Submission
No 30

THE MANAGEMENT AND OPERATIONS OF THE NSW AMBULANCE SERVICE

Name: Suppressed

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Partially Confidential

To whom it may concern

Please accept my submission to the inquiry into the management and operations of the NSW Ambulance Service.

I am not an employee of NSW Ambulance Service. My submission focuses on my observations as an experienced primary rescue operator interacting with ambulance officers at scenes of road accident rescues and other rescue incidents.

My responsibilities as an accredited rescue operator cover all general land and high angle rescue. This includes industrial, domestic and road accident rescue situations.

I would like to say that at all the incidents I have attended as part of a primary rescue crew, the ambulance staff in attendance were friendly, aware of the reasons for the attendance of a rescue service at the incident, had an understanding of the capabilities and general extrication techniques and ethic of the rescue service, and took the utmost care of the casualties in their charge. I'd like to say all that .... but I can't.

In what appears to be more the rule than the exception, I have been continually frustrated at the level of ignorance, arrogance and apathy shown by ambulance officers that occasionally borders in my opinion on criminal neglect.

Generally, most ambulance officers have very little, to no concept of the provision of rescue services in NSW. This manifests itself at road accident rescues when a method of extracting a person from a car is suggested to the attending ambulance officers (usually by removing a side and "flapping" the roof to make space), and is met with either blank stares, or a "no – that's not required".

If the officers *do* understand what it is that is being described, they often think that it is all too hard and will take too long. Neither is correct.

I think many of the problems stem from the misunderstanding of the term "trapped". The accepted ethic for road accident rescues is that a person can still be regarded as "trapped" in a vehicle if the mechanism of injury indicates or suggests an injury that requires immobilisation. This can occur whether the doors of the car can be opened or not. I have seen on many occasions the implementation of neck and spine care using stiff neck collars and KED's, only then to have the ambulance officers twist the casualty around in the seat – often with difficulty and with the casualty experiencing a degree of pain, lift them out of the car through the vehicles door, and walk them to the ambulance.

On other occasions, a door removal is required and performed (removing both doors on one side of the vehicle using hydraulic tools) to gain access for medical care, only to see the same thing occur. Many times I have seen a casualty suffer excruciating pain while being manipulated around in a front seat by ambulance officers because they don't want or see a need to "make space" in order to remove the casualty in the most appropriate way by the rescue service.

The current worlds best practice for removing casualties from vehicles while maintaining spinal alignment and immobilisation of the casualty is by performing a "side removal and forward roof flap" or "roof removal" (removing the car from the casualty rather than removing the casualty from the car). One side - usually the drivers side, is removed, and the roof is cut and "hinged", then folded up and over the windscreen, or removed entirely. This is a relatively quick operation and extremely effective in making space to enable a constriction-free extrication of a casualty on a rescue board out the back of the vehicle. At no time is the casualty twisted or bent – the only movement is to lay them onto the rescue board which has been placed behind their back.

Ambulance officers also benefit greatly by not having to work in a cramped and restricted environment.

This quick and simple method of extrication seems to be completely foreign to nearly all ambulance officers – with the exception of those who are or were rescue trained. But even they are reluctant to go to "that much trouble". It is only after the "hard sell" and convincing them that it will make life easier for them and the casualty – which it unquestionably does, that the casualty is spared what must be a most painful and traumatic extrication.

This point is not made to push an agenda of any kind, but is an attempt to change an attitude towards patient care that seems to miss the point. Placing a cervical collar on a casualty to provide neck support presuming a neck injury and then literally dragging them out by the armpits is missing the point. But I am in the difficult position of not wanting to tell the ambos how to do their job, but at the same time seeing a staggering amount of poor treatment of casualties.

I sight a couple of recent examples.

A young male drives over a small round-a-bout and collides head on with a telegraph pole with enough impact to move the pole in the ground about five centimetres. He is intoxicated and not wearing a seatbelt. His head has impacted the windscreen causing it to crack, and the top of the steering wheel is bent over.
The driver's door is forced open, and after pointing out the windscreen damage and suggesting a "standard" side and roof removal, the ambulance officer states, "nah, we'll just walk him out, he's pissed, he won't feel anything". I kid you not!

A young male has been involved in a motor vehicle accident. The impact and mechanism of injury suggest possible neck injury and he complains of neck pain. After I suggest extrication options, the ambulance officer states that "we'll just pull him out here (the drivers door), there's no TV cameras around are there?"

Given these reoccurring incidents of what seems to be a combination of ignorance, arrogance, and sometimes outright belligerence, I surmise that the collective problems I have experienced are the result of a lack of training given by the Ambulance Service. Not in specific medical care (that's not for me to comment on) but in working hand in hand with other service' rescue crews where a co-operative approach is required to extricate a casualty from an incident. Attempts have been made on my part to organise inter-service drills in an effort to familiarise both 'sides' with what the other does. The benefits of doing this would flow both ways. These attempts have proved fruitless due to the nature of the ambulance service workload, and the fact that the same ambulance crews are rarely seen on a week to week basis.

It follows then that what is lacking is an appropriate level of base line training and experience in working in rescue situations as part of recruit training. Cross service training would help to provide a better understanding of the unique needs that the services and casualties have, and go some way to fixing the greater systemic problems of rescue response delays that are commonly experienced.