It is not a bad idea to maintain your certification through a system; that is a good thing. CTOs are there for you to use them, but personally I never have the time to use them.

My suggestion would be: Make full use of the CTO as an ambulance officer, but be given a block of time each fortnight or each month to actually do it. Give us three or four hours to sit down and go through things with CTOs in regard to jobs that we have done on the road when we wonder, "I wonder if I had done that, would it have had a better outcome?"

**The Hon. CHRISTINE ROBERTSON:** That is a good idea.

**WITNESS J:** We do not get any time with our CTOs. I have set up manikins on more than one occasion and have just started talking about suction, which is the first part of maintaining an airway, and the phone will ring. Forget about the defib' pads and everything else: We have got a job and we are back out on the road. In principle, I have no problem with them. They are a fantastic idea. But in practice they are out there, and management will tell

you that they are out there, but we do not get access to them. People at quieter stations may, but I can tell you that [redacted] do not.

**The Hon. CHRISTINE ROBERTSON:** That is good. Thank you for that.

**CHAIR:** Thank you for your presentation today. You have contributed a great deal already to the inquiry with your comments and your submission. I will give you the opportunity to indicate whether you want to reserve your position on your evidence being published partially, or being wholly in confidential form, whether you want to wait and have a look at the transcripts, or whether you are happy to proceed with that now.

**WITNESS J:** I would probably prefer to wait and have a look at the transcript. I have one more point in regard to the fatigue management policy, which talks about the process by which you can register your fatigue with an inspector. It actually does not address metropolitan officers. It addresses rural fatigue and it says that a rural officer after a job may tell an inspector that they are fatigued. In the metropolitan area we do not have that option. The service says that it will hold transports and after-treatment transports till the day shift. But in reality they cannot. If you raise that with the inspector, the inspector will tell you that it is not your role to tell the radio controller how to issue the jobs or if they choose to give you the job, you should just do it. I heard today that a station refused to do a renal at 6.30 in the morning after 12 hours so the controller said, "Get the next crew up". The next crew also refused to do the job because they had had no down time—it was a three-hour transport—so the inspector sent them all home sick. That is not a fatigue policy.

**The Hon. CHRISTINE ROBERTSON:** We have heard this story.

**CHAIR:** We have received the same information

**WITNESS J:** It is outrageous. I want you to note that the fatigue management policy does not address metropolitan fatigue—continuous workload. I will reserve my position on the transcript.

**CHAIR:** Thank you so much for appearing before the Committee today and for taking the time out of your busy life. We really appreciate it.

**WITNESS J:** Ambulance officers are really grateful for this inquiry and we are hopeful that the outcomes will change our on-road experience. What we do on road is the thing that we always prioritise: looking after our patients. Sitting in the car with your partner is the easy thing and doing the job is the easy thing. It is coping with all the bureaucracy that we find difficult.

**CHAIR:** That is coming through loud and clear. We aim to make the inquiry worthwhile. There is no doubt about that.

**The Hon. MARIE FICARRA:** The people of New South Wales value you.

**The Hon. CHRISTINE ROBERTSON:** Good luck with the progression of your career, which you well deserve.

**WITNESS J:** I would like to stay in the Ambulance Service; there is no doubt about that. But I am not sure that I will be able to.

**CHAIR:** Thank you.

**(The witness withdrew)**

**(The Committee adjourned at 4.47 p.m.)**