LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON JUSTICE AND COMMUNITY SAFETY

(Reference: Inquiry into Immediate Trauma Support Services in the ACT)

Members:

MR P CAIN (Chair)
DR M PATERSON (Deputy Chair)
MR A BRADDOCK

TRANSCRIPT OF EVIDENCE

CANBERRA

TUESDAY, 26 MARCH 2024

Secretary to the committee:
Ms K de Kleuver (Ph: 620 70524)

By authority of the Legislative Assembly for the Australian Capital Territory

WITNESSES

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Amended 20 May 2013

The committee met at 1 pm.

EVANS, MRS DONNA, Executive Director, SupportLink
THOMPSON, MS MELANIE, Referral Coordinator, SupportLink

THE CHAIR: Good afternoon. Welcome to the public hearing of the Standing Committee on Justice and Community Safety for its inquiry into immediate trauma support services in the ACT. The committee will today hear from SupportLink, the Australian Institute of Health and Safety, the Victims of Crime Commissioner, Injury Matters, and the Minister for Fire and Emergency Services.

The committee wishes to acknowledge the traditional custodians of the lands we are meeting on, the Ngunnawal people. The committee wishes to acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region. We would also like to acknowledge and welcome other Aboriginal and Torres Strait Islander people who may be attending today's event.

The proceedings today are being recorded and transcribed by Hansard and will be published. The proceedings are also being broadcast and webstreamed live. When taking a question on notice, it would be useful if witnesses used the words: "I will take that question on notice." That will help the committee and witnesses to confirm questions taken on notice from the transcript.

We welcome witnesses from SupportLink. I would also like to acknowledge Ms Camille Jago, in the gallery, who made a very significant submission to our dangerous driving inquiry and maintains an interest in this inquiry. Would you each confirm that you understand the implications of the privilege statement.

Mrs Evans: I acknowledge and agree to the privilege statement.

THE CHAIR: Thank you.

Ms Thompson: I have read and acknowledge the privilege statement.

THE CHAIR: Thank you. Witnesses must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly. We are not inviting opening statements, so we will go straight to questions.

Could you briefly describe the type of support you are providing in the ACT at the moment in this area of incident or trauma support?

Mrs Evans: As a bit of background, SupportLink works in partnership with ACT Policing. We have a contract with the AFP for ACT Policing, and our role is to support the police in identifying services that people they come in contact with might need, outside of a law enforcement role. Our infrastructure is to have a system where the police come in contact with people—they are trained to offer support to everyone they come in contact with—and then they use our system to select support for primary issues. That could be anything from drug and alcohol issues to family breakdown, family violence, parenting, neighbourhood conflict—all of those issues.

Our role is to establish partnerships within the community with agencies that are funded to deliver support. We get the agency that is funded to provide the ongoing support for that person to make direct contact with them, because our client group are not necessary in a position to consider support as an option or to navigate the social support sector to find what they need. An agency makes contact because the police have said, "Someone will give you a call to follow up and see what is happening." The agency says, "This is what we do. How can we help?" Our role is to establish and maintain those partnerships. It is also to look at every referral that comes through our system to make sure that the right provider is initiating contact with that client and that it is done in a timely manner, to represent the conversation that has been had with that police officer, so that nobody falls through the gaps.

As far as our role in the ACT goes, this is our 27th year of managing referrals on behalf of ACT Policing. The options they have available on the system are the issues that they come in contact with that they have told us they need support for, and then we source the referral outcome for people and make sure that that actually occurs. The one issue we have had for the whole 27 years has been exactly this topic, this issue. It has been our biggest challenge: people who have experienced any type of trauma or anything sudden or unexpected, outside of what would be considered to be a normal life experience.

What we would like to communicate with you in the time that we have—and we welcome the opportunity to do that—is to let you know what our day looks like. Mel is the referral manager for SupportLink. We read every single referral that comes through and make sure we get the right end provider. They are not numbers; they are not data; they are not a transaction. They are actual people's stories that we are finding outcomes for. Mel has an amazing insight into exactly what happens.

We are managing over 6,000 referrals a year, on behalf of ACT Policing. That is what it looks like for us. These are not necessarily all the people who need support. These are the ones that police have identified as needing extra follow-up. Our referrals are only from police; it is not the general community coming in. This does not represent the total number of people who need support; it is only the ones where police have said, "We are really concerned about this person and we need an outcome follow-up." I will pass to Mel to talk about what that experience actually looks like.

THE CHAIR: Okay. Thanks.

Ms Thompson: As Donna mentioned, I do read through every referral. It is not just a referral; it is a person's story. They are quite broad and range across every type of situation that you can imagine where police come into contact with people with trauma. Support following a traumatic incident continues to be one of the services that is most highly in demand but also that is the most difficult to coordinate support for.

We have some brilliant services out there for people who fit those criteria. But where they do not, or where there is not enough information available yet to know if they fit the criteria, there is nowhere to send them and we are left scrambling, looking for a service that will step outside of the criteria and have a conversation with these people. Where we cannot find anyone, we will pick up the phone and have a conversation.

Of the hundreds of referrals that come through—and we have had in the last week alone 30 people who have been in a situation following a traumatic event in the community and they do not fit within any service's criteria—we find that when we speak to them they need someone to pick up the phone and say, "Are you doing okay? Is there anything you need?" Down the track, they might need counselling, and they might be able to access that, but today they cannot.

You cannot get in to see your GP the next day—very rarely can you, and that is if you can afford it and if you have a regular GP. I had a look this morning at what the free and low-cost counselling services have as their average wait times. You are looking at one to six months. The good news is that, for most people who have experienced a traumatic incident, those traumatic impacts can often resolve on their own. But while they are there a lot of damage can be done. You can have loss of income, miss out on school exams for really important—

THE CHAIR: Colleagues, are you happy for Ms Thompson to continue? We are only here until 1.30. To close off my line of questioning: what do you see is needed more? Could you be succinct in that.

Ms Thompson: We certainly need services that are able to not be confined by strict criteria and that are able to provide across-the-board contact in a really timely way so that people can get immediate support to help resolve those immediate needs and then be linked into the longer term supports as needed.

DR PATERSON: Case study 2 in your submission was incredibly powerful, detailing the extent of support that is needed in the immediate aftermath, and particularly the fact that children were present and the dynamics and difficulties with that situation. How many support workers would you say are seeing this? What is the workload and what is the funding that is required to support a scene like this, which might be one of 30 that happen in the ACT each week?

Mrs Evans: We have put together a number of different scenario options. We did provide the costing to budget estimates last year, which we would be happy to provide again. I think where people get a little bit confused is that they see that there is an incident that happens and there might be a person who is impacted, but there actually are often a number of people who are impacted who do not necessarily meet the criteria of coronial—there has not been a coronial investigation or a death—or they do not meet victim referral criteria because they are not a victim. A whole scope of people go through trauma who do not fit under any current service that we have available.

There are a couple of options. That is partly how the former Trauma Support Service evolved. It met a need that police identified: going out, picking up people and then navigating the support that they need. That followed a client-centred approach, not a model itself: "What do you need? How can I help you? What is happening today?" That obviously becomes a very costly option because you are rotating a 24/7 roster of very highly qualified team members.

We are coming back today to say there are other options. We could just provide a follow-up call from a referral, which is what we have done 30 times in the last week, to

say, "What is happening for you? What do you need?" We do not necessarily need to go straight to having a highly funded, responsive, face-to-face service. At the very least, for care and compassionate purposes, we can give you a call and say, "You have obviously had a really difficult time. What do you need? How can we help?" We could start from that point, as Mel said, and move outwards. We could get caught up with what would be an ideal model in terms of a response, but there is also a very simple solution, which is that caring and connectedness model of just checking in with people.

DR PATERSON: Throughout the dangerous driving inquiry, the gap was so loud and clear. It was obvious that it existed. The Victims of Crime Commissioner noted this gap too, the gap that you are speaking to. I appreciate that there are a range of options, but, as for what you would recommend as the best care, would going for that more intensive model of response be the better option?

Mrs Evans: The gold standard would be that, if you have had a significant incident occur, somebody comes and sits with you in that space, whether that is in the gutter or on the side of the road. They stay with you through all of what happens, for the entire time, answer your questions, see what you need, help you figure out the way forward, and they are independent of an investigation or a legal body. That is your best outcome.

Ms Thompson: That also helps you to respond to people who may not be on the radar or to have conversations with police or first responders. It is unrealistic and unreasonable for people who are in emergency response roles to be expected to check in and offer support to every single person who may be impacted in that space.

DR PATERSON: What was your feedback, when you did operate this service, from people who had gone through traumatic incidents?

Mrs Evans: It is life-changing to know that someone is there, to have the questions answered over and over and over—because there is no way you can retain or process information—to have a question answered when you ask for it, not just have information given to you. You actually want to know the answer, so you ask the question. To have that given to you and then to have someone sit beside you is valuable. Everybody has a life history behind them which has affected the way they respond to trauma. To recognise that and to work with that person on exactly what they need is obviously an ideal response—and then to help them navigate that, whether it becomes therapeutic counselling or whether it becomes practical support, whatever that might look like.

DR PATERSON: Thank you.

MR BRADDOCK: I believe you mentioned that you had done some work and provided that through previous estimates. Could you please take on notice to provide that to the committee? I would be particularly interested in that.

Mrs Evans: Absolutely.

MR BRADDOCK: What you describe as the gold standard is to have a skilled person on call and available to provide on-site support. Reading through your submission, the feedback from the police from when the Trauma Support Service was operating was

that there were significant benefits in freeing up police to focus on what they perceive as their jobs and reducing the emotional trauma and difficulties and complexity they have to deal with. Surely that should be part of the business case justifying having that on-site support?

Mrs Evans: Absolutely. The feedback we got at the time was: "Thank you for taking that on board. We have got enough to do. I would never have thought of saying it like that. I would never have used those words. That has been really helpful for me." Often you would attend a job and police then take an active step back. Whether there is conflict or significant trauma, it eases the pressure and allows the police to continue with the job they have. It also helps people to know that, following that job, you are the point of contact for that person or number of people and it is not the police. The investigation continues. You are the contact for everything else that needs to occur for that person. The benefits for them were high. We saw the rewards immediately, both for the police and emergency services responders but also for the community.

MR BRADDOCK: Can you articulate the rewards from the emergency services and police side?

Mrs Evans: Say a call comes through to 000 and you attend at exactly the same time as the ambulance or the police. You automatically are introduced to the investigating officer or the person in charge of the scene. They give you a rundown and then you navigate your way through that scene the whole time you are there. That could be several hours. They can then take a step back.

They will come to you and say, "We need to do recorded interviews. Can you sit with this person during the recorded interview? We need to do some identification. Can you identify who the best person might be for that? Can you go away and find out this? Can you give us that information?" You become the conduit. They get on with the investigation and you sit with someone and explain why there are photos being taken, why there are police there and why they cannot go into the house. All of the things that are happening around the event are what you are managing, while the police are looking at the investigation and preparing their reports. It takes the pressure off them having to manage a small or large number of people who have questions or need things explained to them or whatever that situation might look like.

MR BRADDOCK: Thank you.

Ms Thompson: They need support and compassion.

MR BRADDOCK: Yes. Very important. Thank you.

THE CHAIR: You have talked about the gold standard. I guess you are alluding to what SupportLink used to provide, under an arrangement with the ACT government. Respecting the delicacy that you might want to handle this question with, why do you think that contract was terminated? How was that explained to you?

Mrs Evans: It was not so much that we had a contract terminated. The service evolved because of a need from the community. That is how it was designed and that is how it was implemented: "What do people need? What do police need? What do members of

the public need?" We self-funded that for the majority of that 10 years because we strongly believed in it and saw the outcomes. The police were invested because it reduced the time that police might have to come back to a situation. If people return to work, if their mental health becomes more stable, if they are not going down a path of drugs and alcohol or family violence, then there is an invested interest in that outcome as well.

When we started to ask for support and get traction around that, it became clear that there was an interest from the coronial court. The direction that it went through was that it became part of the Coroner's Court. That is when the funding that the ACT government had indicated would go to trauma support went to coronial counselling. We were very supportive of that because, for us, having the Trauma Support Service and then being able to refer to a counselling service was a fantastic idea.

But what has happened is that the coronial counselling service is primarily there to support the Coroner's Court, and that is there to support the next of kin. You have the next of kin, where there has been a death, and people think we do not need that trauma service because we have coronial support. Then there are capacity issues, so everything else picks up as well. I think what happens is that people tend to use the words "trauma support" and they think of a victim and they think of coronial. They forget that that is actually quite a small percentage of the definition of trauma that might impact people.

THE CHAIR: How, then, did the support you were providing, that 24/7 support at the scene, come to an end?

Mrs Evans: We could no longer continue to fund that.

THE CHAIR: Because?

Mrs Evans: Because we are a not-for-profit. And we—

THE CHAIR: Were you funding it before or was the ACT government supporting that?

Mrs Evans: We were, but a lot of it was with the purpose of having the model put into place, having it researched, having best practice identified, and then, following conversations with government over many years, that it would become a service that was picked up and funded.

THE CHAIR: So, effectively, you carried it for a while and then you just could not?

Mrs Evans: We could not sustain it without a commitment that there would be some funding. As you can imagine, it is quite intense.

THE CHAIR: Thank you.

DR PATERSON: To further expand on this point, Injury Matters, in their submission, talk about 2022, when 18 people died on our roads but 740 people were hospitalised. Regarding those people who are hospitalised and the extent of the trauma of those scenes for them and other passengers in cars, are you able to speak to the extent of the

need and the fact that it is not just when someone dies?

Ms Thompson: Where there has been a serious road accident, whether there is a fatality or not, we will often receive referrals for other people who were involved in that accident. We will receive them for witnesses. We will receive them for friends and family of passengers and for the person in the hospital. Sometimes it extends to colleagues or other people where, for some reason, it has shaken up a previous experience for them, even though they might not have been involved. So we would expect to see dozens of referrals.

As Donna spoke to before, that has happened with the people that police have become aware of and who have opted in for that support. The impact is widespread, and a lot of people are missed. A lot of people will not fit into the mainstream services. We partner with over 50 services, so it is not that we have a lack of partnerships. It is just that trauma is a broad, unique experience for people and there just are not the broad services that can provide the timely, trauma-informed response if people do not fit into their box.

MR BRADDOCK: I am trying to understand what would be the handover points or where would be the most appropriate place to hand over from a trauma support service to whatever it may be—other counselling or continuation through any court-related processes or others? Where would that best occur or how far should that service continue from that initial contact?

Mrs Evans: It depends entirely on what someone needs, but it is usually a warm referral or helping someone onto a pathway. It could be any length of time, but it usually transitions over a couple of months.

MR BRADDOCK: All right. Thank you.

Mrs Evans: I think it is important to also identify that SupportLink is funded by ACT Policing to manage the referrals and the service that is provided to people is delivered by funded services. It is not actually our responsibility to deliver. We are not funded to deliver a service; we are funded to find the services. But the situation we have found ourselves in for 27 years is that we have not got the services that people who have experienced trauma need. We have nowhere to refer these people.

We have had to educate and train our staff to figure out what we can do for people. We cannot say to police, "We will not put that as a referral option on the system," because our job is to find the outcomes for police, for people who need support. We are not saying that we are the best people to deliver a service. We are saying that we need a service. We need somebody to call people and help them when they need it the most.

THE CHAIR: You mean from the scene of an incident?

Mrs Evans: From any trauma.

THE CHAIR: Yes.

Mrs Evans: Or any trauma that does not fit and that is outside of what our current services tell us they will take as a referral.

THE CHAIR: What would be required for you to be there again, in that immediate incident, providing that sort of support? What would be needed?

Mrs Evans: It really comes down to funding. We worked with ACT Policing very quickly to determine that, even though we were a part of a crime scene, it was a huge benefit that far outweighed the need. Obviously, you would need to train people to behave appropriately in that crime scene, particularly when they are talking to witnesses before they have been interviewed. It comes down to funding to have qualified people to attend, be available and respond in an appropriate way. Alternatively, as we have suggested, it could be a call, which is what we have done in the last week, to see how people are: "What do they need? How can we help? How can we help them navigate a way through it?"

DR PATERSON: Obviously, you would attend scenes where someone has committed suicide and those types of things?

Ms Thompson: Or sudden unexpected death. But we also attended higher impact trauma, such as aggravated burglary or attempted murder or things like that. It did not have to be a fatality. It could just be a significantly traumatic event.

DR PATERSON: Yes.

THE CHAIR: Is there anything you would like to leave us with, in closing?

Mrs Evans: The message that we really want to leave is that it is not hard. The gap is huge. It is there. We have been seeing it for such a very long time. We have the conversation with service providers all the time, when someone does not meet their requirements, to help us make these referrals. To actually reach out to someone and say, "How can I help you?" means the world to them. We have had those conversations this week. They are so grateful that you reach out and have a conversation with them about what is happening and then try to figure out what it is they need. It is not a difficult thing to do, and it can be life-changing for people.

I think we underestimate the volume because we get caught up in thinking that it is attached to road fatality numbers or sudden death numbers or some particular data, rather than looking at the general experience. Consider somebody who has a heart attack in a call centre. That is hugely impacting for the people in the workplace who might have had a similar experience with a loved one. All sorts of complex things happen that people need to unpack and then figure out a way forward. They do not necessarily need to go into therapeutic counselling. They just need to unpack it, debrief and figure out a way forward.

THE CHAIR: Outcomes we all want. On behalf of the committee, I would like to thank you for your attendance today. I believe there were some questions taken on notice.

Mrs Evans: Yes.

THE CHAIR: Could you provide your answers to the committee secretary within five business days of receiving the uncorrected proof *Hansard*. Thank you very much for

your submission—

Mrs Evans: There is just one more point. A lot of information was put together to try to get the trauma service refunded. All of that information is available: research, data, numbers, facts. If any of that is any help in determining what a service could or could not look like, all of that work has already been done over a 10-year period. If that is of any help to the committee, we would be very happy to share anything useful.

THE CHAIR: Sure. Is that publicly available?

Mrs Evans: No.

THE CHAIR: Okay. If you are happy to provide that, absolutely.

DR PATERSON: That would be great.

THE CHAIR: You could probably send it to the ACT government too, if you like. That is your call. Thank you again for your time.

Mrs Evans: Thanks for having us.

Short suspension.

SEGROTT, MR DAVID, Policy and Advisory Committee Member, Australian Institute of Health and Safety

THE CHAIR: We now welcome a witness from the Australian Institute of Health and Safety. I remind you of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement. You must tell the truth. Giving false and misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly. Would you please indicate that you understand the implications of the statement and that you agree to comply with it.

Mr Segrott: I understand the implications of the statement and agree to comply with it.

THE CHAIR: Thank you. We are not inviting an opening statement, so we will go straight to questions. How can the ACT support for victims be improved?

Mr Segrott: From the perspective of AIHS, we look at the issue of trauma from the perspective of what happens in workplaces and the obligations that persons conducting businesses or undertakings—employers as they were referred to—have as far as their own workers, visitors, volunteers, passers-by, whatever, in the event of a traumatic incident.

Obviously there are occasions when an organisation will suffer a traumatic incident such as a fire, an explosion or some such thing, and staff of that organisation will have to be evacuated from a premise. There are all of the trauma related elements that are associated with that which have to be managed from the employer's point of view. That is normally where an organisation, depending upon its size and complexity and organisational arrangements, will have standing arrangements with organisations such as employee assistant services or industrial chaplaincy services, or they will have a psychologist that they are able to bring in to help deal with that trauma.

In those circumstances where an employer, a PCBU, has people that are exposed to trauma, they have an explicit obligation under the work, health and safety legislation to try and prevent the trauma in the first place, which is done through a number of practices in terms of emergency preparedness, and then dealing with the aftermath of the trauma. That can be just a standard shock of being involved in it, or it can be the shock of a fellow colleague within the organisation or the industry being severely or profoundly injured or, in some cases, deceased.

From an employer point of view, we would expect the organisation would have arrangements in place to bring counsellors in to make sure we are monitoring the health, safety and wellbeing of the people that are impacted by it.

But there are other organisations—noted in our submission—organisations that are in the first responder area: the ambulance service; the fire brigade; and the police, who deal with this type of trauma on a much more first-hand basis. The expectation of their employers is that they have mitigation strategies in place in order to assist people to deal with it in the first instance, and then provide counselling, support and debriefing services after the event—so that the ambulance officer who turns up to a major accident, whether it is an industrial accident or whether it is a road traffic trauma, does not take

that traumatic experience home with them by themselves—that there are a processes in place that every employer has in terms of their obligations for the health, safety and wellbeing of their own staff. We see there is a legislative expectation already under the work, health and safety legislation and that should be considered a given within those types of organisations.

Trauma as a one-off can be a traumatic accident or, as one client that I work with experienced, a current staff member had a major asthma attack and died over a weekend. We have had another former staff member come back in to visit on the Friday, then have a massive heart attack over the weekend and die. The trauma for the rest of the staff in hearing about the passing of one of their colleagues meant we intervened and provided that type of counselling and support for those staff so that, again, they did not feel isolated and alone and left to deal with that trauma by themselves.

Again, that would be part of what we expect: what any business or undertaking would do under their normal WHS obligations. So that is where the AIHS comes from—from the perspective of what needs to happen in workplaces in terms of workplaces dealing with traumatic experiences.

DR PATERSON: We just heard from SupportLink. My understanding of the service they are proposing, and of your context in terms of the workplace, would be that if there was a heart attack in the workplace you could call SupportLink—an ambulance would probably attend but you would call SupportLink. They would attend. They could engage with staff at the immediate scene but then the workplace would go on to organise counsellors and psychologists to come in.

Mr Segrott: That is correct.

DR PATERSON: Do you believe in that circumstance, that SupportLink or a service like it, would provide a really valuable, sort of transition support service, to engage with employees who are experiencing that immediate traumatic incident?

Mr Segrott: It would be part of the package of responses I would normally expect a reasonably sophisticated employer to have available to them, whether the first response was from SupportLink or their own existing arrangements; a lot of organisations have standing arrangements with employer assistance services that do provide that type of trauma counselling.

SupportLink would be an additional source of support that could be called into an organisation, particularly if the organisation did not have a standing arrangement with an employee assistance program, where they have a look around and say, "Okay, what do we do?" The SupportLink service could act effectively almost like a first response trauma response, and then help the organisation steer in the direction of what else is needed.

In a lot of organisations they will have a work, health and safety practitioner or professional that will provide that level of advice but not necessarily the level of counselling. That is not always the role the WHS professional will play, but they will know where to go to look for the right type of assistance and support that is needed for the particular organisation and the particular organisational circumstances.

DR PATERSON: Has your organisation specifically looked at school responses to traumatic incidents where you have a large community, a community which are predominantly children, but also their families? I know the ACT government does put in place offerings of counselling if there is a traumatic incident that affects the school community, but do you think there is more that we can be doing, particularly in that space?

Mr Segrott: I think, again, it would be a matter of, if that service was available, it could be called upon. I personally work with a number of the large private schools in the ACT in the WHS space and a lot of those schools have school psychologist arrangements and school counselling arrangements that can be drawn in to provide that service. But, again, having an additional arsenal to call on, in terms of response, would be quite advantageous for a lot of the schools that perhaps do not have the sophistication of a complex management system.

MR BRADDOCK: Just a question about the ACT government as a PCBU and its workforce obligations in terms of it is positively sending its workforce into traumatic incidents which are complex, confronting and challenging. Have we met all of our WHS requirements to that workforce to be able to support them with that?

Mr Segrott: I am not able to answer that question in detail, because it has been a long time since I worked for the ACT government in that particular space. I do quite a bit of event management and have quite close dealings with the likes of ACT Emergency Services and that type of thing, and from what I understand, there are well-developed arrangements already in place for the debrief of fire, ambulance and emergency services response people. Without studying it, and the AIHS have not done any specific study on that, it would be difficult to make a qualitative judgement.

THE CHAIR: You have talked about the incident of a trauma—a motor vehicle accident or something like that——is there any established law on the responsibilities of the government or policing to their officers in that kind of setting? It is pretty hard to imagine people who attend those not being significantly impacted by what they have to confront, administer and investigate.

Mr Segrott: It is difficult to completely cocoon people from the impacts, or potential impacts, of being involved in, or the response to, a traumatic road accident incident, but again, going back to the work health and safety legislative principles and that type of thing, the legislative principles apply no matter what work is being done by the workers. The obligation is on the PCBU to have arrangements in place to prevent or minimise the effects of the hazardous situation.

Again, it is a matter of having the right type of skills, having the right type of training, the right type of counselling and support, debriefing services and the like, that would be able to be rolled out. Whether that occurs during the incident—and I would imagine that in some cases there are—some of the firies I have spoken to that have responded to major trauma incidents and that type of thing, have said that during the incident they will be pulled out and rotated so they have a break. During that break, part of that is to debrief about what they have seen and what they have had to do in terms of dealing with the trauma. Again, that is part of the trauma management process.

The police I would imagine have similar types of structures in place, particularly for major road crash responses. Again, they are large organisations, but from a work health and safety point of view, what do we do with the tow truck driver that has to turn up and try to help extricate people or sees the aftermath of the accident; the other passers-by that witness it; or the first other driver that stops and tries to render assistance? It is that type of thing I think that goes beyond the workplace and into what the government's response framework needs to look at addressing.

THE CHAIR: Did you follow the dangerous driving inquiry?

Mr Segrott: No, I have not followed that particular inquiry.

THE CHAIR: Okay, so one of the recommendations from that inquiry—and some would say this is like a sub-inquiry following on from that one—recommendation 22 of that inquiry by our committee said:

> The Committee recommends that the ACT Government urgently fund a trauma service that is available at the scene of an accident and a 24 hour hotline to help victims and their families.

Actually, if I may be so presumptuous, I recommend that report and that government response to you because it certainly overlaps in your areas.

The government noted that recommendation and outlined the series of services that are available that people get connected to through one means or another, but it did make an interesting comment. It said:

> ACT Policing submitted that it was extremely difficult for police to offer trauma support at the scene of an accident due to their primary role to investigate.

Yet, frankly, as ACT Policing and the emergency services are often the first people there, it is hard for them not to feel they have an obligation to someone who is suffering, or a witness, or a family member who turns up. That would seem to be a bit of an OHS issue as well, where police themselves—

Mr Segrott: It would be, yes.

THE CHAIR: have identified a concern that their officers are expected to be that person, but they are not really equipped to provide that service.

Mr Segrott: It comes down to whether they have the right training, the right skills, and whether the resources available at the time are sufficient that there are enough officers there to be able to deal with the actual trauma, and to deal with the people that are affected by the trauma. It comes down to what is the major priority, and I would say that the major priority is dealing with the actual trauma.

THE CHAIR: Would you have a recommendation to the ACT government, or at least you could pass that on to us for us to consider as a recommendation to the ACT government?

Mr Segrott: I will certainly take that on notice and do some work. We have another policy committee meeting next week.

THE CHAIR: Feel free to forward some supplementary thoughts. Anything you would like to say in closing?

Mr Segrott: No.

THE CHAIR: Thank you so much for your time.

Mr Segrott: Thank you for the opportunity.

THE CHAIR: On behalf of the committee, thank you for coming and appearing before us, and also for your submission. You have taken some questions on notice, so thank you for that. Please provide your answers to the committee secretary within five business days of receiving the uncorrected proof *Hansard*.

Short suspension.

YATES, MS HEIDI, Victims of Crime Commissioner, Victim Support ACT, ACT Human Rights Commission
HICKMAN, MS JACQUELINE, Legal and Policy, Victim Rights and Reform, Victim Support ACT, ACT Human Rights Commission

THE CHAIR: We welcome to our inquiry the Victims of Crime Commissioner. I remind witnesses of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement. Witnesses must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered a contempt of the Assembly. Can you please confirm that you understand the implications of the privilege statement and that you agree to comply with it?

Ms Yates: Yes, Chair.

Ms Hickman: Yes, Chair.

THE CHAIR: We are not inviting opening statements, so we will go straight to questions. I made reference to the dangerous driving inquiry and the government's response to that inquiry report:

> **Recommendation 23**
>
> The Committee recommends that the ACT Government provide funding for the Victims of Crime Commission to:
> a) provide a wrap around service families of victims as a result of dangerous driving;
> b) support people with non-fatal injuries as a result of dangerous driving; and
> c) extend support for victims of 'negligent driving'.

The government has noted that recommendation. I have a broad question: have you noticed any change in terms of support, funding or resourcing, in your capacity supporting victims of crime, and particularly those who experience serious trauma?

Ms Yates: In responding to that question, I begin by acknowledging the fact that that recommendation, and indeed many of those considered by the dangerous driving inquiry, drew on the evidence of victim-survivors.

In doing so, I recognise the importance of all public policy being informed by those with lived experience. I recognise that there are victim-survivors who are watching these proceedings today, and I recognise that the advocacy that they take on as an act of public service occurs having experienced significant and irreparable loss. I thank those individuals for the fact that, in the aftermath of horrific harm, they are choosing to come forward and talk about how we can make the system better for others.

In relation to expansion of funding or services, Mr Cain, as detailed in our submission, we did receive funding to be able to commence providing services under the Victim Services Scheme to the family members of those killed in motor vehicle collisions caused by a criminal offence. That service expansion commenced when the regulation changed at the beginning of April last year. It has made a huge difference to the families and individuals who have chosen to access our support, in being able to provide victim-

led case coordination.

Our colleagues at SupportLink talked about the many different impacts that losing a family member can have on people's employment, on their ability to undertake university exams or go to school, or on their ability to keep paying the rent. We provide a wraparound service that starts with saying, "How can we help?" and goes from there to offer a broad range of supports and financial assistance. That might be assisting people to take time off work to attend court or coronial proceedings. It might be about making sure that they have safe and secure housing or providing financial help for lost wages due to the impacts of the loss of their loved one. There are all sorts of things that we can provide.

Ms Hickman: The amendment to the regulation also means that witnesses of particular instances that resulted in death may be eligible for the Victim Services Scheme if they witnessed a "violent crime", which would encompass culpable driving causing death. We have been able, particularly over the last couple of months, to assist more people that are coming through referrals through Support Link who may have witnessed a traumatic incident that resulted in a death on the roads. Prior to the regulation being amended last year we were unable necessarily to assist, even through the Victim Services Scheme. That goes beyond the families; we are able to assist more individuals. Part of that wraparound, and facilitating that counselling, is offering other information. Our case coordinators may identify other support services that they may need, so we are in a better position to be able to offer assistance outside families, through that regulation.

THE CHAIR: Do you think anything different is happening at the actual site of an incident, from your point of view?

Ms Yates: I think that the gap identified by the victim-survivors who provided submissions to the dangerous driving inquiry, and by our policing and emergency services colleagues, remains at the point of someone attending roadside or in somebody's home—a traumatic incident.

We are not funded as a 24/7 crisis service. We are able to respond very quickly in business hours, where we may be contacted by a community member or receive a referral from police or another service. We go out to people's homes to meet them, or to hospitals or police stations, where they might be waiting. But there is still a gap outside business hours, in terms of having someone attend whose sole duty is to account for the needs of a victim-survivor or a witness to that traumatic event.

DR PATERSON: Through the dangerous driving inquiry, we heard from victims who have survived very traumatic car accidents. There is also culpable driving causing grievous bodily harm, which is, again, a horrific offence to have occurred to someone. Do you think we need to go a step further, and what level of full-time equivalents would you need to be able to engage with those people and families who have survived but who have been victims of very serious road trauma?

Ms Yates: I acknowledge that there is a large cohort of people affected by motor vehicle collisions in that way, where there is not a death but nonetheless there are lifelong impacts for them and their families. We have assisted a range of individuals who would

fall within that cohort, in the context of their charter rights as victims of crime—for example, in advocating for them to receive information and updates from police, and questions and concerns they have had about the prosecution phase, including the giving of victim impact statements etcetera.

We have not undertaken an analysis in terms of the volume of those matters. We have quite clear stats, as I know the committee is aware, in relation to road deaths. We have not analysed the stats for that broader cohort. I would say that cohort of individuals would benefit from the types of service that are available under the Victim Services Scheme, but it would involve a substantial growth in the number of people eligible for our services. At present we would not be able to provide the 24/7 support that police have articulated as being a current gap at the scene of motor vehicle collisions.

DR PATERSON: Do you help victims to navigate the motor accident insurance scheme?

Ms Yates: Yes.

DR PATERSON: We heard in the inquiry about the difficulties that victims have in navigating that scheme. Is there anything in that respect that you think would be helpful or changes that need to be made to better support people through that process?

Ms Yates: We are grateful to have the resources now to assist people to navigate that system where a family member has been killed. However, even with our expertise, we know about the incredibly demanding bureaucratic steps that families have to step through. With us standing beside them now, and at times in front of them, when we take on the communication with MAI on their behalf, we think there are still significant improvements that need to be made to that scheme to make sure that individual victim-survivors or their families can access their entitlements in a timely way.

DR PATERSON: They have recently been conducting a review. Have you had an opportunity to have input into that review?

Ms Yates: Yes. The MAI came to meet with us when the review was finalised to discuss various aspects. We have appreciated the opportunity to have regular engagement with some of the senior policy officers there about the kinds of changes we see from a practical perspective that would make a difference for families. They have not all been implemented at this stage. I hope the review will be a refreshed opportunity for government to consider some of those changes that really are about saying that, for this scheme to deliver for the ACT community, the process of accessing entitlements needs to be simpler, particularly at a time when people are often experiencing significant grief and trauma.

MR BRADDOCK: What happens during a period when it may or may not be clear as to whether a crime has actually been committed? Do you commence rollout of your support services during that period of time?

Ms Yates: As you might imagine, we receive referrals or individuals reach out to us at a time when a criminal investigation has not yet been finalised. In accordance with the legislation, we are required at that time to determine "has suffered harm because of an

offence", and we assess that on the civil burden: "Is it more likely or not at this point in time that a crime has occurred?"

We really rely on information from our criminal justice partners to assist us to make that decision. For example, if the referral has come from police, they will often give us quite a lot of information about matters that they are looking at that assist us to determine whether or not a crime may have occurred, and we will follow their lead. If they are saying, "We are investigating this matter; here's a victim," that is weighting in our decision-making criteria.

It is not unusual for us to commence providing support during a criminal investigation on the balance of probabilities that they will be a victim of crime. It may well be that charges do not end up being laid or someone is not convicted. However, we are grateful to be able to step into that space and to acknowledge that, of course, we also assist where someone has not yet reported a crime to police.

MR BRADDOCK: Paragraph 7 of your submission talks about the delay of two to three months for delivery of counselling and therapeutic services. I am interested in what the impacts of that delay are in terms of the outcomes for individuals.

Ms Yates: Indeed. That delay is highly unfortunate, and one that is incredibly difficult when we are trying to respond to the needs of community quickly and efficiently. Part of that is being driven by the substantial increase in community members choosing to access our service over the last five years. For example, we have had over a 300 per cent increase in people making financial assistance applications, and around an 80 per cent increase in people accessing case coordination.

We partner with over 140 small businesses in Canberra who provide counselling, mental health, social work support and tutoring to children who are having trouble at school in the context of family violence—a whole lot of providers who operate at our reduced rates, compared to market rates, in order to assist people in their own community. Those delays are about us not being able to keep enough approved providers on the books so that timely counselling is available.

MR BRADDOCK: I imagine those delays are also having negative therapeutic impacts for the individuals, their families and community.

Ms Yates: Indeed. We are glad that our case coordinators can assist people with a broad range of practical support measures whilst they might be waiting to see a counsellor; nonetheless those delays certainly mean that we are missing the opportunity for early intervention.

Something that would assist us in that regard is for the hourly rates that we pay to those providers to be increased, to be closer to market rate. For example, if we could compete with NDIA payment rates for various professionals, we think more providers might choose to work with victims of crime under the Victim Services Scheme. That is something that we have put to government for consideration.

THE CHAIR: How is your relationship going with emergency services and police? Are there any ways to make that as smooth as possible, or are you fairly content with

that interconnection in terms of providing this ongoing victim support?

Ms Yates: Do you mean specifically in relation to motor vehicle collisions, Mr Cain, or more generally?

THE CHAIR: It can be any trauma, but a motor vehicle collision and either serious injury or death is obviously not a bad case study. Is everything working and are the different agencies and arms of support working well enough together?

Ms Yates: We certainly receive a steady flow of referrals from ACT Policing, either directly or through the Support Link portal. There are times when we receive a referral some time after an incident and, when that referral comes through, it appears that consent was in fact given by the victim to police for a referral much earlier on. We have spoken to police about that, in terms of making sure that that referral comes in in a timely way, particularly when it has been in relation to a significant traumatic incident.

Further, we continue to provide education and outreach across each of the ACT Policing stations so that they are aware of what we can provide. Although we are a small jurisdiction, there are lots of different options available, and police are not always across the breadth of help that we can provide, so we are always looking to strengthen that referral relationship.

THE CHAIR: Do you have regular briefings or catch-ups with Policing and emergency services to make sure there are no misunderstandings or gaps?

Ms Yates: Absolutely. Most days I am speaking to a senior member of ACT Policing across one of the teams. I meet with the three commanders each month and speak with the Deputy Chief Police Officer or the Chief Police Officer as required. We have those standing meetings, as well as a very collegiate approach to picking up the phone when something does not seem quite right, or where they would like our office to assist on an urgent basis.

THE CHAIR: With that example you gave where consent had been given earlier but it was not identified, can you provide some detail on how that process happened and how it was overlooked, from your point of view?

Ms Hickman: At this point, unfortunately, not necessarily. It is something where it would be most appropriate for us to workshop with the different officers and the like, to see what the breakdown may have been, because we are not particularly sure. Given that we get most of our steady flow through Support Link, there could be any number of reasons why there may be a small delay. It may be that there are alternative options for referrals in instances where someone is deceased that should come directly to our agency, for instance. That is something that I am sure Heidi and I can work through, to ensure that the referral pathways for these traumatic incidents where, on balance, it arises by virtue of the commission of an offence, land in our lap as quickly as possible.

THE CHAIR: Are you happy to take that on notice and respond to the committee with your understanding of how that gap—

DR PATERSON: Maybe we can ask Policing.

THE CHAIR: We could ask the police, of course, but you have mentioned it as something that you identified.

Ms Yates: Mr Cain, it probably goes to management of individual cases by individual officers who may not have put the referral through in a timely way, as opposed to any systemic issue. The second thing I would add is that, whilst it has been for almost a year that we have been able to assist this broader cohort of victim-survivors, that still may not be known by every ACT Policing member. That is something that we absolutely want to work on with them.

THE CHAIR: Obviously, it is ideal, if someone gives consent for a referral, that it happens immediately.

Ms Yates: Yes.

THE CHAIR: It does not need to happen a second time.

Ms Yates: No; it can just occur once, for it to come to us. In significant traumatic incidents, it is not unusual for a senior police officer to pick up the phone to us and say, "I need you out at a house", "Can you speak to this family later today?" or "The family are overseas; can you contact them?" We are grateful to have those informal referral pathways, as well as the SupportLink pathway.

DR PATERSON: I want to refer to the gap that exists once you get the referral. There is also what occurs from the accident scene; there is a case study, and SupportLink's submission was very powerful and demonstrates that sort of immediate, on-the-scene trauma support. Do you think that, if we had that service in the ACT, when victims get referred to you and get to you they may be marginally less traumatised by the process of what they have had to go through? Do you think it would be of benefit to victims that you are working with, from the point when you meet them?

Ms Yates: I am reflecting also on the submissions of Ms Jago and Mr McLuckie to the dangerous driving inquiry, which absolutely highlighted that gap in support. Also, our ACT Policing colleagues make clear the impost on officers where they have to attend to their primary investigatory functions and care for a victim-survivor or a witness, and the impact that can have in relation to their mental health and wellbeing and, indeed, the contribution to burnout, which we absolutely need to attend to. I think that, absolutely, there appears to be a gap there around attendance at incidents and rapid assessment of whether, for example, they would be eligible for our service or support from one of the other agencies that JACS detailed in their submission around those bereaved by suicide, for example.

As our SupportLink colleagues mentioned, it is not entirely clear what kind of service would best address that gap. One of the things I have spoken to my police colleagues about is whether the notion of expanded resourcing of their victim liaison officers is an option for filling that gap, noting that I understand at present their VLOs are on a two-shift roster; they do not have coverage overnight.

If it is police who are primarily attending these traumatic incidents in the first instance,

or emergency services, is it more efficient to have trained victim responders come out with police, attend, work alongside those investigators and do the follow-up which they so often do in relation to crime, or is it better that we have an independent community organisation providing that service? I certainly do not have a settled view, but I would agree that there is clearly a gap in terms of attendance at the scene of traumatic incidents which is impacting victim-survivors, witnesses and our police and emergency services colleagues.

MR BRADDOCK: Whilst you do not have a settled view as to who might be the best ones to provide the service, do you have an idea of the pros and cons of the expanded VLO support unit or independent community organisation that would provide that service?

Ms Yates: There are a number of things that we have considered in that regard. One of them is noting that we understand issues of potential duplication were raised when government chose not to step in and fund the SupportLink service some time ago. I think it is important that whoever is attending at that time is well positioned to connect victim-survivors or witnesses with an appropriate service which can then be with them, often long term—and often might be working with people for three, four or five years. We want to ensure that, if we are funding a new service, we are not duplicating services.

One of the strengths of expanding VLOs is that, of course, police are one of the few 24/7 services that currently operate in the ACT. Expanding that shift might be a more straightforward process than creating a 24/7 roster. Obviously, any VLO who was not called out to a traumatic incident but was on duty would be attending to core victim support work in that time. Nonetheless I am sure that our SupportLink colleagues and others might know of other matters we have not yet considered regarding why having a community service is more suitable. I would certainly be open to considering any other matters they might raise.

MR BRADDOCK: In terms of the handovers that might happen between a VLO and your service or a VLO across to coronial inquiry and support services, what are the impacts of each handover, and is that a problem or is it quite acceptable to recognise that another organisation is the best fit to provide the support that a particular individual needs?

Ms Yates: I think victim-survivors are very clear that anything that can be done to minimise them having to tell their story and build rapport with multiple services is important. The question is how quickly the right service can connect with someone. By the right service, I mean the one that can give people the most choice in relation to access to specialist services that may best fit their needs.

If we are looking to fill that gap, some of the primary principles we should be examining are about how we make sure that an accurate assessment is made very quickly as to whether there is a funded long-term service that can work with that person and how warmly we can connect that person with that service.

As a small jurisdiction, I think we often do that well. If someone has encountered someone who is eligible for our service in the community, if they call us up, we do not say, "Send us an email." We will say, "Would you like to come in and meet with us and

have a cuppa?" That person might come in with a victim of crime; we have a discussion about how we can help and their needs, without it being a bureaucratic handover of the client.

DR PATERSON: One of the suggestions in the government response, around a recommendation to urgently fund an on-the-scene trauma support service, was that there are services like Access Canberra, mental health or Lifeline that people can call. Are you able to speak to whether they are appropriate services at the time of an accident and an immediate trauma occurring? Do you need a person there, to be with people?

Ms Yates: I would say that, at present, the option of having a person there is not available. Whilst it might not be required at all times, we would say that, in many cases—and you have certainly heard from those victim-survivors who have provided submissions to this committee—it is important to have a point person that is there for them—not undertaking an investigation or providing paramedic support but there for them.

Of course, our specialisation is with people affected by crime. When they get to us, whether that is a couple of hours or many years after an incident, there are a broad range of supports we can offer to them that they can choose from, depending on what they need. But in the context of some of the other services highlighted by JACS, we would note that a number of those provide phone calls only, which may well meet the needs of some people, but we think that the in-person support is crucial at that initial moment, for many.

Ms Hickman: And I would, in particular, note the submission of Mr McLuckie, whose primary information need at the time was information around the investigation—not necessarily something that the police could offer but just more information. As wonderful as the services that JACS have identified are, they cannot necessarily address that gap that Mr McLuckie and, indeed, other submissions were talking of. That gap is a more specialised and tailored assistance where they are able to see the relevant stakeholders and what is occurring, and they are able to have an individual there present who knows who is there, what is happening and can assist with those immediate information supports. That is something that, in particular, Mr McLuckie called for, and he should be listened to. It is nuanced.

DR PATERSON: Again, going back to SupportLink's example of a scene at a house after an accident, where of course many people were turning up, there were lots of children there and very raw trauma was being experienced by many—33 people I think they say were impacted. Those 33 people would not come to you and to your service—so, again, just to speak to that gap. They are all probably, in different ways, looking for information and experiencing that incident in their own way. Having someone at the scene there addressing the family's needs at that time—how critical is that?

Ms Yates: I think our policing and emergency services do their absolute best at those points in time. I am sorry; I do not have that scenario at the front of my mind, so I am not exactly sure. If a crime has occurred—for example, there was a road collision causing death last week—it is not unusual for us to work with a large number of witnesses. There was an incident at the airport last year where we had a very large number of witnesses to a criminal offence. Whilst we are certainly able to assist large

cohorts of people affected by a single incident, if there has not been a crime then our service cannot assist. Again, we assess on the balance of probabilities and are always mindful to step in where appropriate to assist people, but that notion of having someone there who can work out what is going on and connect people with the right people, I think, is really important.

DR PATERSON: I have a question regarding the coronial process. Again, we have heard from victims before about the length of time that process can take, and I am interested in the level of support your office provides victims through that process. Does it need to be sped up? Is it taking too long and having quite detrimental impacts on families?

Ms Yates: Yes. I would note that I have had the privilege of working with the Coronial Reform Group and the Alliance for Coronial Reform, composed of community members who have lost a loved one and gone through the coronial process, throughout my time as Victims of Crime Commissioner in the last six years. There are many aspects of the coronial process, including the coronial court, which families say could be reformed to ensure that the needs of families are better met, but also the needs of those working in the system.

At present, if someone is eligible under the victim services scheme, where there is a coronial that includes investigation of a criminal offence, then those families are often connected with our office and we are able to provide assistance through criminal, civil and coronial proceedings, often over a number of years. But, at the moment, we have inequity for those families where there is not a related criminal matter, and they are still having to navigate coronial proceedings.

There are clear calls from the community for services to meet the gap for those families, whether that be by an expansion of our office's functions or by the establishment of a specialist service. We acknowledge the good work of the Relationships Australia coronial counselling service. We acknowledge that they also experience significant delays and limitations in meeting families' needs, due to the funding remit that they have.

This is an area that absolutely needs attention. I know our dedicated coroner, Coroner Archer, and our Chief Coroner are very interested in looking at what can be done to address delays and other matters. It is certainly a priority issue for many in the community.

DR PATERSON: Working with victims of crime who have families who have been bereaved from a motor vehicle accident, are you able to speak about them going through the coronial process? I understand they need the death certificate, often, to engage with motor accident insurance claims and the agency process. How difficult and lengthy are those processes for your clients in that situation?

Ms Hickman: It is very dependant. I understand that community members have advocated very strongly in relation to the bureaucracy around the death certificate, and there may be, as I understand it, some reform in how information is obtained and moved through as a result of both the review and advocacy in that element. There is a bit of ambiguity as to how one obtains the relevant evidence base to establish that there is a

bereaved. Indeed, I do not think anyone particularly knows at this point, but I do not understand that it needs to include a coronial inquest or any coronial process, or indeed a criminal matter, in order to obtain that.

It is simply a significant difficulty that some of our clients have experienced. We speak to that in our submission as to that being simply a difficulty with complexity that seems to require either a little bit more information as to how one does it, or, better yet, remove that requirement as a burden on the family members of recently bereaved. But I am unsure as to where that is at, at the moment. One would only hope that that requirement would not sit on the shoulders of recently bereaved; however, I do not understand that it is connected to the coronial process.

Ms Yates: Absolutely, community members are quite clear that having a single support service—going to your question, Mr Braddock—with them through the negotiations with MAI, through the giving of evidence in criminal proceedings and through the coronial process can make a real difference.

DR PATERSON: Western Australia provided a submission. They have a service called Injury Matters that looks specifically at road trauma and immediate trauma support. Do you think that another aspect—speaking to the inequalities of our system—is to be able to support people, whether they are victims of crime or not, who have obviously experienced significant trauma and potentially many health issues in that? Do you think we should potentially be looking at a road trauma service in itself?

Ms Yates: Again, because our remit is victims of crime, we have not looked at a detailed analysis of who is affected in that cohort. I am aware of the well-resourced WA road trauma services. I think they offer lifelong counselling from the get-go, and I recall someone indicating that either funds from red light cameras or speeding tickets go directly to that organisation, so it is great that they have those stable resources to draw on. We are a small jurisdiction and without further analysis of the volume of people who are in that cohort who are not eligible for other types of support or services. It is certainly not an area of our expertise.

THE CHAIR: Thank you. Is there anything you would like to add in closing?

Ms Yates: Again, I would reflect that it has only really been the voices of lived experience, I think, that have driven the committee's important attention to these issues. I acknowledge those individuals who have come forward to tell their own stories and to call for a better system for others. We would not be here without them.

THE CHAIR: On behalf of the committee, I would like to thank you both for your attendance today. The committee will now suspend proceedings.

Hearing suspended from 2.37 pm to 3 pm.

LUKJANOWSKI, MS SANDY, Chief Executive, Injury Matters

THE CHAIR: Welcome back to the public hearings of the committee's inquiry into immediate trauma support in the ACT. Witnesses are to speak one at a time and will need to speak directly into the microphone or your computer for Hansard to be able to hear and transcribe you accurately. Proceedings today are being recorded and transcribed by Hansard and will be published. Proceedings are also being broadcast and webstreamed live.

When taking a question on notice, it would be useful if witnesses used these words: "I will take that question on notice." This will help the committee and witnesses to confirm questions taken on notice from the transcript. We welcome witness from the Injury Matters group. I remind you of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement. Witnesses must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly. Could you confirm that you understand the implications of the statement and that you agree to comply with it?

Ms Lukjanowski: Yes, I understand and agree to comply.

THE CHAIR: Thank you so much. We are not taking an opening statement, so we will just go straight into questions.

Ms Lukjanowski: Sure.

THE CHAIR: I note your comment in your submission that you are not necessarily very familiar with the ACT trauma support scene, but we heard a bit earlier that you have a fairly embracing and comprehensive scheme in WA for assisting victims, families, witnesses, and even officers and emergency service workers—

Ms Lukjanowski: Correct.

THE CHAIR: —from the scene of a major incident where trauma is involved. Could you explain in summary for the sake of the hearing what service that is?

Ms Lukjanowski: Yes, sure. One of our flagship programs at Injury Matters is called the Road Trauma Support Service, and within that service is exactly what you just mentioned there. We provide support to absolutely anybody located in Western Australia, or residing in Western Australia, who has been impacted by road trauma. It could have been at any point in time, and it is irrespective of blame and judgement, and also irrespective of level of involvement.

We see everyone from a volunteer first responder or paid first responder right through to somebody that provided some first aid or was first on the scene, witnesses that drove past, family members caring for people post-incident and people that have lost loved ones, and everything in between. People can come and see us for as long as they need to, or they can re-engage with the service as they need. Our aim is always to work in that restorative capacity so that they can get back to their daily activities and living, and get back to work and to being productive within the community; however, we remain

available to them should they have difficulty at anniversaries or other difficult periods along the way.

THE CHAIR: You are not for profit, so where do your funds come from to provide this service?

Ms Lukjanowski: We are funded for the Road Trauma Support Service via the WA Road Safety Commission. Those funds specifically come from what is called the trauma trust account in Western Australia, and they are funds that are accumulated through traffic infringements in Western Australia. We receive a small proportion of the funds that come into that particular account.

DR PATERSON: We conducted an inquiry into dangerous driving last year, and it has definitely highlighted the lack of immediate trauma support available to people navigating those situations; but we just heard today from the Victims of Crime Commissioner. The commission supports people who have been the victims of crime where a death has occurred on our roads. I note in your submission you have looked at the ACT stats, where, in 2021, 740 people were injured. Can you speak to the level of trauma that those 740 cases may experience and the level of support that your service provides to people in equivalent situations in WA?

Ms Lukjanowski: Yes, sure. Essentially, we work within a trauma-informed model, and it is person centred, so we work to enable the individual. Some people might get what we call a brief intervention. That is really based around mental health first aid and giving that first level of intervention just to normalise what is going on for that particular individual so that we are starting that help-thinking conversation. Of those people that are directly impacted, there are up to 29 per cent going on to develop things like PTSD.

Then you have your secondary cohort, which is what you were mentioning before. We refer to it as that ripple effect. It is all those people just very slightly to the side, but there are significant impacts to these individuals. There are significant changes in relationships and family dynamics, whereby we might see people go from being a partner or a wife to a primary caregiver, and that can change things quite dynamically.

We see with those particular individuals that it is a bit tricky. It can be a bit of a "how long is a piece of string" because some of those people might have other issues that are congruent to that. Therefore they might have a more substantial impact than somebody that may be directly affected. But generally they make up a very significant proportion of the people that are directly impacted, because for every one person that is impacted you have a handful of people around the edge that either saw or were involved in the actual crash or are involved in directly supporting that individual post the crash—their family members—and vice versa. There is a lot of complexity to it; however, we do evaluate, and we do look at that data, so if any of that is of help to you, we can give you that within a West Australian context.

DR PATERSON: That would be very helpful. Do you provide on-the-scene trauma support?

Ms Lukjanowski: No, we do not. That is one thing that we do not provide; however,

to complement our overall service offerings we have some things that are more based within health promotion. That is where we look at minimising some of the harm and looking at ensuring that there is no further injury or what goes on to be subsequent long-lasting injury.

It is generally a lot of regional communities that we see. WA is a big state, so we tend to go out to regional communities and our work is more community based. We sort of post up out there. We will see people on the ground, but we will do more work at that community and local government level. We do a lot more of that as opposed to attending a scene, or we have been to a couple of different incidents where it has not been long after quite a critical event.

One of the last ones we went to was where some young people from a school community were lost. We went down there to provide some extra support, but a couple of weeks after, because at first, obviously, in that circumstance schools bring in their own psychologist teams to be able to give support. We came in as that sort of support had quietened down, to provide not just to the students impacted, but to the wider school community as well.

MR BRADDOCK: I suppose I have a question in terms of the business hours of the operations you have there. Is it just a 9 am to 5 pm, five-days-a-week sort of operation, or is it more extended into evenings and weekends?

Ms Lukjanowski: Yes, that is what we are at this point in time. We run the normal band of business hours, which is about 8.30 to 4.30, Monday to Friday; but during the evenings we always have quite a clear message that we make sure that we leave on our voicemail, which directs people to more crisis-based services—Beyond Blue and Lifeline, as well as mental health supports directly at WA hospitals. I would not describe us as an acute, in-the-moment service; however, if someone calls us in distress during our normal hours, we do seek to speak to them and follow that duty of care to ensure that they get to safety and are getting the support that they need for that moment.

MR BRADDOCK: Do you provide any specialised supports for emergency services and police workforces, in terms of how they deal with road trauma?

Ms Lukjanowski: Yes. We do a couple of different things. As I mentioned before, we have some of those complementary programs that go alongside. We do some training that is particularly aimed at professional first responders. We recognise in WA—and I am not sure whether it is a similar issue over in the ACT—that even for something as simple as notifying of an adverse outcome or a death, the training that is given to police is not extensive. And that also helps them in delivering the message. However, it does not necessarily completely focus in on the self-care that they may need. So we provide some different course works that can assist with that. We do a lot of different sorts of education programs that support people with that.

Again, with WA being quite large—I am not sure whether or not you guys have the same infrastructure or complexity around having a lot of volunteer workforce out in rural locations—we recognised that we needed to put something in place that really supported our paid first responders that are out in regional locations, but there are supporting teams of volunteers. And often there are different complexities that you have.

There are people that are closer to that crash, and may know people connected to that crash. The complexities are quite different. So we have been quite aware of the impacts in rural WA and have done quite a bit of work choosing to focus on that with regards to the educational component that we are able to provide within our contract.

MR BRADDOCK: Thank you.

THE CHAIR: Are you aware of how other states or jurisdictions provide similar services? And are there any lessons to be learned from other places, do you think?

Ms Lukjanowski: I think so. I mean, it has been interesting. I have been with Injury Matters for just over eight years, and directly involved with the Road Trauma Service for that period of time. And it has been tricky. What I have seen is a lot of different services come and go through different states. A lot of them would get up and get going, and they would obviously be volunteer based at that particular point in time. But they hit a wall at a certain point whereby they cannot keep servicing, or they are not able to continue or grow the breadth of that particular service.

We have quite a good relationship with Amber Community, which is over in Victoria, and it provides quite a similar model to us. However, theirs is a little bit different; they have some slightly different constraints with regard to the people that they are able to see and for how long, and some of those different bits and pieces. We have been quite fortunate here in WA that we have the ability to service the people that are coming to us, and we have not had to start limiting visits or anything along those lines. In the future it may be something we need to have a look at but for now we are able to service the need as it is.

I think there have been lessons about continuing to build a network across states and continuing to share information. We share resources, and I guess that is one thing that is definitely available to anybody impacted by a crash across Australia, irrespective of whether your state has a service. Each of our agencies ensures that we have resources that are easily accessible so that any consumer in Australia can hop onto our website and have a little look at certain resources. We have everything, from what to do after a crash, to supporting a child after a crash—all sorts of different types of resource materials to support people.

By continuing to build that network of post-crash care more broadly across Australia, I think that we could continue to build on that wealth of information. We could share the education and the different resource modules that we are making. I think that we could have an even bigger impact by sharing resourcing and information across states.

THE CHAIR: I have a supplementary question on that. Is there a national covering body for your type of organisation?

Ms Lukjanowski: No. I wish there was. It is a bit of a tricky one. Injury Matters is a bit of a unicorn. There are not too many people that work within that direct injury space. Definitely, we, as an organisation, are having more of a look at how we can provide support across borders and into other states that need things.

I am sure you guys hear this all the time. Every sector will come and tell government

that they need more money, and they need more funding. I completely understand. I know that injury is a particularly difficult one because we kind of fall through a lot of cracks. In this instance there is a bit of mental health, there is a bit of transport—there are a whole heap of different elements at play—so it can sometimes be tricky to get something in place to really be able to support what is needed.

We have gone for grants in the past that have been national. Previously we sought a grant from the National Heavy Vehicle Regulator to provide some post-crash care to truck drivers and heavy vehicle operators, just as an acknowledgement of the fact that the road is their workplace. We are seeing an increasing impact to heavy vehicle operators, with an increase in vehicular suicide and people choosing to have crash events involving those large vehicles. But also, just because of their prevalence around Australia they are often first on scene. A lot of different companies are seeking to train them in trauma, care, and all sorts of different things. It is quite scary to think that somebody that just wants to drive from A to B and do that great job for our country might happen across a really traumatic situation and feel that they need to respond.

DR PATERSON: We have heard a lot from victims in the ACT around how challenging the motor accident insurance agency is for them to navigate—

Ms Lukjanowski: Yes.

DR PATERSON: —and I noticed in your submission that you speak to the role that you play, in terms of your equivalent insurance commission in WA. I was just wondering if you can go into more detail about that, and what works and what does not work in WA?

Ms Lukjanowski: Yes, sure. I will give you a really brief overview of how our system works here. I am not sure if Canberra—the ACT—also has a catastrophic injury scheme and similar types of things. That is all run through the insurance commission of WA. But then some of those third-party claiming types of mechanisms are also done via that.

So we will often have Injury Matters and the Road Trauma Support Service as a referral pathway. A part of the support that a particular person might be getting as part of their rehabilitation post road crash is they may be referred to our service. They will come and have their visits with us and, potentially, if they are entitled to any kind of a settlement through the insurance commission, the insurance commission will work out whether they feel that there should be some further road trauma support or anything of that nature. So, rather than paying a private organisation, they pay Injury Matters, and we do it at—not the private rate; I am sure the private rate is even higher—that minimum WorkCover kind of rate, for us to provide the service. What we do with that money is that we put that back into purpose. That is what we use to continue to build more of the work that we do to support our first responders, and it supports a lot of our regional work even further. We are funded to get out to each of the regions, but that gets us out there a little bit more and helps us to engage. It sort of puts money back into it, so it really helps that to work a lot better.

There is another thing that we support. Our Catastrophic Injuries Support scheme is for mental health support and that does not extend to the loved ones—a family member. That is where we really come in under the road trauma support banner, and we are able

to say, "You guys support the person that is catastrophically injured. We can help take care of mum or dad or partner, or whoever that might be." Because obviously they have an extremely long journey ahead of them, too, and their support is critical as well.

So working alongside ICWA has really helped to build those pathways so that we are supporting people more holistically all the way around. I guess, from there as well, police, ICWA—the insurance commission—and ambulance drivers are our biggest referral pathways. And then obviously people love a bit of Google these days, so a lot of people find us that way now, which is really good. But they are really our most utilised referral pathways at this point in time.

DR PATERSON: Thank you.

MR BRADDOCK: I am interested in how Injury Matters refers to WA victims support services and coronial support services, and just how that interfacing works, given the number of different services that might be assisting the individual who has been affected by a road trauma?

Ms Lukjanowski: In terms of our relationship with people like victims of crime and coronial services, we are a referral service for them. A great deal of people may come through, and they will say, "Road trauma support would be able to see you," and send them our way. That is how most of the traffic is directed. We do definitely direct back the other way. If we find out that somebody is going through a court case, or there are a few other bits and pieces happening for them as part of their work with us, we are able to say, "You know, you can go back and talk to Victims of Crime," and we can connect in that way.

And I guess the other thing, picking up from the last question a little bit, is that we also built that mechanism to be able to give feedback back with the boards—that is something really important—and with the insurance commission. We often go back to say, "A person feels really intimidated by this particular part of the claims process or this particular expectation. Do you have further information for us so that we can better explain this or let this person know where they will be able to get some information, so that they feel more able to engage in that part of the overall process or system?"

MR BRADDOCK: Is there much interface between yourselves and the police, in terms of supporting people as they go through police and judicial processes?

Ms Lukjanowski: Yes. There is quite a significant amount. We get a lot of referrals directly from police officers—so much so that we have a third-party referral pathway. And that is for people that they might have spoken to roadside. We have a little wallet card that police carry—it is just a small one, but it folds out—and that pretty much gives the person the first bit of information that they might need, not too long post-crash, about how to contact us and other related services. Ultimately, we do support people while they may be incarcerated. We can support people through that process. We can support the families of people that might be incarcerated or going through the court process, and we are also able to support professional first responders if they feel they would like to get support based on what they are doing as well, and we align with their help.

We have actually done quite a lot of training as well with—I am not sure of your equivalent over here—what we call Main Roads over here, which are the people that mainly work on the highways and keep them in good repair. They often have to move on-road crashes. We have got a couple of tunnels, and they have to keep them clear. So we have been doing more work with some of those maintenance types of organisations as well.

MR BRADDOCK: Yes. Thank you.

DR PATERSON: What percentage of the people that seek support through your service would be witnesses to accidents?

Ms Lukjanowski: I would have to go away and have a good look at that if you wanted a percentage. I would be able to give you at least a rough idea.

DR PATERSON: Yes; just a rough idea is fine.

Ms Lukjanowski: The last time that we looked at that data, I was aware that it was around one-third, and they are the people that spend the least amount of time with us. Often, they only need what we would call a brief appointment—that small, quick appointment that really works on supporting and normalising what that person is feeling there and then. That is a pointed access to resources, and we will often then send them some specific resources based on what their conversation was. Only a small percentage of them would then move through into formalised counselling.

MR BRADDOCK: Sorry to jump in with a question. What sort of time delay would it take for you to provide that initial consultation?

Ms Lukjanowski: We try to do that very quickly. Most of the time, actually, we do it on the day. So if the person is available that day, we will talk to them that day. The absolute worst I have heard it being, during a bit of a busy spell just before Christmas, we were three days out. So we try to do them quickly and timely, and we also make sure that they are all clear before Christmas. We obviously finish up at that Christmas break, but we work with our clients so that they are ready for that little break during that period. They have their appointments up to and straight after, but we also make sure that there is no backlog before we go so that everybody has had some form of care, and we know that they are in a good place, or they know exactly where they can go if that should change for them.

THE CHAIR: Looks like we are pretty much done here. Is there anything you would like to say in closing?

Ms Lukjanowski: I think we have pretty much covered a lot of it, but I would definitely say that it is really, really valuable to have a look at the importance of supporting people. People's mental health after trauma is vital. The outcomes are really easy to measure in terms of people being more engaged with restorative programs and able to move back to their pre-community activities, post road trauma. So I think that is a really valuable investment. I do understand that it can be a bit tricky to work out all the mechanisms, but it is definitely a very valuable opportunity to be able to support people within the community and has positive outcomes.

THE CHAIR: Thank you. Just for your information, our process here is that the committee will produce a report. The government has up to four months, I believe, to respond to that report and to our recommendations. This particular inquiry is a bit of a follow-up from an inquiry that we did into dangerous driving in the ACT, and all of this material is publicly available. I am not sure if you are aware of where all that sits, but perhaps our secretariat could send you the links for your interest.

Ms Lukjanowski: That would be great. Yes; that would be wonderful. We have definitely found the landscape really interesting. We will definitely be watching out, seeing what you guys go on to do, and hopefully Injury Matters will be in a position to put our hands up, should something come out in future, to say that we would love to help out in some way, shape or form.

THE CHAIR: Thank you very much. I am not sure there are any questions taken on notice. No. Again, thank you for your attendance today. We will have a very short break until our next session at 3.30.

Short suspension.

BOUDRY, MR DOUG, Deputy Chief Police Officer for the ACT, ACT Policing
GENTLEMAN, MR MICK, Minister for Business, Minister for Fire and Emergency Services, Minister for Industrial Relations and Workplace Safety, Minister for Multicultural Affairs and Minister for Police and Crime Prevention
PHILLIPS, MR WAYNE, Commissioner, ACT Emergency Services Agency
JOHNSON, MR RAY, Acting Deputy Director-General, Justice and Community Safety Directorate
DAVIS, MS MEGAN, Acting Assistant Commissioner, Corporate, ACT Emergency Services Agency

THE CHAIR: We welcome this afternoon the Minister for Emergency Services and officials. I will remind witnesses of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement. Witnesses must tell the truth. To give false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly. Could you each please confirm that you understand the implications of the statement and that you agree to comply with it.

Mr Boudry: Yes, I understand the statement and agree to comply with it.

Mr Gentleman: Yes, I understand the statement.

Mr Phillips: I understand it as well.

Mr Johnson: I understand.

THE CHAIR: Thank you very much. We are not taking opening statements, so we will go straight into questions. Minister, I refer to the government response to the dangerous driving inquiry and recommendation 22 of that inquiry. I will read the recommendation in full. It is not very long:

> The Committee recommends that the ACT Government urgently fund a trauma service that is available at the scene of an accident and a 24 hour hotline to help victims and their families.

That was a recommendation of this committee with respect to its inquiry into dangerous driving. The government response was to note that recommendation, but I draw attention to a particular statement about ACT Policing:

> ACT Policing submitted that it was extremely difficult for police to offer trauma support at the scene of an accident due to their primary role to investigate.

Minister, how do you respond to that concern expressed by ACT Policing, of which you are minister? Are there any plans to improve that concerning situation?

Mr Gentleman: Thank you, Mr Cain, for the question. I acknowledge, firstly, that we may have people that have been in a trauma incident listening to this inquiry, and our thoughts go out to them as they recover from those traumatic instances. That includes, of course, the families of those particular victims, our frontline emergency responders, policing, ACT emergency service members and witnesses to those events. Our thoughts

are with them as we answer these particular queries for you.

It is important, of course, that we do have a response, where necessary, Mr Cain, and the government's submission to your inquiry does highlight that. Whilst police can do the best they can in responding to an incident at hand, they often have a dual role. One role is that they have to respond at hand providing as best service they can in that emergency, but then, later on, they may have to do different work around that particular response. I might ask Mr Boudry to enhance on how it feels on the frontline for police who work through that.

Mr Boudry: Thanks, Minister. In relation to police response to incidents such as road trauma, often we have not only traumatised victims but also traumatised witnesses and, potentially, family members. Also, as the minister pointed out, there is the frontline emergency services, including police and fire and ambulance, that may be involved in any response.

I think in terms of a police response, there is that dual role in terms of not only managing the incident and the follow-up investigation into that but also the challenges of dealing with trauma. Obviously, dealing with trauma is a very specific skill set in those sorts of incidents such as fatal accidents. Police can do the best they can on that, but there is a challenge in terms of making sure that that is coordinated to ensure that the proper support services are in place for the victims of that trauma, whether they be family members, the actual victim or witnesses.

THE CHAIR: Is it the view of ACT Policing that that immediate trauma support is not there?

Mr Boudry: I think from an ACT Policing perspective there is a gap in that at the moment. Police do the best they can. In terms of dealing with it, as it stands at the moment, we do the best that we can, and it is an expectation on our officers that they can do it or that they do do it. Is it the best way? There are probably models that could be explored.

Mr Gentleman: Police are there immediately, usually, at the scene of that trauma. They provide that immediate response, as they are the first responders. If it is not police, then it will be either paramedics or our fire and rescue service, and they have similar training as well.

But I think what we need to look at is that gap immediately after the very first response. And when we look at trauma, it is that experience you see, as you indicated, at a road accident, for example. Whilst police can do the best they certainly can, there could be the gap immediately afterwards. Referrals can occur almost straightaway. We can refer victims and/or family and friends to referral agencies that can take up the secondary response to the trauma, but that immediate response is normally from the first responders.

THE CHAIR: That referral obviously means there is a later, subsequent session, perhaps with a counsellor or professional, but not at the scene, which obviously still leaves it in the hands of the police to manage that. Is that the case?

Mr Gentleman: That is correct, yes.

MR BRADDOCK: You are saying they do the best they can. Is the limiting factor here the skills and training for the police and emergency services, or is it the structure of who they are and the roles they are fulfilling, or is it the resources and availability at the site that is the limiting factor?

Mr Boudry: I think there is a range of aspects to that. If you have a look at what the role of police is in something like a fatal, the primary role is to actually respond to the incident and actually investigate what has occurred.

In terms of dealing with trauma, I think you would find the Victims of Crime Commissioner—I know from talking to her that dealing with trauma and grief is a more specialised skill set. It does not necessarily sit with police, and I would not propose that you get a frontline police officer being expected to be trained not only in the investigation but also in terms of being able to manage and deal with grief and trauma. Also, in terms of capacity, depending on the size of the scene and how complex it is, that resourcing implication may come into effect—depending on how large and how complex the scene is.

Mr Johnson: Perhaps, if I may, I will expand on that. One of the potential challenges at the point of the scene, where it is happening, is that everybody's needs may be different. It could be a psychological need. It could be an emotional impact. It could be just navigating the system and the processes. And not everyone needs ongoing trauma support. I am saying there is a lot of people who will move through those phases with the support of their family rather than, necessarily, professional support.

I guess the challenge for policing, particularly, is establishing the scene, being able to work like humans do with humans at the scene, and then connecting people with whatever service they most need, but they might not necessarily know they need them at that point either. I think sometimes it takes a little while for you to understand what your needs are post the event.

DR PATERSON: Having been part of the dangerous driving inquiry, this was so strongly identified by victims and we are just defining it now. I want to speak to the submission of the government that says:

> In the first hours and weeks after the incident, it is important that people affected … have their basic needs met … The provision of this care does not require a specialist, it can be provided by a supportive family member or friend.

It goes on to say:

> Best practice is for first responders to attempt to mobilise existing support networks and natural resilience.

Can we talk about best practice and that, perhaps, that is not best practice and there is a gap? It is not really the role of police to mobilise the family members and then support at a highly traumatic incident where, as we have just said, grief and trauma support is really the specialised care that needs to be provided. Can we speak to the fact that there is a gap and that we do need to do more in terms of best practice?

Mr Gentleman: Yes. I suppose we go back to the activity that police are doing at the time. They are managing safety at a crash scene, for example, offering the trauma support that they can at the time and they are managing the rest of the work that they have to do with regard to investigating the incident at the same time. Then there is the work emergency services do in looking after the victims of the accident at the same time and getting them to a support service, usually at emergency services at the hospital, for example. All of their skills go to—I have not been there, but I would imagine this—managing the trauma of the victims and those involved in the accident in those circumstances immediately, whether it is police or ambulance services, for example, and managing the scene as well, making sure the scene is safe. The secondary part of trauma support probably would not come until a little bit later, and this is why we look at referrals and ask families to support as well.

DR PATERSON: We heard from SupportLink earlier who used to provide the service at the scene. In their submission, they use a case study of a car accident where they go back to the home and manage, as they say, 33 people, basically, over the space of a few days and weeks after the accident. They identify a very clear need for that service. It is before the referral service and it is after police or emergency services respond at the scene. Do you think that we can explore that gap—that there is a gap that we can look at filling and that it is important to fill it?

Mr Gentleman: It is certainly important that the committee hears from all the responders and takes into account their particular input. There are things that you just talked about that we would perhaps not see but they see. In that sense, we would be looking forward to what the committee sees and what the committee would recommend to government.

DR PATERSON: Thank you.

THE CHAIR: I might add a supp to that. That really was the focus of the dangerous driving inquiry, where we had firsthand reports from victims and families of victims. What you are looking for has really been done in significant substance, and obviously that generated our committee report. I will be coming back to this. The government noted the significant recommendation that was really fuelled by the families of victims. It is not that much more needs to be heard, surely. That is a comment. I will hand to Mr Braddock.

MR BRADDOCK: Thank you. Given the ACT government is sending its ACT Policing and ESA workforces into scenes which are challenging, complex, emotive and traumatic, and it seems by the government's own admission that they lack the skills and capacity to effectively deal with some of the instances, how are we meeting our workplace health and safety obligations as an employer towards those workforces?

Mr Gentleman: That is a very good point, Mr Braddock. I, as the work-safe minister, take that on board as well. Police have a very strong support network for their staff that deal with trauma and it is the same with our Emergency Services Agency. They have a lot of systems and work support officers on the frontline to ensure that they can be supported after seeing traumatic incidents. It can take quite some time for that to work through. I will ask Mr Boudry and the team to provide some instances of how that

occurs.

Mr Boudry: Thanks, Minister. ACT Policing has a welfare officer network alongside what we call SHIELD, which is for further services that are available to be given to our members in terms of making sure that they are safe. That includes both physical and psychological treatment in dealing with their exposure to traumatic incidents. I will give an example. Last week, we had a particular fatal which was traumatic, not only for the victim and their family but also for all our first responders. We had a welfare officer on scene at that particular incident responding to the needs of our primary responders to ensure that they were properly cared for and were also referred to any follow-up services that they may require.

MR BRADDOCK: It is fantastic that all those programs are in place, but, surely, shouldn't we have a skilled, capable team that is able to meet all the requirements of such a devastating and traumatic incident—an appropriately skilled person who can deal with witnesses and affected parties' emotions at that point in time?

Mr Boudry: Going to the point around SupportLink, you could look at their submission. Feedback from ACT Policing is highly complimentary of the trial that was done with them. In terms of having an appropriately qualified response, they did provide that and they provided it across an operational time frame that police work to, which is a 24-7 operation. If I were talking from an ACT Policing perspective, having that appropriately qualified response is highly important.

MR BRADDOCK: Thank you.

THE CHAIR: Minister, you have heard all of that. You have the dual roles of workplace safety minister and police minister. The response from the government to the dangerous driving committee report noted the recommendation for an at-scene trauma service. Just to say, "It is noted, and here are some things that can be referred to," surely must disappoint you as both police minister and workplace safety minister?

Mr Gentleman: I must say, I am very confident in the work that ACT police and our frontline responders do across the ACT. That is reflected, perhaps, in the way that the government responded to that report, having identified that there is support there already and that the skills and operational capability of those frontline responders are indeed up to par.

THE CHAIR: No; that is not the point. The point is: how can police be expected to offer specialised trauma support at the scene of an incident? That was the concern expressed, and the government's response was to simply say that police can refer people to a service. We are clearly hearing that having some sort of specialised trauma support at the scene is the most preferred outcome.

Mr Gentleman: That is a position or a point you put. You are referring to a committee recommendation that the government has responded to and you asked me for a position on that, so that is what I responded to.

THE CHAIR: So do you agree with the government response to the committee recommendation?

Mr Gentleman: Yes. You have put forward a position that you feel should be adhered to and the government noting it understands that is your position and that there are responses in place already, which we have described.

THE CHAIR: But, given that other responses from the government to our committee recommendations range from "agreed" and "agreed in principle" to even "agreed because it is existing policy", do you, as minister responsible for police and work health and safety, find it acceptable that the government has simply noted such a crucial committee recommendation?

Mr Gentleman: I do not think there are any semantics in whether it is "noted" or "agreed". It means we understand the position that you have put, and we believe there is a response in place.

THE CHAIR: It is not just semantics; it is the fact that it does not say "agreed".

MR GENTLEMAN: Okay.

THE CHAIR: That is the big difference between noting something and "agreed".

DR PATERSON: Mr Cain, you are debating it.

THE CHAIR: I will hand over to Dr Paterson for a substantive.

DR PATERSON: Thank you. The Victims of Crime Commissioner's office spoke about how they have had an increase in their funding to address people who have had a family member killed on the road due to a crime that had been committed. We spoke to Injury Matters, the WA trauma support service. They see anyone who has been injured on the roads: injured, impacted, witnessed—anyone. Regarding emergency services broadly, I am interested that statistics in one of the submissions said that, two years ago, there were 750 injured people from road accidents in the ACT. Do you see a need for referrals at accident scenes where there has not been a fatality? There could be traumatised people and quite complex scenes as well.

Mr Gentleman: Yes. We would like to see far fewer accidents on our roads. We will see technology change the level of road accidents. Cars are becoming much smarter. There are fewer interventions between cars and pedestrians, for example, than happened years ago. In fact, I chaired a committee quite a number of years ago about vulnerable road users. We were told by ANCAP, which is the Australian crash-rating agency, not to spend too much money on road infrastructure and those sorts of things—barriers between cyclists, for example—because cars will be much smarter and they will not run into pedestrians or cyclists at some point in the future. We are starting to see that now, which is quite pleasing. But, in the meantime, of course, we still need to provide all the safety aspects that we possibly can for those who are potential victims of accidents, including pedestrians. I am pleased to see that we are seeing fewer. The take-up in the ACT of new smart vehicles will mean that we will see fewer more dramatically, in a quicker time frame.

DR PATERSON: Could you speak to the complexities of scenes at accidents that do

not have a fatality but might have a lot of witnesses or multiple people involved—the extent to which we see accidents like that on our roads?

Mr Gentleman: Yes. I will just go back to what I was saying, that the smarter the vehicles are the less chance we have of human error, so the more chance we have of fewer accidents into the future. Getting back to your question, the nut of it is that—

DR PATERSON: To understand the complexity of scenes, where there is perhaps no fatality but there—

Mr Gentleman: The trauma involved for the witnesses and the people involved in the accident is real—for sure—and we see that. That is why we have the backup services as well—to provide later support after the accident has occurred. There are a number of services that can be referred to in order to assist people who have been involved in a traumatic incident.

Mr Johnson: I can expand on that. When you are talking about witnesses, not all of them always stay at the scene. You might well find that a number of witnesses left the scene, either before police arrived or subsequent to police taking names, and went about the rest of their business. Their needs potentially transfer; they are just not at the scene anymore. The machinery that needs to allow them to get access when they need it and where they need it is an important consideration.

DR PATERSON: Again, police are not necessarily the right people to respond to witnesses at those scenes, but those people may actually be quite traumatised from a scene and therefore need trauma support.

Mr Johnson: Potentially. As I said, it may be that some of the witnesses left the scene before police arrived, so police would not have even made contact with them. Maybe the contact with police is quite subsequent, so their need is actually separate to any response, for want of a better way of describing it.

Mr Gentleman: We have made some recent amendments to the Victims of Crime Regulation 2000, which have increased the range of victims eligible for access to support under the Victim Services Scheme. That now includes family members of victims who might have been killed in a motor vehicle accident or accidents involving an offence, for example. We have certainly made some changes along the way.

MR BRADDOCK: Just to ensure that any recommendations the committee comes up with do not duplicate what already exist with the victims of crime team or the victim liaison officer role, do they have any part to play, particularly around dealing with traumatic scenes and road safety issues, that we should be aware of or should consider before we make any recommendations?

Mr Gentleman: Yes; there are certainly the roles that they have. I do not have the detail in front of me. Mr Boudry?

Mr Boudry: Thanks, Minister. First, in terms of victim liaison officers, we have a capacity which does not duplicate what is in victims of crime team. We particularly have a good working relationship with the Victims of Crime Commissioner essentially

around how we refer cases to them. I note that there are sometimes delays in terms of that referral, and that is quite often driven by the fact that you have the dual role for a police officer, trying to deal with the trauma but also trying to deal with the investigation.

In terms of the services and making sure that they are fit for purpose for a particular individual, you can potentially have a witness who has been traumatised by a particular incident and may have a mental health issue. They will require something very different to another witness who does not have that same mental health issue. Are police able to deal with that and specifically work on that? No, I do not think so; that is a more specialised role. In terms of being able to coordinate that with the Victims of Crime Commissioner and her team, I think that works at the moment. But do we need an immediate incident response? Yes.

MR BRADDOCK: That is also reliant on there being a crime or a victim per se. If it is a traumatic incident, would those supports be able to kick into play?

Mr Boudry: At the moment?

MR BRADDOCK: Yes.

Mr Boudry: Yes. We can bring our victim liaison officers out, but I note that it is not always a 24/7 capability as it stands at the moment, so there may be a delay between the actual incident and the VLO capability kicking in. But we do have the ability to also refer through SupportLink at the moment. That is another capability that we are able to use.

MR BRADDOCK: Can you confirm: is it a two-shift VLO arrangement at the moment? What business hours does that cover?

Mr Boudry: No. It is generally a business-hours capability for us at the moment, but we can work with those individuals too.

MR BRADDOCK: Thank you.

THE CHAIR: Minister, we seem to have talked about the role of police at these sorts of incidents, but I wonder if emergency services would like an opportunity to share their own experiences and the challenges they face in the same sorts of situations that police and victims would find themselves?

Mr Gentleman: For this, we look to the frontline responders, Mr Cain. Police have an operational capability and a protocol that they use when they attend a scene. Safety would probably be the first protocol. Paramedics, for example, with ESA would look to securing the scene for the safety of those who have been injured and those that may need support afterwards. There are a number of operational protocols that work together with ACT Policing, our paramedics, and fire and rescue that would include managing traffic, for example, in some circumstances. I will ask our new commissioner to give you some detail on how that would work.

Mr Phillips: Thanks, Minister. I want to first of all acknowledge that the work that our

ordinary people do daily is extraordinary—things like going to motor vehicle accidents. Our staff, with the good work that we do with the three services, particularly police, firefighters and ambulance crews, work together as a cohesive team to get good outcomes—the best outcomes we can—at a motor vehicle accident. When it comes to my two services, the fire and ambulance services, they are very role-specific. It is about a quick response at the scene.

Ambulance staff are patient-centric. The people in the car or the people injured are at the centre of their attention, treating the trauma, the physical trauma, and then transporting them to hospital as quickly as possible. Our firefighters are geared towards making the scene safe, not just for firefighters but also for paramedics, police and the people trapped in the vehicle, for instance, and also then extracting the person in partnership with the ambulance service. The fire and ambulance services in particular are centred towards the actual scene itself, making the scene safe and ensuring that, once the patient is transported to hospital, firefighters can then make the scene safe. Then our role in that particular instance is seen to be done. Regarding any further role in the area with regard to the vehicle being removed or investigated, traffic et cetera, we leave that in the hands of the ACT police.

THE CHAIR: Thank you. How are emergency service providers, including the ambulance service, coping with being at a traumatic event and perhaps even being drawn upon for some assistance in that area?

Mr Phillips: Assistance with the—

THE CHAIR: By family members—

Mr Phillips: If it is okay, I might hand over to Megan Davis with regard to the role of a paramedic at a motor vehicle accident.

THE CHAIR: Thank you. You will need to indicate that you understand and agree to the privilege statement.

Ms Davis: Thank you. Yes; I acknowledge the statement.

THE CHAIR: Thank you.

Ms Davis: When a paramedic crew arrives at the scene of a car accident, for example, obviously their main role is to identify how many patients there might be at the scene. They will do a quick look around and a triage of sorts to see who has been impacted and to also work out who the patients are. They then will treat those patients at the scene and call for further ambulance support if they require further stretchered vehicles to transport patients from the scene to hospital. Does that answer the question? Was there more to that one?

THE CHAIR: Thank you. There is the experience of dealing with people who are going through some trauma at the scene, whether they are family members who turn up or are there.

Ms Davis: The paramedics will, of course, provide support as best they can under the

circumstances. It is on a very situational basis. If someone is critically injured, they are going to be focused on that person, but they will, wherever possible, provide some support to the bystanders, witnesses and family members; particularly if they have also been in the vehicle, they will have to do an assessment to make sure that they are not injured and they do not need to be transported to hospital as well.

THE CHAIR: Thank you.

MR BRADDOCK: I have a supplementary, Chair. Mr Phillips, can I check whether any of the volunteer workforces, the SES or the RFS, would be called upon to respond to a traumatic incident?

Mr Phillips: Yes; they are actually. We have had some instances in the last few months with regard to assisting ACT police in some search and rescues—our SES volunteers in particular. There were two searches over Christmas time and one search just recently. On the activation of the SES assisting ACT Policing in the search and rescue, we also activate our peer support network. In the last six months, we have doubled the size of our peer support network right across the whole agency. SES is no exception to that. We have SES volunteers who are peer supporters, we have chaplains and we have on-site support. We also have follow-up type support. ESA at the moment has some on-site psychology for all our staff. The psychologist visits volunteer units as well as on-shift fire and ACTAS units, and we also have the referral system through a contract to ensure that our people are looked after to the best of our ability.

MR BRADDOCK: Thank you.

Mr Gentleman: It is worthwhile adding, Mr Braddock, that there is some practice for our volunteers with regard to this sort of work. We have held some demonstration weekends out at Birrigai to basically show our volunteers what can occur at a particular scene. They are very well orchestrated. A lot is worked through the scenes and the scenes are quite realistic. Our volunteers are given a view of what could occur when they go through a search and find someone or what they might see in a road accident, for example. We try to provide as much training in advance as we can.

MR BRADDOCK: Thank you.

Mr Johnson: I will add to that in regard to peer support: I think there is some good research that tells us that some of the best inoculation against vicarious and post-traumatic stress for first responders is peers. The peer support network actually has an effect greater than you would realise than in the context of thinking about them just as peers. Research tells us that that is a really effective way of preventing it, rather than letting it get to a point where it needs treatment, so I just thought that was a useful bit of data for you.

THE CHAIR: Thank you.

DR PATERSON: In the situation of a fire that may have victims and lots of people at a scene, would police be called to that scene as well or does the fire service mange that scene?

Mr Phillips: All emergency services. If we get a call to a house fire, all emergency services would be called. Firefighters, for the obvious reasons, would attend reports of people trapped inside the building or injured as a result of the building. The paramedics would be called as well to assist firefighters with patient care, and then fires are investigated by ACT police. I will leave it to Doug to answer that question, but police would eventually be involved in any fire in a domestic house.

DR PATERSON: So, again, police would be managing the scene and the people—

Mr Boudry: Yes. Essentially, for something like that, we would assign police for the commander to manage the overall response. Obviously that work is hand in glove, as Commissioner Phillips said, with fire and ambulance in terms of that response. Once that has been taken care of from a fire perspective and the premises has been rendered safe, and we have taken immediate care of any casualties within that scene, obviously, there is an ongoing police investigation into how that actually occurred and whether it potentially meets the criminal threshold of arson or something like that.

DR PATERSON: And a supplementary question on the ambulance service. In terms of a scene where someone has had a major medical incident or something in front of family members or at home, when you leave that scene with the patient is there any support for family members who may be quite traumatised by what has occurred?

Ms Davis: The paramedics will normally try to support the family as best as they can. It very much depends on what the circumstances are, but they will provide support to the bystanders or the family members as well. Normally a family member goes with the patient to the hospital as well, so the social workers can be called in at the hospital and support family members as they might arrive at the hospital under those circumstances.

DR PATERSON: If it were just one ambulance there that took the person who needed care and a family member to the hospital, would there be any support services sent to the house or social workers or anything?

Ms Davis: No.

THE CHAIR: Minister, you are the minister in this session. You are the Minister for Fire and Emergency Services, the Minister for Industrial Relations and Workplace Safety, and the Minister for Police and Crime Prevention, so we have certainly got the right minister here, if I might say. I would just like to read recommendation 22 from the committee's report into dangerous driving:

> The Committee recommends that the ACT Government urgently fund a trauma service that is available at the scene of an accident and a 24 hour hotline to help victims and their families.

Minister, do you agree with that recommendation?

Mr Gentleman: I certainly think that what we have heard today in this inquiry—what I have heard today—indicates that there is more support needed for those victims of traumatic incidents, particularly on the roads, and you have talked about that particular recommendation. I would certainly take that on board. I think that the skills we have with our frontline responders are exceptional. We see police and we see our paramedics

do an amazing amount of work, and our fire and rescue people, in supporting Canberrans at their most vulnerable time. I want to thank them again for the work that they do. If there are conversations within government for further support, I would be supportive of that.

THE CHAIR: This committee obviously has a similar appreciation for our police and ambulance and emergency service workers. Is there anything you would like to say in closing, Minister?

Mr Gentleman: Once again, to our frontline responders: thank you for the work you do. To the victims that may be listening again today: we acknowledge your concerns and your sufferings. We certainly want to make Canberra, the safe town that it is at the moment, a safer town into the future as well. I think that the work we are doing on the ground for the training for frontline responders is appropriate and up to date, and we will keep that going. Of course, the other work that we see, as I mentioned earlier, in smarter vehicles will certainly help us into the future too.

THE CHAIR: Thank you. On behalf of the committee, I would like to thank all of our witnesses for your attendance today. I do not believe there were any questions taken on notice. Again, I would like on behalf of the committee to thank our emergency service, police and ambulance workers for all that you do. You are in harm's way and obviously at the scene of traumas. This also is a potential harm to you, and we wish you all the very best, of course, and thank you for your service.

Thank you also to Hansard and broadcasting for their support and to our secretariat, of course. If a member wishes to ask questions on notice, please upload them to the parliamentary portal as soon as practicable and no later than five business days after the hearing. This hearing is now adjourned.

The committee adjourned at 4.13 pm.