Submission No 67

INQUIRY INTO RESPONSE TO MAJOR FLOODING ACROSS NEW SOUTH WALES IN 2022

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The Hon. Walt Secord MLC
Committee Chair
Select Committee on the Response to Major flooding
Across New South Wales in 2022
NSW Parliament House
Sydney NSW 2000

Dear Mr Secord,

Thank you for your consideration of my submission to this inquiry. The recommendations in this submission address gaps and failings in the crisis response as it pertains to health: medical (acute and sub-acute), mental health (acute and sub-acute), and disability. Throughout the February and March floods 2022, I provided mental health support to evacuees and acted as a volunteer coordinator for a community-led health response across parts of the Northern Rivers region. I helped to coordinate the efforts of volunteer doctors, nurses, psychologists etc. I visited and liaised with multiple evacuation centres in the Richmond, Ballina, Lismore, and Tweed shires. I liased with volunteer medical and mental health professionals, community wellbeing groups, senior management within the Primary Health Network (PHN) and Local Health District (LHD), functional area coordinators within the Local Emergency Operations Command (LEOC) centre, team leaders from the Australian Defence Force (ADF), Defence Recovery Australia (DRA), Rural Fire Service (RFS), and civilian search and rescue groups.

From a health perspective, what I repeatedly encountered was an official response lacking planning and preparedness, resulting in a response that was either completely absent or glacial, uncoordinated, and scarce if it eventuated. The medical, mental health, and disability needs of flood-affected residents across the region was predominantly left up to volunteer

health professionals and community groups. After I witnessed the same lack of response during the March flooding event as I had in February, it was evident that 1) the issues were caused by inherent failings within the emergency operations system, and 2) no rapid learnings from the February flood were had or were being acted upon. A more detailed account of my experience and objective observations has been included in an Appendix. For the sake of brevity, I have included the following recommendations without substantial context and examples; however, those can be provided if requested.

Recommendations

1. The State Emergency Management Plan (SEMP) needs to be reviewed and updated to:
    a. be fit for purpose for disasters of increasing frequency and magnitude
    b. appropriately designed for area of concern: urban, regional, rural, and remote
    c. address issues of planning and preparation to move from a state of reactionary response to preparedness, and
    d. address overall problems with command, control, and communications
2. A complete review and overhaul of the role of Department of Community Justice (DCJ) in disaster welfare. In particular, clarity on the involvement and responsibilities of DCJ regarding the crisis health response. Staff from DCJ are not adequately trained to triage or respond to medical, mental health, or disability concerns.
3. People holding functional area coordination roles need to be reassessed for suitability and subsequently replaced or retrained. Furthermore, coordination of functional area coordinators may need to be shifted from the responsibility of the combat agency commander during a disaster who is primarily focused on search and rescue efforts.
4. Increased inter-agency training and communication between emergency response agencies need to be introduced to prevent agencies operating in silos.
5. The Primary Health Network (PHN) and the Local Health District (LHD) should conduct a joint needs assessment for crisis health response to better inform response needs and define individual department roles and responsibilities.
6. The creation of a dedicated disaster response health team operating within the emergency operations command centres. This will improve health-related crisis response communications and control whilst reducing the overreliance on the volunteer SES operators who are not adequately trained in crisis health response.

7. The creation of (paid) dedicated volunteer coordinator roles to act as a calm, capable, trained, informed, and connected interface between emergency service departments and volunteers (health and welfare) during a disaster. Harnessing and coordinating the volunteer workforce is critical to fluid, fast, an effective response during large-scale, rapidly evolving disasters when official departments are likely to be overwhelmed.
8. Funding for the development of a community-led disaster strategy that allows for a coordinated and resourced volunteer response capability. This can work in tandem with the volunteer coordinator interface role.
9. The creation of a virtual / cloud-based system of health resources, templates, referral pathways, key points of contact, supply and equipment options etc. that can be accessed by health volunteers during a crisis. Additionally, an opt-in system of vetted health professionals registered for their willingness to respond during a large-scale crisis in their area.
10. An investigation into and mitigation of logistics, staffing, and supply issues caused by localised disaster impact (e.g., flood and fire) as well as subsequent road closures. Contingency plans need to be developed. Greater communication and coordination between emergency response agencies, combined with suitably trained functional area coordinators, could more effectively utilise transport logistics, supply, and HR chains to meet the needs of the disaster-affected citizens on the ground.
11. The improvement or development of strategies and methods for adequate and timely gathering and dissemination of information to disaster-affected residents and the volunteers helping them.
12. The inclusion of a dedicated disability-focused response in the emergency management plan.
13. The development of culturally and linguistically specific response requirements.

It is my intention in sharing my experience and these recommendations that they can inform fundamental changes to NSW disaster response. I hope these learnings can be used to protect lives and improve wellbeing for residents of NSW during natural disasters.

Appendix

During the initial flood, there were many volunteer-run, pop-up medical clinics (the AEC was my primary location), thrown together with donated medical supplies and loaned equipment. These were set up to service the acute and sub-acute medical and mental health needs of evacuees staying at or nearby the centres. These clinics were essential due to the flooding of multiple general practitioner (GP) clinics, evacuation of Ballina hospital, significant road closures, and overall magnitude of the disaster. There was no St John's ambulance presence at AEC (or the majority of evacuation centres). Key points of contact (POC) at evacuation centres were not known, which made the sharing of vital information and resources difficult. In its place, a network of health professionals operating in a volunteer capacity across the region had been set up through personal contacts (i.e., friends and acquaintances who also work in health).

The Department of Community Justice (DCJ) staff acting as centre management failed to respond across a number of critical functions (a collated characterisation by many volunteers and members of the community). DCJ did not assist with information, resources, POC, referral pathways, or provide a communication conduit between evacuation centres and/or emergency service departments. At AEC, a member of DCJ staff explicitly stated that they had "nothing to do with health". The local Health functional area coordinator (HealthFAC) – Ms Maryanne Sewel – was largely unknown, did not conduct a needs assessment, or offer assistance from either the Primary Health Network (PHN) or Local Health District (LHD).

In an attempt to rectify this issue and obtain key health POC details to facilitate communication and resource channels, I visited in person or made contact with multiple other evacuation centres in the region: Ballina, Alstonville, Goonellabah/Lismore (GSAC and SCU), Ocean Shores, Brunswick Heads, Murwillumbah, Mullumbimby, Evans Head, and Coraki. It became evident that all evacuation centres were operating in silos, doing the best they could as they went. From all accounts, there were no official health templates, information sources, referral pathways, policies, procedures, lines of communication or key hierarchy of control etc. Medical administration volunteers were creating medical records documents from scratch to facilitate accurate and legal medical record keeping.

At the evacuation centres, the person identified as being "in charge" / main POC, either from a health or welfare perspective, were volunteer leaders. If they were present, the role of DCJ staff was ambiguous and perceived as a hinderance more than help. There was a

palpable lack of competence, confidence, and leadership displayed by DCJ staff in the role of disaster welfare and centre management. If DCJ had any involvement it was in the welfare capacity alone. At no point were DCJ involved in the health response - this fact is very important due to issues with the command, control, and communication failures within the SEMP as indicated above.

The PHN did not provide medical or mental health support during the crisis response phase apart from later contracting the street clinic van for Lismore that eventually also visited Coraki. The van resource itself was slow to arrive and highlights inherent failings in the planning and preparation phases of the SEMP. Indeed, this acutely demonstrates how it is purely reactionary and inadequate even at that.

The LHD involvement at many evacuation centres was initially limited to the supply of RATs for Covid-19 testing. At AEC, this arrived on Wednesday 9th March (nine days after flood), after an outbreak had occurred at SCU evacuation centre. The LHD's involvement at AEC increased to start paying one of the nurses who was already volunteering and assign one mental health nurse who subsequently only appeared for one half day. On the closing day of the evacuation centre (after almost two weeks in operation) the LHD sent one nurse for a couple of hours. This was after the lead GP – Dr Alex De Marco - and I had requested LHD staff earlier in the week to take over from volunteers facing burnout and needing to return to their families and jobs. The representative from the LHD – Ms Rae Rafferty – was seemingly as helpful as she could be. Although, she explained that primary care needs were the responsibility of the PHN and the LHD was struggling with staff shortages. The mental health support at AEC was given by me, a retired psychologist (Mr John Noble), and some of his associates from Lifeline.

At other evacuation centres, there was either no response from the LHD or the PHN at all or an equally slow and limited response. For example, a volunteer nurse who had been acting as a clinical lead at the GSAC evacuation centre did not have LHD staff take over until Wednesday 9th of March (nine days post-flood). The volunteer doctor at Coraki – Dr Cam Hollows – was not taken over from until the roads opened and the street clinic van arrived. A volunteer doctor and a nurse at Murwillumbah were still trying to seek basic medical supplies on Tuesday 8th March (eight days post-flood). Like at AEC, the large majority of mental health support across the region was given by volunteers. As an NDIS service provider connected to the disability community, neither me, associates in the sector, or our clients witnessed any formal assistance to people with disabilities or their carers across the region

during the crises. Community groups and volunteers were facilitating action by offering and providing help and coordinating responses to requests for help.

On the evening of 28th March 2022, when another flood evacuation order was given for Lismore, I visited the Lismore SCU evacuation centre. On the one hand, it was my intention to again offer assistance if needed. On the other, I purposefully conducted an information gathering exercise to witness the crisis response unfold from the beginning to see if a) the system would respond appropriately and b) if any rapid learnings from the February floods had been put into place. Unfortunately, it was evident that the same broken template of a response would be followed.

Firstly, despite people evacuating through flash flooding in the dark and the significant risk to injury that posed, there was no St John ambulance or any other first responder presence. When asked, the DCJ staff member stated they had no intention of requesting one until "possibly tomorrow afternoon". Not only did they not know the correct referral process and if it was actually their responsibility, they didn't know where the local emergency operations command (LEOC) was. They also believe the LEOC was "closed for the day". Furthermore, there were no mental health clinicians present or planned to be. This is despite the PHN coincidentally opening the new "Head to Health" facility on the SCU campus that very day. Regardless of the fact flood evacuees would knowingly be heading to SCU from that afternoon onwards, retraumatised by a second flood in a month, the Head to Health facility was only open during normal business hours and no mental health support staff attended the evacuation centre after hours.

The lack of a planned health response was mirrored around the region. This included Coraki that was cut off by road again and had to rely on a volunteer doctor and paramedic who were ferried in via civilian boat crews. Within a 48-hr period, that doctor attended to a brown snake bite, a heart-attack, and a high-fever newborn that all had to be airlifted out. These patients were among many other less emergent care needs. Those with acuity that may have evolved into emergent if not treated by that volunteer doctor or had a pharmaceutical logistics channel been provided by the civilian boat crews. Once again, there was no mental health, disability, or culturally appropriate response for the high population of First Nations people in the area.

The lack of planning and preparation for even the most basic health response highlights and reinforces the major themes related to issues in the SEMP: problems with **command, control**, and **communication**. Firstly, the SEMP incorrectly assumes that the DCJ staff member at an evacuation centre will assess the situation, request health services,

and act as a key POC. However, through conversations with many staffers at different locations, it was clear that DCJ are not aware that it is within the scope of their responsibilities. As previously mentioned, DCJ don't believe their role has anything to do with health. Indeed, the staff members I spoke with did not even know what the PHN or LHD are. Nevertheless, what is strikingly obvious to anyone in the health sector is that DCJ are neither trained nor qualified to appropriately plan for or to triage the medical, mental health, and disability requirements of disaster-affected evacuees.

In an effort to force an appropriate official health response at SCU and Coraki, Dr Alex De Marco and I made contact with a range of senior management representatives from the LEOC, the LHD and PHN. From a medical standpoint, we were informed that St John's did not have available resources and were contracted mainly to the Tweed region; the LHD were not persuaded to act as they saw their role as one related to acuity and emergency only; the PHN did not act unless their services were requested from someone like the HealthFAC; and the HealthFAC did not have oversight of either area and tried to refer back to the LHD, the PHN, or DCJ.

With regards to mental health, a team leader from the LHD disaster response team – – informed me that they had very limited resources and one mental health nurse would do some assertive outreach in Coraki once the roads opened up, but their focus had to be on "diagnosable pathologies only". A senior manager from the PHN – – informed me that there was no intention for any mental health practitioners commissioned by the PHN to attend evacuation centres or do outreach; they were focussing their efforts on the recovery centres. Those which were coincidentally closed again due to flooding. There was no intention by PHN to utilise the list of vetted volunteers that had put their hands up to assist as PHN didn't "perceive a need". However, I was told that if I could personally "assess the need and coordinate the response" would help meet the need with the list of volunteers. There was no mention of identifying people with a disability who might need assistance.

In the following days, Dr Alex De Marco and I spent countless hours on the phone relaying my concerns about the lack of a health response that was leaving flood-affected residents vulnerable. Eventually, after working our way up the health chain to find a solution, our concerns were raised to the highest levels in the LHD – Director of Disaster Response – and the PHN – Director of Operations . In response, a mental health team and the street clinic van visited SCU, a doctor and paramedic swapped out the volunteer doctor in Coraki, and a mental health nurse visited Coraki evacuation

centre. Frustratingly, however, after all this effort to achieve some form of an official health response in Coraki, neither DCJ, the council, or State Emergency Service (SES) communicated the health presence to residents of the area. I had to do it via social media community groups.

Of additional concern was that there was no plan to check on people who had been cut off by road or telecommunications; some since the first flood due to the slow receding natures of the backwaters in that area. I relayed my concerns to managers in the PHN and LHD. I even offered a logistics avenue for outreach via civilian search and rescue boat teams who were offering support where SES could not provide the service. This was to no avail. The DCJ staff member in Coraki believed those people would "log a job" with the SES if they had a concern, despite residents not having any form of telecommunications (phone or internet), or any other immediate avenue to connect with the SES. To add further barriers, the SES lines were jammed, and DCJ assumed these residents would know to call SES if they needed non-emergent health assistance. Once again, this highlights how ill-prepared DCJ are to adequately plan, prepare for, and triage medical and mental health needs.

The PHN and LHD demonstrated consistently over both events that they had no intentions for an outreach mental health response other than the one mental health nurse visiting the Coraki evacuation centre. This experience led me to develop a database system where people with health (medical, mental health, disability) needs in the surrounding area could be identified and targeted. I made connections with team leaders from the Australian defence force (ADF), Disaster Response Australia (DRA), Rural Fire Service (RFS), and civilian search and rescue teams. During the course of their duties attending to households, team members who flagged a need for assistance could relay that to their team members and their team members to me for entry into the database.

I communicated the intention of this database to be a centralised point for oversight, a way of targeting PHN and LHD resources, and a mechanism for the vetted volunteers to fill the gaps left in the official response. Additionally, it was a way to ensure people needing help did not fall through the cracks. I was assured by the emergency response team leaders, and from the PHN, that no centralised health databased existed and it would be a very valuable tool. However, once I attempted to share this resource with from the LHD and Ms Ayla Hope from the PHN, I was informed that they "did not want my assistance". They wanted to keep the referral pathways in the "official channels" through the key POC. Evidently, the "official channel" was the aforementioned logging of a job with the SES. The key POC was the naive DCJ staff member on the ground.

"If a tree falls in a forest and no one is around to hear it, does it make a sound?"

Ultimately, across the region during both crises an adequate health response was not provided due to the invisibility of the need and poor governance. The HealthFAC expected DCJ to do a needs assessment and request services. The LHD and PHN don't provide services until a request is made, and who provides what services is a political and funding football. The DCJ staff member isn't trained or qualified to do a needs assessment. All of the people within the system believe they don't need to respond because there is no one highlighting a need. Meanwhile, disaster-effected residents who do have critical health needs are left abandoned or are helped by volunteers filling the gaps. When someone like myself tries to highlight the realities, offer assistance and a workable solution, we are shut out of the process for not having an official title and/or already being part of the existing ill-functioning and bureaucratic system.

Overall, problems with providing health coverage and a handover / takeover by either the PHN or LHD were exacerbated by politics, issues with state and federal funding, and inherent failings of the SEMP. Evidently, which department covers what element of care (acute, sub-acute, primary care, pharmacy etc) during a crisis is not clear to the departments because the emergency plan does not appropriately account for the variables during crises or crises of such magnitude that span an entire region. The result is a chasm of service provision leaving vulnerable citizens at the mercy, willingness, and availability of volunteers.

There are many striking examples of what the medical, mental health, disability, and culturally specific needs were during these crises that I have left out of this document for brevity and clarity. Although this document highlights the broad failings of the system that need to be addressed, it is through those specific examples that learnings can be used to inform fundamental changes in future crisis response. I, and members of our community-led disaster response health team (doctors, nurses, psychologists, disability support workers etc.), would welcome further discussion on these matters if permitted. There are undoubtedly and unknowable number of lives that were saved during these crises thanks to the efforts of dedicated and community driven health professionals. It behoves the panel of this inquiry to take heed of the lessons learned here to ensure the protection of life and foster wellbeing in inevitable future disasters.