Submission
No 130

THE MANAGEMENT AND OPERATIONS OF THE NSW AMBULANCE SERVICE

Name: Suppressed

Date received: 25/06/2008

Submission to the General Purpose Standing Committee No.2
Inquiry into the Management and Operations of the NSW Ambulance Service

Attention: The Inquiry Chair - Ms Robyn Parker MLC

I am writing to you at this time to share my experiences and impressions of the NSW Ambulance Service, in which I spent years of my life. My story is both typical and unique of officers who have served and left the NSW Ambulance Service (ASNSW). I commenced employment with ASNSW in and resigned voluntarily but reluctantly in , frustrated, despondent and damaged.

I commenced service in and spent most of my year career in the area. During this time I was involved as

I had the opportunity to observe and be involved in a system where questionable and sometimes corrupt practices were commonplace.

It is difficult in a submission such as this to know where to start, however at the outset I will say that the one reason why the ASNSW is able to function at all and deliver any patient care services is because there are still good, dedicated but extremely frustrated officers who still care for others. I don't want this submission to be taken as the ravings of a disgruntled ex-employee, but now almost years after, a reflection on the systemic problems that are still hamstringing the ASNSW in the areas of management and operations. Some of what I will relay to your committee was common knowledge in 'the service' at the time and others accounts are personal experience over years, some of which is painful to recount.

The ineptitude of management in the ASNSW is well known amongst its relatively small workforce. The management culture is one of nepotism, elitism and cronyism, where poor performance of managers is covered up and individual positions protected and where poor performers are promoted beyond their level of competence. A culture still entrenched with the influence of the 'Masonic Lodge' amongst elements of senior management. The promotion and clinical progression system is frequently manipulated to advance select individuals and/or to act as payment for services rendered or to serve personal agendas.

[following section omitted by Committee to protect identity of author, as requested, and to remove adverse mention]

Who knows how many officers were injured or endangered during this time? Senior management refusing to accept that Ambulance Officers could be the target of abuse or physical violence and that the ASNSW had a responsibility in ensuring a safe workplace, opting rather to focus on the notion that officers themselves were largely responsible for violence and aggressive behaviour.

Officer safety always took second place to response KPI compliance and the risk of senior management 'looking bad' to the department. One frequent practice is to respond an ambulance to an incident from a completely different geographical area while waiting for resources to become available, this responded vehicle will never reach the incident but the purpose is to be able to maintain response time targets and to be able to reply to any media enquiry that the service responded a vehicle in a timely manner.

Various reports went unanswered, most not even resulting in an acknowledgement of receipt. The common practice amongst senior management was not to provide any feedback to staff, this process was explained to me by a senior manager thus, 'if you receive no feedback you just have to assume that they are happy, if they reply it means they have a problem with your work'.

Operational decisions on issues such as vehicle selection or staffing levels were made by senior management without adequate consideration of operational needs or officer safety but largely on short-term budget 'imperatives'. One such vehicle purchase decision meant that during a cardiac arrest only one officer could perform resuscitation on a patient, due to weight restrictions. Other vehicles still being used, necessitates pulling a patient out of the vehicle onto the roadside during resuscitation attempts, due to space restrictions. Single officer responses to emergencies including situations that armed Police will not attend alone, are commonplace. Long distance single officer transfers between medical facilities requiring officers who had already worked up to 14 hours to drive several hours at a time without breaks, a co-driver or any consideration of fatigue issues. Officers were frequently threatened with discipline action for requesting rest time due to fatigue after continuous day and callout work overnight for days at a time.

Sexual liaisons between all levels of management and staff were not uncommon and are frequently associated with meteoritic rises to positions of authority within the

organisation. These liaisons whilst common knowledge, were not openly discouraged within the organisation by management. Ambulance resources and facilities were used to pursue or further these relationships.

Contracts and tenders have been awarded in breach of government policy and law i.e. inducements of goods and services have been accepted by management. Pressure has been placed on committees to make recommendations to support individual pecuniary interests. The awarding of contracts consistently showed the incompetence of management in their failure to consider the implications on other systems and the future needs of the organisation, often failing to undertake adequate consultation with relevant parties and industry experts.

Vehicles are frequently deemed to be operational without a complete inventory of emergency equipment or serious mechanical defects, placing the public and ASNSW staff at risk. Driver training is inadequate and despite the average officer responding to more urgent calls than Police or fire personnel, there has been no advanced driving tuition.

Serious inequities exist in the way in which clinical incompetence is dealt with. Operational officers with management positions or elite clinical status have blatant 'indiscretions' largely ignored in 'investigations' whilst those at lower clinical or management status are 'crucified' for relatively minor errors in judgement. At least one senior paramedic in has been reported to senior management on numerous occasions for the consistent administration of unauthorised dosages and/or contraindicated combinations of drugs to patients and falsifying records. No effective action has been taken to date. Another paramedic was employed from another state where he had been dismissed as a senior manager (due to allegations of fraud) and took up duties without the appropriate or required level of training or

qualifications required to operate as high-level clinician in NSW. This appointment was made because of a personal relationship with a senior manager. These practices I believe are widespread in NSW and in any other clinical setting or industry would not be tolerated and result in dismissal, if not legal action.

Incompetent management are protected by management.

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Poor financial management directly influenced the ability of officers to carry out their work. Management directives were frequently made to road staff to change the service stations brand they go to refuel their ambulances. The reason for this was understood to be that the ASNSW had been refused credit by a fuel supplier so they would try another. The directive may change from month to month and any officer caught at the wrong supplier after filling up would have to pay for fuel out of their own pocket until the ASNSW were able to reimburse the expenditure. These directives were common toward the end of the financial year along with restrictions on the vehicle workshops restricting expenditure to amounts less than the cost of a cheap vehicle battery, without authorisation by the Divisional Manager. A process that brought maintenance and repair to a virtual standstill, further endangering the public and staff.

I have witnessed bullying and racial vilification by senior and other management, abuse of authority and deceit, favouritism and character assassinations, cover-ups and lies, fabrication of evidence and victimisation.

There is a perception that the suicide rate in the ASNSW is high due to the inherent stresses in the job i.e. attending to the sick and injured. This is partly true as the

challenges of this work are not easily understood by family or friends. However whilst there is a lack of real and practical support by management of officers involved in stressful or tragic incidents, the suicides, marriage breakdowns and mental breakdowns I have witnessed over the years were largely contributed to by frustration with and/or lack of support from management. I have seen good, honest and competent officers, spiral into depression, self abuse and leave due to the lack of vision of management and the ability of management to rob who they chose of a future, sense of worth or any reward for good work well done. An officer that I respected very much recently committed suicide by gassing himself in a car. There are no prizes for guessing that he was at the time, frustrated by a dispute with management.

any chance at a career was cut short. I was isolated, cut off from any career path, pushed into a dead-end high stress job where I too had a mental breakdown and was unable to work. ASNSW management labelled my condition as a 'tantrum' and refused to accept any responsibility I am still being receiving counselling and medication for depression. If true and despite contradictory medical opinion, this must be the longest tantrum in medical history. This principle of not accepting any responsibility for suicide, self-harm, drug and alcohol abuse, mental health issues and resignation is the mantra of ASNSW management. Your committee need only request, no demand, to see the 'exit interview' data collected by the service, (which is never published), it would show a clear and unmistakable theme, that sees recruitment never keeping up with resignation caused by poor management, lack of support and systematic, unfair treatment by management. The underlying culture of management in the ASNSW is not to support staff and to assume fault lies with staff themselves. This is seen as a strategy to protect senior management and 'the good name of the service'. If people ask me why I left, I give them the same reasons I have outlined in this submission, 'politics and bad management'. I don't hold a grudge

I do feel however that I was robbed of my health, my spirit and a job at which I enjoyed and excelled because of the management practices and culture of the ASNSW. The public would be surprised if not shocked by the tenuous state of operations and the amount of luck involved in getting any ambulance response in NSW at all. As a successful manager now,

I have learnt much from management of the ASNSW. I have learnt how not to manage staff and how not to run an organisation. I wish for the remaining dedicated staff and the people of NSW, that the recommendations of your inquiry will bring about real and lasting change to the NSW Ambulance Service.