Report of the Medical First Responder Sub-Committee

September 2015

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Introduction

In May 2015 the Union's State Committee of Management established a sub-committee to investigate and make written recommendations on the possible introduction of a 'medical first response' (MFR) role for FRNSW permanent firefighters, including:

- the international and interstate experience in other fire services with 'MFR';
- the extent of an FRNSW role (eg, whether all stations or some, voluntary or mandatory);
- the nature of an FRNSW role (eg, CFR, EMR or CAT 1a only);
- the health, safety and wellbeing implications for members of 'MFR', and their mitigation;
- the training and/or training competencies required to undertake 'MFR' safely and efficiently.

The sub-committee's report will inform the State Committee's deliberations on wider industrial and political considerations of 'MFR' including remuneration, demarcation and ultimately if the role should be performed at all. Whilst the sub-committee was not expected to report on these matters, it has made some comments in this regard.

The sub-committee was chaired by Union President, Darin Sullivan and comprised of the following six rank and file members, who were selected for their expertise, rank and/or ability to represent the broad and balanced views of the membership on the question of emergency medical response:

David Castle	Station Officer, 96 Schofields
Nate Chellew	Training Officer BA/Hazmat
Andrew Connon	Inspector, MS2
Mark Dobson	Senior Firefighter, Wellbeing Coordinator
Tanya Marshall	Station Officer, 27 Parramatta
Martin Paddon	Senior Firefighter, 64 Lakemba

The sub-committee held four formal meetings between June and August 2015.

Feedback was sought from the FBEU membership via a dedicated email account (mfrsubcom@fbeu.net) and from numerous station visits. The Union's online member's forum was also used as a medium between members and the sub-committee during this process. All written feedback was acknowledged by the chairperson and considered as part of the sub-committee process.

An evidence-based methodology approach was adopted by the sub-committee wherever possible. The following report represents the process, findings, and recommendations of the MFR sub-committee as confirmed by its final meeting on 27 August 2015.

The sub-committee thanks the FBEU for the opportunity to take part in this process, and hopes the research and findings is of some assistance to the Union's State Committee of Management in considering these recommendations.

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Definitions

For the purposes of this report, the following is a brief description of the medical response role currently in place for NSW (retained) firefighters, and the role previously proposed for (permanent) NSW firefighters.

Community First Response (CFR)

Community First Response (CFR) is a program where FRNSW retained (only) firefighters (or SES and RFS in some areas) at identified and specific fire stations respond to medical calls where no (or limited) NSW Ambulance resources exist. The program was originally installed without the FBEU's agreement. An industrial dispute and work-value arbitration resulted in an agreed model operating and a determination on remuneration for the CFR role. There are currently nine retained stations (up from an initial six) officially performing this role.

Medical First Response (MFR)

Medical First Response is the term commonly used to describe a new response role proposed for FRNSW permanent firefighters. Unlike CFR, MFR is intended to be implemented where NSW Ambulance resources exist and are available, with firefighters responding to life threatening incidents (only) together with NSW Ambulance crews due to quicker FRNSW response times. Firefighters would tend to the patient's life threatening injury or illness until the arrival of NSW Ambulance.

Terminology

The sub-committee considered whether a more accurate title (and acronym) for the role currently referred to as 'Medical First Response' (MFR) exists, and how that might relate to the perception of such a role internally and externally given the stigma attached to 'Medical First Response', in particular the term 'Medical'. The sub-committee considered the following options, noting the Community First Response (CFR) term already used by FRNSW, NSWRFS, and SES:

- Medical First Response (MFR)
- Metropolitan First Response (MFR)
- Urban First Response (UFR)
- Emergency Medical Response (EMR)
- Firefighter Medical Response (FMR)
- Firefighter First Response (FFR)
- Urban Firefighter Response (UFR)
- Emergency First Response (EFR)
- First Aid Response (FAR)

The geographical, industrial, and functional possibilities of any emergency medical response role in NSW led the sub-committee to conclude that 'Emergency First Response (EFR)' is the most appropriate term.

International and interstate experience

Research was carried out by the sub-committee on various models and experiences in Australia and abroad, and considered in the context of the sub-committee's terms of reference.

Victoria

Program

Melbourne's MFB has an agreed emergency medical response model in place called Emergency First Response (EFR). The MFB was the first fire service in Australia to implement a service-wide emergency medical response program. The program has been running since 2001 and was negotiated with the UFUA's Victorian Branch after a pilot study. The MFB is a smaller fire service than FRNSW by all measures, save perhaps funding. MFB firefighters respond primarily to cardiac arrests[1]. The MFB employs a Clinical Director to oversee the scope and delivery of the EFR program. All data and training is owned by the MFB.

Response

The MFB model includes a minimum of two firefighters trained to undertake EMR on each EFR appliance. Firefighters perform outduties to meet the minimum two EFR firefighter requirement. The Category 1A, no signs of life, response requirement is strictly adhered to with no long-term call creep apparent to date. In the event of false or misleading calls being made by the public, the OIC has the ability to assess the situation and give a “Code 4” to Communications and the ambulance service. MFB EFR calls represent approximately 11% of the MFB's total calls. Research reported a dramatic shift in MFB core role since inception. In 2013/14 MFB responded to approximately 36,671 total responses, 4803 categorised as EFR calls[2].

Victoria's emergency communication centres have been privatised, however all Ambulance Victoria calls are vetted upon receipt, with response parameter agreements in place.

Ambulance Victoria is responsible for the incident once on scene. Seasonal shifts in response also occur, eg in summer, calls tend toward less urban areas.

An emphasis is placed on MFB own patient care records being kept. Ambulance Victoria takes its own records once on scene, incorporating what the firefighters had carried out prior to ambulance arrival. MFB records are kept and used for debriefs and statistics by the MFB Clinical Director.

Training

Firefighter training involves an eight day continuous course designed by Melbourne University Clinical and Paramedic Services (MUCAPS), with a day refresher course every two months and a four day recertification course every 2 years. Basic Life Support (BLS) qualified firefighters are expected to assist. Within two years all firefighters were EFR qualified. Recruits undertake a half EFR training course at their college along with BLS, then having completed one year placement at a fire station, they then complete the second half of their EFR training to attain full qualification. The MFB considers one year of operational firefighter experience as being a sufficient learning curve prior to full EFR exposure.

Welfare

MFB firefighters are given hot debriefs following each incident. An employee assistance program appears to be in place and on-going training every two months is also used to debrief and review incidents with qualified paramedics. The MFB Clinical Director also oversees EFR welfare issues. The MFB has 50 peer supporters for 48 stations. Firefighters are allowed to ‘park’ their qualifications and opt out of EFR. This is seen as a key part of their stress management and welfare. There appears to be no discrimination against members who exercise this option, although the extent to which they actually do so remains unclear.

Remuneration

There is an on shift allowance of $1.95 per hour[3]. This would equate to a pay rise of $93.60 per week, or a 6.1% pay increase, for a FRNSW Senior Firefighter on current Award rates.

Perception

MFB firefighters appear to be comfortable performing EFR. While some opted out in the initial roll out, after two years most firefighters were still performing the role. Anecdotally, it appears those not participating realised they were still involved at incidents, and therefore decided they might as well be involved (and paid for it).

The MFB retains all data on EFR calls and manages its medical interventions separate to Ambulance Victoria. Difficulties in extracting key information from Ambulance Victoria were cited, as well as the MFB using successful response outcomes as a morale boost and incentive for firefighters. The Clinical Director role was also cited as an important part of this.

It was reported that initially there was a great deal of anxiety towards EFR amongst ambulance staff but that now it is the reverse, with Ambulance Victoria appreciating the attendance of MFB firefighters due to their high quality CPR which allows ambulance staff to concentrate on other clinical procedures.

Australian Capital Territory

Response

ACT Fire and Rescue (ACTFR) attends all types of medical calls to assist ambulance, and there appears to be no boundaries around response types or limits. Research suggests an initial EFR call rate of roughly 11% in the late 1990's, easing slightly to 8% by the mid 2000's. The employment of 35 additional ambulance officers in 2010 was followed soon after with a drop in the ACTFR's EFR call rates to 1.5% for 2012 and 2013.

Training

ACTFR firefighters receive generic first aid training over one day, which appears to be in line with basic first aid responses. Firefighters then receive a one day BLS refresher annually similar to FRNSW. Melbourne University Clinical and Paramedic Services (MUCAPS) studied training levels in ACT and judged that it was inadequate for role undertaken.

Welfare

This appears to be limited to the standard employee assistance program and normal station post-incident debrief.

Remuneration

No remuneration appears to have been awarded for undertaking EFR in ACTFR. ACT firefighters made a pay claim in 2004 through a work value case, however the UFUA's ACT Branch advised that remuneration for medical response was not considered in that matter and that it remained intent on prosecuting a wage increase in compensation for the EFR role.

Perception

ACT Branch officials reported that ACT firefighters are happy to undertake emergency medical response and that the work is a valuable asset to the community and firefighters. An ex-ACT firefighter and current FBEU member in his submission to the sub-committee disagreed. His view was that "one shoe does not fit all" and that emergency medical response was added to ACTFR "under the radar" by ACTFR management back in the early 1990's, with no remuneration and no extra training, and that remains contentious amongst ACT firefighters.

Tasmania

Program

No official emergency medical response program exists for firefighters in Tasmania, however there is a program similar to that of FRNSW CFR whereby twenty two volunteer fire stations across the state have agreed to an MOU with Ambulance Tasmania to provide additional assistance to the ambulance service.

Response

The twenty two fire stations respond in circumstances similar to that of FRNSW CFR stations to a variety of calls due to shortfalls in the ambulance coverage to improve response times.

Training

Standard first aid training aligned to PSTP is provided, which is Apply First Aid and Advanced Resuscitation with a one day refresher.

Remuneration

None.

Aviation Rescue Fire Fighting

Program

Aviation Rescue Fire Fighting (ARFF) responds to approximately 1000 emergency medical responses each year at Sydney airport alone. If ARFF is called to a medical call, an ambulance is always dispatched. It was also reported that the biggest benefit (to the patient) is that ARFF can quickly respond to anywhere on the airport and start what is often life-saving work.

Response

It was reported that 'mission creep' has occurred for the ARFF emergency medical response program, insofar as it was originally intended for life threatening incidents only but has slowly since changed to include less serious calls. NSW Ambulance provide and administer drugs, airway management and transport.

Training

Advanced first aid and an advanced resuscitation certificate is provided, using the AEDs and oxygen resuscitation packs stored on ARFF appliances.

Welfare

The role is not voluntary, however ARFF firefighters are given the option to be moved from the primary responding appliance for periods of time if required. Health and wellbeing support not reported.

Remuneration

There appears to be no allowance or additional payment for the emergency medical response role.

Perception

The ARFF emergency medical response role was reported by one interviewee as a value add service, providing good public relations, and is now accepted as part of general ARFF duties. It was also reported that NSW Ambulance members were originally against ARFF taking on an emergency medical response role, but that the working relationship is now good. ARFF firefighters showed some concern that "mission creep" and their currently unfettered response

agreements and boundaries require attention.

Queensland

No emergency medical response program exists apart from assist ambulance. The UFUA's Queensland Branch has considered an emergency medical response role but has so far rejected taking this after internal discussion and consideration. Queensland Branch officials report that the decision to not take on the role was predominantly made due to concerns around training, remuneration, and (overwhelmingly) firefighter health and wellbeing.

Western Australia, South Australia, Northern Territory

There appears to be no formal emergency medical response role in these fire services.

New Zealand

A new emergency medical response model is being trialed using a dual purpose fire and medical response vehicle for use in rural/remote communities. There appears to be specific training for those involved in the trial by St John's Ambulance (who are the main medical response provider in NZ) to update or add to firefighter first aid skills. Further information was difficult to obtain within the limited time available to the sub-committee.

Communication, submissions, and feedback

Written submissions

Forty nine member submissions were received by the sub-committee. Attached to this report is a de-identified collation of those submissions, except where members specifically asked for their submission not to be published.

The sub-committee found the member submissions to exhibit the following general themes:

- A lack of trust toward FRNSW senior management and government in regard to implementation and operation of, training, response, and welfare if an emergency medical response role was progressed.

- Concern that an emergency medical response role would be used as a 'band-aid solution' for major problems facing the NSW Ambulance and the NSW health system broadly.

- A preference to not perform an emergency medical response role if given the choice. It remains less clear as to whether this is dependent on an effective model and remuneration, and whether this is a genuinely majority view, or if those who are opposed are simply more motivated to express their view.

- Concerns falling broadly into what the sub-committee termed the "four pillars" of EFR: response, training, welfare, and remuneration.

- A recurring theme of frustration with the state of the NSW health system, and a desire to help fix those problems properly and to support any campaign to that end initiated by other unions.

The sub-committee found the submissions helpful as a part of the overall process, and appreciated members taking the time to submit their feedback.

Station forums

Station forums were carried out by several sub-committee members throughout the life of the sub-committee.

Overall, there remains strong scepticism amongst the membership and a general reluctance to carry out this role. This ranged from a mild preference against taking on the role to outright hostility. Conversely, very few members were found to support the proposal, and none who whose support was unqualified.

The sub-committee found an overwhelming absence of confidence in the membership that the employer could or would provide the training and/or support necessary for safe and effective implementation.

It is clear that remuneration is not the membership's primary concern, but rather training and members' welfare.

Detailed discussion occurred at station forums around the political landscape, the Victorian experience, and what might be achieved if proper training, welfare, and response protocols were in place.

The frustration found in written submissions around the state of the health system, and a preference by members to fix NSW Ambulance and the health system instead of taking on this work was replicated at a station level.

Ongoing comments by FRNSW management to the effect that, “MFR is inevitable" or "you'll be doing it within 12 months” or that “the Government has already set aside 2.5% for it" ” are eroding trust and damaging the ability to calmly consider and discuss this issue. The sub-committee found such statements to be either demonstrably wrong (ie, MFR has already been "coming within 12 months" for several years now), or hearsay masquerading as "inside knowledge".

Similarly, the sub-committee's station visits found that the training currently being delivered to permanent firefighters by NSW Ambulance paramedics is (rightly or wrongly) now widely understood by members to be EFR implementation by stealth[4].

Another concern raised by members was the negative impact on morale of media reports on the issue. Statements made by Government and FRNSW representatives are undermining trust and members' goodwill. The recently reported suggestion that remuneration is the only concern of firefighters and their Union was understood to have come from FRNSW and the NSW Government, and deeply offended many members.

It is clear that the membership has not appreciated the manner in which the employer has approached this issue to date.

FBEU members’ online forum

Membership feedback and discussion on the forum remained broadly consistent with the comments and views gathered through face to face meetings and written submissions. Discussion on this topic has occurred for some years now via the FBEU online forum, all of which remains available online for further information, review and/or comment.

Key considerations

The sub-committee ultimately resolved to adopt a “Four Pillars” approach to any emergency medical response role considered for FBEU members, being:

Response
Welfare
Training
Remuneration

Response

Extent of an FRNSW role

The sub-committee considered whether all stations, or only some, should participate in any role taken on. The sub-committee also considered whether senior officers would perform part of any role (and if so, what part), which would also help determine who could/should receive remuneration. Other considerations in regard to extent of any role performed included:

- Whether an emergency medical response role for FRNSW permanent firefighters should be voluntary.

- How a 'safe harbour' (opt-out) provision could be included to allow non-participants to continue their normal employment as a firefighter, performing the role of a firefighter (or officer) at a workplace which does not perform an emergency medical response role.

- Minimum staffing requirements (eg, two fully trained and qualified operators) for an emergency medical response role.

- The training and use of non-station based firefighters (eg senior officers and Directorate staff) in any emergency medical response role.

Nature of an FRNSW role

The sub-committee considered the difference between CFR and emergency medical response roles (MFR/EFR), and how other agencies were defining response roles (eg, Category 1A only). Other considerations in regard to the nature of any future emergency medical response role included:

- If FRNSW should only be responded to calls identified as having the potential to provide a good patient outcome from intervention.

- The adequacy of a Category 1A qualification. The sub-committee views the 1A category of calls (issued by the Pro QA triaging system of NSW Ambulance) as requiring further filtering by implemented policy or protocol to protect firefighters from unnecessary responses, eg. to incidents where the patient is quite clearly deceased or it is suspected that the patient is unlikely to respond to any intervention.

- If a station or firefighter could be placed offline for EFR calls in the event of a stressful incident at the discretion of a Station Commander/Duty Commander.

- The advantages of a dedicated clinical director, whose role would include (but not be limited to) managing training, response and welfare issues, as well as data management and liaison with NSW Ambulance and other services.

- The value of an incident helpline and contact point specifically for any EFR role (similar to FIRU support) on a 24/7 basis. This could be facilitated by, or operate under, the Clinical Director, but should be a dedicated contact point for crews at an incident requiring patient or incident advice.

- If it was possible for an OIC to Code 4 from an emergency medical response, without repercussion, if he/she considered the incident outside the scope of the emergency medical response agreement.

- The role and powers FRNSW communications would have in any medical response model, including control of call types with technological infrastructure in place in FRNSW communication's response software.

- The impact of staffing, rosters and station boundaries could have on response models and station selection.

- How an emergency medical response role would impact on retained members and stations, particularly in the Greater Sydney Area (GSA), and the consequences of any metropolitan model on regional and country areas (permanent and retained). The sub-committee notes that the report and recommendations are inclusive of these points, retained members in particular.

Welfare

Health and safety implications of a medical response role

The sub-committee considers members' welfare to be crucial to any EFR role. It is clear the membership shares that view. There appears to be broad consensus with the employer on this point, too.

The sub-committee considered the need for an increased capacity in dealing with welfare issues. Information was provided by FRNSW that identified the following areas requiring consideration before any medical response role is established:

- Occupational Stress
  - Job demands and how taking on a new role increases workload and responsibilities, which has an impact on firefighters' mental health.
  - New and challenging work environments.
  - New roles that have an increased level of interaction with the public, including interaction that may cause stress to firefighters.
  - Significant organisational change.
  - Increased levels of critical incident exposure.

- Unprepared Response
  - Need for sufficient preparation for a new role, which can predominantly be addressed by training however training levels directly impact on firefighter competence which is linked to confidence and the impact of exposure to traumatic incidents.
  - Clearly defined roles and guidelines to provide guidance in challenging situations (also addressed in the response section).
  - Specific training to ensure firefighters have an increased understanding of mental health, enhanced ability to look after themselves and their peers and the skills to interact in with stressed bystanders.

- Occupational Violence
  - Crews will have an increased risk of attending incidents that are, or could become, violent.

- Health and safety
  - FRNSW ability to check and maintain vaccinations.
  - Effects of increased patient handling - physical and emotional.
  - Relevance of current infection control policy.

- Access to 24/7 support.
- Bullying and harassment considerations, eg members ‘opting out’.
- Fatigue management policy assessment.

Training

It is the view of the sub-committee that training (including skills maintenance) is vital to any successful emergency medical response role. Research and feedback from the membership also identified this as a priority.

The sub-committee looked at the various ways other states deal with this, particularly the MFB model.

The sub-committee considered whether a broad approach should be taken to training, with a much wider scope to perform tasks than currently exists to do this role, or whether to focus on doing the ALS/BLS core roles only, with a strong emphasis on doing that well?

There are varied medical response programs in place around the world and throughout fire services in the Asia-Pacific region. As the nature of the response capacity changes from one organisation to another, so too does the training undertaken by that organisation. Melbourne, ACT and New Zealand are possibly the agencies most closely aligned to FRNSW who undertake an emergency medical response role. Each of these has a different response capacity, medical role, training, and funding regime.

ACT appears to provide an ad-hoc response due to ambulance non-availability, however its training also appears of a lower standard than the MFB's and only covers that required by PSTP PUA12, ie HLTFA311 Apply First Aid and HLTFA007 Apply Advanced Resuscitation Techniques. This is the current level of training undertaken by FRNSW.

New Zealand is trialing a medical assistance role with specific vehicles and training via the professional ambulance service (St John). This should not be confused with a qualification from the St John’s Ambulance in Australia as St John's in New Zealand is the professional ambulance response service, just as NSW Ambulance is here.

Melbourne’s EFR model is suggested by FRNSW to be similar to the model FRNSW management desires. The MFB's training also aligns with PSTP PUA12, for which FRNSW issues qualifications. Unfortunately this appears to have led FRNSW management to believe that if MFB firefighters hold the same qualifications as FRNSW firefighters, and the EFR models are the same, then FRNSW is ready to commence EFR now. The sub-committee rejects this view as dangerously simplistic and grossly inadequate given the superior training afforded to MFB firefighters compared to FRNSW firefighters.

MFB firefighters' EFR training includes an eight day continuous course designed by Melbourne University Clinical and Paramedic Services (MUCAPS) with a refresher course every three months and a two day recertification course every four years.

Feedback from the membership highlighted the concern of FBEU members over training and welfare, in particular FRNSW’s ability to initiate and maintain appropriate training.

While the current level of FRNSW first aid training meets (on paper) the MFB's same minimum requirements, the reality is that the MFB training extends well beyond that minimum in recognition of the "real world" requirements of EFR. The confidence, knowledge and skill of FRNSW firefighters would be tested if the training currently provided was not improved.

The sub-committee concluded that there was no guarantee that an increase in the level of qualification would increase the confidence level of firefighters. This would instead require an increase in the volume and frequency of the training, the latter of which would also result in

FRNSW improving its ability to maintain competence in first aid skills according to industry standard refresher/recertification programs. Currently, FRNSW adherence to this appears somewhat low and there is a significant proportion of firefighters who do not hold a current first aid qualification.

The sub-committee considered FRNSW's engagement of four NSW Ambulance Officers on secondment to provide follow up training after the first aid recertification is delivered by a FRNSW instructor, and the pros and cons of such. The frequency and volume of this NSW Ambulance training has not approached anywhere near the levels of training the MFB provides for its firefighters via Ambulance Victoria. If EFR was to be adopted then an increase in the training frequency at the current level would be required well beforehand.

Consideration was given to whether this is best served in shorter more frequent drills (eg two to four hours face-to-face with an NSW Ambulance trainer every three months), with an additional one day re-certification every twelve months aligned to the industry standard for HLTFA007 Apply Advanced Resuscitation Techniques[5] (equivalent to sixteen - twenty four hours per year) as opposed to the current eight hour re-certification once every three years.

Remuneration

Industrial work value and political considerations

The sub-committee looked at several key areas when considering the industrial work value and political aspects of any emergency medical response role. To assist the committee in this endeavour, key union and employer representatives were invited to address the sub-committee, including:

FRNSW representatives
FBEU industrial staff
FBEU members/firefighters
UFUA ACT Branch officials
FBEU officials

Contact was also made with firefighters and union officials from Victoria, Queensland, Western Australia, Australian Capital Territory, New Zealand, Northern Territory, South Australia, and Aviation Rescue and Fire Fighting.

The sub-committee is of the view that there is clearly work value associated with these roles. However, given the complexity of the industrial, legal, and political issues around this matter, the sub-committee was unable to recommended any quantum at this time. The sub-committee resolved to defer to the State Committee of Management, noting that a work value case could be initiated at some point to at least determine what the value of EFR is (even if it can no longer be awarded) before the matters around response, training, and welfare are prosecuted as required.

The sub-committee noted that the CFR decision required those CFR allowances to be funded internally. This could not be sustained for an EFR allowance or other payments given the greater number of permanent firefighters who would be performing the role.

Community First Response (CFR) vs Emergency First Response (EFR)

The sub-committee noted the Community First Responder (CFR) dispute between FRNSW and FBEU, and the subsequent IRC arbitration and decision[6]. The sub-committee notes in particular Justice Staff's finding that CFR was of greater work value than the emergency medical response role (EFR/MFR) undertaken by the MFB (and, it follows, that proposed by FRNSW).

2013 FBEU Special General Meeting (SGM)

The FBEU's current policy on 'Medical First Response' (MFR) was adopted by the membership at the June 2013 Special General Meeting, and reads as follows:

Medical First Responder

"That this meeting recognises:

a) the intention of the O'Farrell Government and FRNSW management to pursue a Medical First Responder (MFR) role for permanent firefighters, without any extra pay;

b) that MFR work may be introduced even if a serious and sustained industrial campaign is undertaken to resist it;

c) that remaining uncommitted as to whether or not we should perform this work is no longer an option;

and therefore confirms the Union's in-principle support for the performance of this work by permanent firefighters subject to two conditions, being:

1) the O'Farrell Government's agreement to a 12.5% wage increase for all members who agree to perform MFR duties; and

2) the endorsement of any proposed MFR model for FRNSW by a subsequent General Meeting of members;

and further resolves to actively and stridently resist any attempt by FRNSW management to implement MFR unless and until conditions 1 and 2 above have been met."

HSU and APA

There is considerable history and interaction between the FBEU and the Health Services Union (HSU) in regards to the question of emergency medical response roles for firefighters in NSW. A separate association representing paramedics, the Australian Paramedics Association (APA), also now operates in NSW.

The sub-committee considered whether to make further contact with the HSU and/or APA regarding emergency medical response roles for NSW firefighters. The sub-committee's chairperson, Comrade Sullivan, reported (in writing) on the history of both this matter and of the FBEU's relationship with both organisations, referring also to his related post on 4 February 2013 on the Union's website forum. Comrade Sullivan's report to the sub-committee included:

"It can be seen that the FBEU has previously written to the HSU, met with the HSU, and over a long period of time the HSU has said nothing about NSW firefighters performing an MFR role. Further, the Government has issued two significant and controversial policy statements regarding this matter over recent years which were again met with silence from the HSU.

In June 2013 a decision was handed down in the Industrial Relations Commission (IRC) in regard to Community First Responder (CFR) followed by the FBEU Special General Meeting (SGM) in June 2013 where members, in the absence of any comment/view from the HSU, voted to perform MFR subject to a 12.5% wage increase, together with an agreed appropriate model, to be further endorsed by a subsequent general meeting. There has been no contact from the HSU throughout that process either.

In 2014 the FBEU inserted CFR and the awarded 7% increase into the Retained Award, putting to bed the question of whether firefighters will ever perform such a role or not. During this time the HSU was at liberty (and had every opportunity) to intervene in the CFR case and subsequent Award matter to raise its concerns (if it had any) with us. It did not.

The time for the HSU to weigh in on this with the FBEU is gone.

It is my view that even if the HSU miraculously agreed to meet with the FBEU or the FBEU MFR sub-committee, there is a risk that the HSU could make demands that the FBEU can't or won't meet. This would make the situation worse for all parties, and the process a waste of time. Further, our general meeting policy position would be undermined if other unions oppose our member's strategy on this issue. There is nothing to be gained by meeting with other unions at this point in time.

That's not to say we should, or have, closed the door on the HSU. Of course if they came to us we would engage with them and consider their views, but the time for us to ask them has well and truly passed. The FBEU State Committee of Management should have carriage of this question going forward, and will of course keep these options open.

Based on the evidence provided by my information to the sub-committee, the current political climate, the current membership direction, and internal process underway, it is my strong view and recommendation to the MFR Sub-Committee, that it should not contact the HSU (or EMSPA/APA), and that the sub-committee can address it's terms of reference without such contact."

The sub-committee accepted the chairperson's advice.

Banning EFR

The effectiveness and utility of a ban on performing an emergency medical response role, should that be required, is a major question - and challenge - for the membership.

Whilst industrial action clearly remains an option, it is noted and accepted that such a ban or instruction would place members in a difficult position, and unlike other Union instructions, may not be observed by all Union members.

The sub-committee makes no recommendation or comment on this other than to note that it obviously requires careful thought and resolution by the Union's officials and membership.

Intentions of the NSW Government

The NSW Government's intentions with regard to an emergency medical response role for FRNSW remains unclear.

The sub-committee examined a 2014 NSW Government and FRNSW proposal for an emergency medical response trial in Sydney. While that did not eventuate, the risk remains that the employer may attempt to implement an emergency medical response role for permanent firefighters without Union agreement.

Recommendations

Principle Recommendations

Current medical response problems

Feedback from members and discussions with FRNSW senior management confirmed NSW Ambulance communications centres are forwarding calls (and sometimes serious medical calls) to FRNSW, many of which appear to be more than traditional 'assist ambulance' calls. The sub-committee sees this response problem as a priority to address regardless of any discussion around an EFR role.

Recommendation 1

That regardless of any decision on an EFR role, the FBEU should urgently require FRNSW to reassess response protocols and the MOU between NSW Ambulance and FRNSW with a view to restoring the pre-existing status quo and creating clear rules around 'assist ambulance' calls.

Should the FBEU pursue an EFR role?

The sub-committee considers the warnings of management that fires are decreasing and that our occupation is threatened unless we take on this new work to be neither new nor convincing. That is not to suggest that no benefits would accrue from our adoption of EFR, only that the alternative (ie not doing it) does not ensure our ruin. It is also clear that FRNSW is nowhere near ready to take on such a role in a way acceptable to the membership. The sub-committee found that no evidence exists to confirm any responsible way (or need) for firefighters to perform an EFR role in NSW at this point.

Recommendation 2

That the FBEU should not undertake an EFR role now, or in the foreseeable future and further, that the FBEU should actively resist any move to a medical response role without General Meeting agreement.

Recommendation 3

That the term 'Emergency First Response (EFR)' is the most appropriate and accurate way to describe this role, and recommends the Union use this term from now on when referring to a medical response role or model.

Contingent Recommendations

The sub-committee acknowledges that the question of whether we do this work may not be left to the FBEU to determine. If the employer decides to force the issue, or it becomes a dispute, then our Union will have no option but to respond, whether by industrial action, or negotiation, or a combination of both. This report makes no comment on the tactics or prospects of success of either, save to observe the existing 2013 SGM decision, that any ongoing restriction on emergency response would be challenging, and that any negotiated outcome must ensure the health, safety and well-being of FBEU members.

The remaining recommendations will not be required if the employer does not pursue an emergency medical response role, or if Recommendation 2 is adopted and successful.

In any other event the Recommendations 4 to 31 are provided as minimum pre-conditions for the acceptance of any emergency medical response role for FRNSW permanent firefighters.

Pillar 1: Response

Recommendation 4

That fire stations should be categorised as EFR stations for the purposes of training and response (and allowances - see Recommendation 26). This should be subject to negotiation and agreement between the parties, and consideration given to placing this decision making process to a statutory body or committee (see Recommendation 31).

Recommendation 5

That any EFR model should have specific boundaries around the call type. The 1A category of calls (issued by the Pro QA triaging system of NSW Ambulance) needs to be further filtered to protect NSW firefighters and the community.

Recommendation 6

That OIC's at EFR incidents should determine whether it is an EFR incident and therefore, whether or not to remain. This should be protected through policy, monitored and reviewed regularly by the parties, with a 'no mission creep' agreement/policy in place.

Recommendation 7

That participation should be voluntary. Members should be able to opt out of the EFR for set periods of time to facilitate health, safety, and welfare.

Recommendation 8

That a minimum of two qualified EFR operators be required for response to any to EFR incident.

Recommendation 9

That specialist appliances should be included in any EFR response model.

Recommendation 10

That maximum call triggers should be in place to protect members and stations from over exposure, so that a station and/or a qualified member would be stood off for a period of time once calls to EFR incidents hit a certain point).

Recommendation 11

That consideration should be given to patient fees for a medical response in order to help fund EFR operations and payments.

Pillar 2: Welfare

Recommendation 12

That FRNSW capacity around welfare and peer support should be increased in line with the recommendations of the FRNSW 'MFR Mental Health Working Group'. These recommendations are:

- One day mental health training for all prospective EFR crews including a session on:
  - mental health literacy;
  - identifying and assisting crew members at risk;
  - interacting with relatives and bystanders at EFR incidents.

- A more structured procedure to identify critical incidents and the provision of appropriate interventions.

- A process to record EFR incidents and regular contact with ambulance trainers to ensure skills maintenance in relation to debriefs.

- An increased level of critical incident support.
  - increased size of the Peer Support team;
  - more regular communication and education on managing exposure to critical incidents.

Recommendation 13

That enhanced systems of automatic debriefs should occur after any critical incident attended by any FRNSW firefighter.

Recommendation 14

That any EFR model should see a MFB-type Clinical Director in place to liaise between FRNSW and NSW Health, to maintain data, to monitor training and to oversee the CFR program.

Recommendation 15

That FRNSW should develop and implement an incident helpline and contact point specifically for any EFR role (similar to FIRU support) on a 24/7 basis.

Pillar 3: Training

Recommendation 16

That the initial training for any members performing an EFR role should be four days minimum to allow for both the first aid training and the additional training in mental health to prepare for the role.

Recommendation 17

That the qualification recertification should be a day face-to-face training session every twelve months, aligned to industry standard for HLTFA007 Apply Advanced Resuscitation Techniques[5]. This is above and beyond the industry standard for HLTFA311 Apply First Aid, but is a requirement for HLTFA007 and should be delivered by FRNSW first aid trainers.

Recommendation18

That ongoing two to four hour skills maintenance visits (on top of agreed first aid training) should be carried out by a trained paramedic four times per year, including informal incident discussions and technical revision.

Recommendation 19

That training and skills maintenance should be enforced, perhaps by installing a penalty or change in response status where either falls below any agreed standard.

Recommendation 20

That recruit firefighters should undertake EFR training at the college and complete a one year placement at a station before taking on the role formally.

Recommendation 21

That staffing levels in FRNSW E&T Directorate should be increased to accommodate appropriate and ongoing training, including a designated First Aid Training Team Leader responsible for managing both FRNSW uniformed trainers and NSW Ambulance trainers on secondment together with other relevant resources.

Recommendation 22

That a joint FRNSW/FBEU education and communication program (funded by the employer) should take place internally prior to any trial or other implementation. This should also be applied to external public relations and education about any future medical response role;

Pillar 4: Remuneration

Recommendation 23

That additional remuneration is both warranted and necessary for permanent firefighters who undertake any EFR role.

Recommendation 24

That EFR cannot be undertaken within current FRNSW funding levels, and that FRNSW funding therefore be increased to deal with the cost of any new model without impacting other areas of FRNSW.

Recommendation 25

That any remuneration for EFR qualified members at an active EFR station should take the form of an allowance, indexed with other pay rises.

Recommendation 26

That remuneration and payment should be available to any member of any rank who is actually performing any new role. In the case of retained firefighters who respond with and assist EFR permanent firefighters, consideration needs to be given to establishing the ability for a weekly allowance to be paid or incorporated into the retainer.

Recommendation 27

That any EFR model should be clearly recognised and provided for within the relevant Award(s) including remuneration, training, response and definitions etc.

Recommendation 28

That further policy development around transfers and allowance issues arising from any EFR role should take place before implementation, noting an expected increase in workforce issues as a result of any EFR implementation.

Review

Recommendation 29

That a trial should be carried out before the introduction of any final model, and should only be undertaken if all four pillars (ie, response, welfare, training and remuneration) are resolved. A joint review should be conducted and findings issued following the conclusion of the trial, and prior to any further implementation.

Recommendation 30

That any EFR model should include a mechanism for its formal, annual joint review by the FBEU and FRNSW.

Recommendation 31

That a statutory body (or consultative committee) similar to the FSJSC should be established comprising NSW Ambulance, FRNSW and FBEU representatives, and possibly ambulance employee representatives also, to monitor and respond to ongoing EFR/CFR issues.

References

1. Boyle, M J, Williams B, Bibby, C, Morton A, and Huggins, C, Open Access Emergency Medicine journal article, *The first 7 years of the metropolitan fire brigade emergency responder program – an overview of incidents attended* [2010].
2. Metropolitan Fire and Emergency Services Board, *Annual Reports,* multiple years
3. Australian Industrial Relations Commission Decision Dec 1608/96 P Print N6987, *Firefighting Services – Wages – Firefighters and firefighting Officers – Victoria – Award 1996*
4. *Basic Life Support in Practice Course: NSWA and FRNSW working together to save lives, FRNSW* (2015)
5. Public Safety Training Package: HLTFA007 Apply Advanced Resuscitation Techniques
6. Crown Employees (NSW Fire Brigade Retained Firefighting Staff) Award 2008 (No 3) [2013] NSWIRComm 52, 21 June 2013

Attachments

1. Medical First Responder sub-committee terms of Reference, 11 May 2015
2. Feedback/submissions from members collected from 4 June 2015 to 27 August 2015
3. FRNSW Memorandum, *Medical First Responder Risk Assessment, FRNSW Health and Safety Branch (2013)*
4. FRNSW submissions in IRC Matter No. 123 of 2014, *Background discussion of Medical First Responder concept* (2014)
5. Sydney Morning Herald, *Firefighters working with ambulance officers would save lives, experts say, 14 December 2014*
6. The Daily Telegraph, *Unions are 'potentially' putting lives at risk, says Fire and Rescue NSW Superintendent,* 10 March 2015
7. St Marys Standard, *Shake-up of emergency services slammed as 'Band-Aid solution',* 25 February 2015
8. Sydney Morning Herald, *Failure to use firefighters to fill NSW Ambulance Service shortfalls is 'costing lives', 30 August 2015*

Medical First Responder Sub-Committee

Purpose

To investigate and make written recommendations to the State Committee of Management on the possible introduction of a medical first response (MFR) role on each of the following matters:

- the international and interstate experience in other fire services with medical first response;
- the extent of an FRNSW role (eg, whether all stations or some, voluntary or mandatory, etc.);
- the nature of an FRNSW role (eg, CFR, EMR or CAT 1a only, etc.);
- the health and safety implications for members of MFR, and their mitigation;
- the training and/or training competencies required to undertake MFR safely and efficiently.

The sub-committee's report will inform the State Committee's deliberations on wider industrial and political considerations of MFR including remuneration, demarcation and ultimately if the role should be performed at all. Whilst the sub-committee is not expected to report on these matters, it is welcome to do so and any comments made in this regard will also be considered.

Composition

The sub-committee will be chaired by FBEU President, Darin Sullivan and will comprise the following six rank and file members who have been selected by the State Committee for their expertise and/or ability to represent the broad views of the membership on the question of MFR:

David Castle	Station Officer, 63 Blacktown	B Platoon
Nate Chellew	Training Officer BA/Hazmat	Overlap Roster
Andrew Connon	Inspector, MS2	C Platoon
Mark Dobson	Senior Firefighter, Wellbeing Coordinator	Special Roster
Tanya Marshall	Station Officer, Parramatta	A Platoon
Martin Paddon	Senior Firefighter, 64 Lakemba	C Platoon

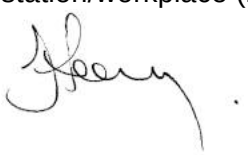
The Union's staff will provide administrative support to the sub-committee as required.

Meetings

The sub-committee will meet at the Union office on Thursday 4 June, Tuesday 7 July and Thursday 23 July on each occasion commencing 9:00 am and concluding 12:00 to 12:30pm. Lunch will be provided following each meeting.

Sub-committee members rostered on-duty will be released from duty by FRNSW without loss of pay for the time necessary to attend each meeting, including the time required to travel to and from the meeting. Sub-committee members who are rostered off-duty at the time of a meeting will receive a Union allowance of $173 per meeting.

Sub-committee members will be paid by the Union at the rate of 35.72 cents per kilometre (ie, the Specified Journey Rate) for the return distance from their home (if rostered off duty) or their station/workplace (if rostered on duty) to the Union Office.



John Henry
Senior Vice-President and
Acting State Secretary

Monday 11 May 2015

MFR Sub-Committee feedback received
1 June – 27 August 2015

The following is a reproduction of the 48 written submissions received by the MFR sub-committee. These submissions have been de-identified for the purposes of this report, however members are still able to access the Union's website forum to review, consider and/or comment in open debate. One submission expressly requested not to be published publicly, which has therefore not been included, but was considered by the committee as part of the overall feedback.

Date: Wednesday, June 3, 2015
Subject: MFR - the melbourne model and annual leave

Gday

Just wanted to raise a couple of points re MFR.

At 42 we have had to do a fair bit of mfr/cpr in the last 6 months, its always horrible and has way more of an effect on the crew than any other part of the job. I know that a lot of people see it as inevitable but we are pretty staunchly against doing it.

12.5% works out at only $88 a week before tax for a QF
I fail to see how the senior first aid course we have qualifies us for this work.

The main thing i wanted to point out though is in relation to the melbourne model which everyone seems to be talking about as the benchmark.

If mental health for fireys is going to be the most important thing in deciding this, which it should be. Then i would say that the best thing for a firefighter over all the peer support and psychiatrists in the world is time off from work with your family and loved ones.

MFB firefighter receive not only more pay and better (ambulance provided) training. But they also receive another month of annual leave a year which i would suggest is much more beneficial than anything else.

MFB work a 4 month on 1 month off annual leave cycle.

From the MFB award:

(a) Notwithstanding clause 28.2, an employee working the 10/14 roster and other employees of public sector employers will be entitled to 65.06 days annual leave per annum inclusive of the NES. Such leave is to be taken on the following basis:

(i) for employees subject to the 10/14 roster, such leave will be taken in periods of 28 calendar days within alternating periods of 20 weeks and 24 weeks; and

I would appreciate if this came up in the discussion, look forward to seeing the outcomes

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Date: 1 June 2015 2:22:02 pm AEST
Subject: FBEU INQ - For MFR group

Should we take on MFR, then we all know that there will be cases, likely many cases of firefighters suffering mental health issues which may take them off operational firefighting all together.

So I think we should make sure that if say, for example, a fire'y in the Gong develops a mental illness as a result of MFR, and cannot work on the trucks anymore, then they will be found an alternative position within that area (eg. the Gong) where by they can work under the DnD arrangements.

Date: 1 June 2015 10:40:32 pm AEST
Subject: MFR

My fear is that it will be exactly like it was for Rescue, the brigade told the government that yeas we can do it and it was thrown in the laps of the fireys with a training package that is still not any where near world class.

I am not a paramedic, i dont think like one and i dont want to be one. Yes i put my first aid skills to work when required but confronting this situations daily is not something that i would like to see happen.

Let the govt either invest in the ambulance service or amalgamate the two services and bring in professional health workers.

Cause am sure that we will not receive any formal training and no money is worth the extra stress on firefighters

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Sent: Tuesday, 26 May 2015 10:48 AM
Subject: MFR Sub -Committee

Sir

Having read SITREP 18/15 I took particular interest in the formation of the MFR sub-committee.

I noted that the committees make up is only from the permanent Firefighters.
With no retained representation how can any findings or recommendations accurately reflect implications for both retained and permanent staff.

The retained Firefighters in the past and continuing at present to have decisions that effect them directly being made without any representation.

An example of the lack of presence is highlighted in SITREP 18/15 where there is not a single mention of retained contained with in the document.
If this committee is to have any credibility than there needs to be representation involving all parties effected.

My back ground is 28 years as NSW Ambulance paramedic and 18 years as retained Firefighter.

I am neither for or against MFR but if it is implemented it will effect (*Retained fire station*) and more importantly the retained staff that work here.

Therefore retained representation should be a priority.

Sent: Tuesday, 19 May 2015 11:07 AM
Subject: MFR sub-committee.

Dear Madam and Sir's

I would like to offer you the following information regarding MFR, based upon my personal experience whilst employed by the ACT Fire Brigade *(some identifying dates of employment was removed)*.

Over the period of approx 6 years and 6 months, I estimated the call loading of MFR to be 11% of all fire calls.

I also estimated the exposure to deceased persons was about 33% of all deaths encountered per annum during my period of employment in the ACT, with the majority of fatalities resulting from motor vehicle collisions.

The number of fatalities which I experienced ranged between 6-12 persons per annum, during my period of employment.

Conducting CPR during this period was about 2-4 times per annum.

In comparison during the 12 years of employment by FRNSW, my direct exposure to human fatalities is about 4 in number, and I have not conducted CPR at all to date. (I might just be lucky)

I would like to state my concern for the mental welfare of the firefighter who will exposed to this type of work.

It "will" increased their exposure to human fatalities and trauma, which over time can affect the mental health of a firefighter and this may significantly reduce their period of employment as a firefighter.

As with other emergency incidents there are often traumatized family members present, which can make this type of work difficult and traumatic for the firefighter.

Shortly after my resignation from the ACT Fire Brigade, I was informed by a former colleague that 10 Firefighters and Officers with up to 25 years service were medically retired for mental health issues.

Prior to 2006 the ACT Firefighter had been doing MFR for 15 years without remuneration.

In the 2006 ACT Firefighters Certified Agreement re-negotiations the rank of Senior Fire fighter received an approx $15K wage increase, which was reflective of the MFR work being carried out, and also included the requirement for an SF to be primary rescue trained.

I hope that this information might prove beneficial to the MFR sub-committee.

Date: 20 May 2015 19:02:34 AEST
Subject: RE: first responder

I hear you and I agree that it is a difficult moral dilemma. I would much rather that something was done to fix the ambulance problem than band-aid it with under-trained, inexperienced firefighters that really don't want to do it.

History has shown that regardless what we agree to, the training will be minimalist, perhaps not initially but it will fade away like the rest of it has.

Let's have a look at our training history:

- Is everybody USAR Cat 1 yet? I doubt it as I only got mine this year (I think it was introduced 1999 or 2000).
- How's the confined space training travelling?
- I have not seen much of the Road Crash Rescue rollout.
- There are still rescue stations and operators without twin rope.
- Many still have their BLS go out of date and from lack of chasing.
- HAT1 and HAT2 seemed to suddenly fade away.
- They still haven't caught up with Working at Heights.
- I don't remember my last BA refresher.
- Or my last Compartment firefighting training.
- The Rescue assessors cannot keep up with demand.
- And neither, or so I hear, can the Workplace Assessors.
- There was talk, briefly, of professional development training, if you could convince your Zone to pay; like that would happen.

I have digressed and I don't mean to dump on you. Nor do I wish to debate it with you because that was never the intention of my email. It just stirs up strong feelings, as I am sure it does in many others including yourself. So feel free to filter the off topic rant, I am sure that you know where I stand.

Just back on topic for a minute; I'd probably feel different if there was evidence that we would actually be doing some good but I feel that it is a bit of a "wave the flag" opportunity more than anything else. And I do feel guilty for feeling this way.

Thanks heaps

On Friday, June 5, 2015, xxxx, wrote:

Hi all

I haven't seen anyone else's submissions but here are my thoughts.

I am supportive of MFR for a number of reasons:

1. We've been doing it informally since I joined the brigade in 1980. If anyone came to the station door and told us that someone had collapsed nearby we would ring Comms and do our best to treat them until the ambo's arrived. MFR is just an extension of that.

2. We are authorised under Section 6 of the Act to take measures to protect life whether or not there is a fire

3. We are here to serve the public who ultimately pay our wages . I'm sure they would be happy to have the nearest fire crew try to help them if they are in trouble. They probably don't care what uniform someone is wearing, they just want help.

4. We wouldn't be replacing Paramedics, just providing basic medical care until they arrive.

5. I live near a permanent station and I would want them to help me or my family as soon as possible while we wait for a paramedic to arrive.

6. NSW Health is a bottomless pit for taxpayer funding and it is unrealistic to expect that the public can fund hundreds of extra paramedics to bring response times down.

7. If I was at a station and found out that someone had died just around the corner I would be upset that we hadn't been called to try to help.

8. We need to expand our skill base because the number of structure fires are falling each year and if we don't make ourselves indispensable to the public we will become less relevant in the future.

Just a few thoughts off the top of my head…

Date: Saturday, June 6, 2015
Subject: Assistance

Hi Guys,

I have a unique perspective on CFR and MFR.

I worked in part with Commissioner on CFR in the early days, and I was involved in the acquisition development of the current EMTP & AED. I was part of the CFR subcommittee in the early days as well due to my diverse medical experience. The commissioner asked me for report many yrs ago on the likelihood of firefighters to make time critical life saving interventions leading to out of hospital outcomes.

I am a degree qualified Intensive care paramedic. I have worked in both private and public ambulances services as well as working in major NSW Trauma hospitals.

Happy to assist you with any information for your discussions. Thanks for you time.

Date: Tue, Jun 2, 2015 at 9:56 AM
Subject: ASNSW changes of response

Hi Darin,

Attached is a document outlining all the changes that are gradually occurring to our 'response grid'.

To explain what this means, our urgent codes of response are 1A, 1B, 1C. These are all lights and sirens responses, some of them dictate different levels of response (ie number of vehicles

and clinical skill).

The change you'll see to categories such as 'fire unknown status' and 'explosion no priorities symptoms' are the types of categories that house fires are usually created as. This happens from FRNSW firecom to the relevant ambulance control centre via ICEMS communication. Until the last few weeks, house fires were always urgent jobs; requiring the allocation of the closest available transport car and a supervisor. Occasionally a special operations paramedic will also be turned out.

The changes now are that a '2 immediate' category is assigned, meaning the responding resources travel under normal road conditions, irrespective of the distance. They will also be called off for 'higher priorities'.

Now ASNSW will try and counter this by saying that paramedics have the choice to travel urgently to 2 immediate cases. While this is true, the vast majority of ambulance staff do not understand the inherent risks of breathing apparatus, structure fires and internal firefighting and are unlikely to travel urgently to a standby case.

By the same token, although strictly instructed not to do so, some control centre supervisors are denying crews' requests to travel urgently to these standby cases. I am one such example and this is now why I'm reaching out to you.

ASNSW will also claim that their rationale for change is statistics based; the majority of responses to fire incidents don't result in treatment or transport. However you and your members are well aware about how unforgiving your work can be sometimes and how important safety is, and I strongly feel this is something being overlooked (ignored even?) by an emergency service struggling each day to handle its workload.

You mentioned previously about treating this confidentially, and for this I thank you in advance. However, this document, while an internal document, is actually freely available from the health services Union website- https://www.hsu.asn.au/wp-content/uploads/2015/04/Control001.pdf

Regards,

Paramedic, Sydney Station.

Subject: MFR
Date: 16 June 2015 10:35:52 pm AEST

G'day all on MFR committee,

I'm out so I know for most of you my opinion means shit BUT please don't take my comrades into MFR in any way shape of form. If you're going to recommend anything, make it to fix the bed block at hospitals and put more ambos on the road.

On Sat, Jun 20, 2015 at 10:19 PM, XXX, wrote:

Dear mfr committee, cc Jim Casey, Darin Sullivan and Stephen Cresswell.

A bit about me. Fire fighter for 17 years. I don't yet consider myself a cranky triple striper! 13 years in the cbd between *(listed stations deleted)* and now a few years at *(station deleted)*. I've

been a ladder operator, bronto operator and more recently a rescue dick. I'm a keen participant of union activities, forum, general meetings and SCoM meetings as an observer. I've been quite vocal on the MFR thread and was asked to sit on the MFR sub-committee. I'm on annuals and the meetings don't fit with kids school holidays and time away etc so I unfortunately I could not commit to assist. Next best thing is to put my two bob's worth in via you guys.

It's interesting to me to see the Department has changed their 'face' of mfr recently.

Quite some time ago I attended a forum where one speaker from the Dept spoke for mfr for quite some time. He had all sorts of wonderful stat's from Melbourne. Now I can't remember the exact figures he was sprooking but the context was something like 8% of calls saved a life. He was banging on about the lives they saved and all of the positives. I guess that's his job to do that though, feed us the positives in the hope we take on the job easily. He was a bit miffed when I asked a few questions on some important things involved with his stat's. I asked if 8% of calls saved a life that would mean that 92% of calls were dead bodies.... sorry to be so harsh, but that is the reality of it. He really was uncomfortable that I'd asked that question, because it's all nice and fluffy to save a life on the 8% of occasions, but really to plain ignore the 92% of calls where our members will be faced with the harsh reality of a dead body was really not something the Dept wanted pointed out.

They'll pull on the heart strings and play on the willingness to help that all fire fighters have, but we really must remember the flip side of the happy statistics, the majority of calls, will be a dead body. It's not something I ever planned to face, but it comes with the territory of being a firefighter, to have a few bad calls. Taking on MFR is going to dramatically increase the number of dead bodies our members will face in our career. It's not something I want to take on full stop, regardless of how much cash is on offer. That's just me though, I understand there will be members that do want to take on MFR.

What I would ask is that all members be given a full opportunity to consider all the facts and not be shielded from the harsh reality of dead bodies like the Department was originally doing the first time they tried to sell this to members.

IF members choose to take on MFR the things to consider need to be:

It's the Government's job to provide the best to the community. In health they really are doing a crap job. If the system needs more ambo's or more hospital beds then that is what they should be fixing, not putting a band aid on a broken system and using us to cover for Ambo's.

Just because they do it else where in the world (firies doing MFR) isn't an excuse or reason to do it. the yanks get on the roof of burning buildings too (and fall through) but we aren't going to do that 'just because they do it' are we?

If we take on MFR is this taking away another person's job? My cousin is an ambo and has been for over 10 years. I would hate to see someone lose a job or an new ambo recruit not get a job because we take on MFR. It's their core role, boost their ranks if they need it.

I've never been in need of utilising any PTSD services, so I really don't know much about that system. But with seemingly more members (or is it the same numbers but we are hearing about more of them?) suffering PTSD, is it really wise to be taking on a task where more exposure to causes of PTSD is 'par for the course' for the MFR role? Can the Dept system cope with an increase in workload if PTSD cases increase? Can the D&D cope if more members are claiming? Are we going to see the Dept turn a blind eye on members in the hope members leave and thus increase the turnover of firies (which is a target they have been trying to increase for years)?

Training... well we all know that training has fallen into disrepair recently. Training costs money. Money is something that isn't handed out easily any more. Training is suffering day after day and the effect of that wont be seen for some time in the ranks of firefighters. Do we really trust the Dept to give us correct and enough training in a non core role when we can't get a first aid refresher regularly, can't get a ba refresher regularly? What's their answer, outsource the training to Ambo's. That's probably the only thing they'll do correctly! But how long will it last?

Money, well we've already voted on that. Personally 12.5% wasn't enough. For me 20% wont be enough. If I don't have to do MFR ever I'll be happy to forgo any payrise handed out.

Suggestions:

Specialised stations. We already have bronto stations, rescue stations, is it a possibility to argue for MFR stations? That way you can go into or request out of an MFR station if and as required for your personal health. That would also solve the problem of forcing members to do MFR. To avoid doing MFR they just don't go to those specialised stations.

Safe guards. I think that if MFR is actually taken on it should be done on a trial basis so that we can pull out if it's not working. Not sure if that's a possibility or if we start it then that's it and it's in forever.

Don't let threats scare us. One of the lines Mr Mullins has used in the past is that we're not busy enough and one day the Govt will come after us and rationalise. We'll see station closures etc if we don't take on new roles like MFR. Don't let these statements come into play. We've had a battle with an unfriendly Liberal Govt that came after us with closing stations (yes temp closures but closures still the same) and it took a while but we forced their hand and broke them. I can't see any Govt closing fire stations in the near future so don't let threats of doing so take a place in the MFR discussion. Closing a fire station is a political nightmare because we made it one. The worst they can do is open up stations slower than we would like, but they wont close stations 'cause we'll make it a nightmare for them again... and they know it.

Finally,

I think we're the smallest public service union, yet we're the best organised, strongest and most united union. We're always up for a fight and out for protecting our conditions. this shouldn't be any different. The Govt or Dept really haven't been successful in forcing anything much upon us, this shouldn't be any different.

If it were up to me I wont be doing any form of MFR if I can help it. I'm probably in the minority but there aren't too many positives I can see in the MFR debate so I'd rather not touch it with a 20 foot pole. For me the negatives far far out weigh any positives.

On Sat, Jun 20, 2015 at 9:07 PM, XXX wrote:

G'day,

I was at an MVA today and met up with an ambo, *(name deleted)*. He, until recently, was a retained FF at *(station deleted)*.

I asked him about MFR and while having a neutral stance on the issue, raised a lot of questions.

He was main concerns included:
how will we deal with many fatalities (he had been to 13 in a month);
how will we deal with the high rate of fatalities (over 90% in this category);
the inability to remove a patient from the scene when it is the only option;
the limited equipment.

He said he would be happy to contribute to conversation.

I don't have his contact details at hand, but I am sure the guys at *(station deleted)* could help you out with that.

Date: 22 June 2015 3:01:47 pm AEST
Subject: Additional safeguard : My thoughts on MFR.

Dear mfr sub committee,

Just want to add an additional suggestion to the safeguard section of my email.

That it be written into any agreement with ambos management that an incident of mfr cant be downgraded in priority once we arrive.

As an example, when I was at Darlo we had a guy slipped on the footpath in wet weather and came down on the corner of the gutter breaking his forearm between wrist and elbow and being unconscious as a result of the impact. Member of public who saw it walked into stn and we took the bronto emt pack and assisted. It was reported as a heart attack to us by the pubilc. As we got there to assess he came too enough to chat and we knew not heart attack. A third person on the phone to 000 was asked by the operator if any assistance was on site and they confirmed uniformed (as opposed to off duty) firefighters were rendering assistance. From all accounts the classification of that incident then plummets down the order in ambo system because an emergency service is in attendance.

I dont want this to happen in an mfr situation. If we get called we go, but so should ambos with no downgrading till an ambo gets there.

PS- I'm writing this as im assuming mfr will get in... but I really still don't want to do it!

Subject: mfr
Date: 23 June 2015 4:43:28 pm AEST

Hello.

I would like express my feelings about the possibility of having to do MFR.

I joined this job to help people. Although first aid has never been my forte, I am pleased to do it. However, I believe that the government is using this innate characteristic of the firefighters goodwill in order to prop up a shabby health and ambulance service. Using firefighters to do the work of ambos is a band aid approach to the real problem in the health system. It is not a solution. At the end of the day my job as a firefighter is a means of paying my bills and I refuse to allow my goodwill to the community of NSW to be taken advantage of (because of the lack of good leadership from the government) at the expense of my health. Especially so because the MFR calls we will be attending are **not fire related**. I don't mind administrating

first aid when it is fire related, such as cooling burns with running water or administrating oxygen to someone overcome by smoke inhalation, but I object to administrating first aid when it is non fire related. I understand that the brigades view is that we are already first aid trained and that we should be used as an easy fix to the ailing hospital system. You know the old saying " if I wanted to be an ambo I would have joined the ambulance service"

I believe that this is another step towards lowering our work conditions - what other non fire related callouts will the government have us do if we cave in to its current demands? Will they then consider using us as cops and hand out fines for traffic infringements? Where will it end? We are standing at the edge of a very slippery slope.

Furthermore, Even if we got 12% increase, I believe this to be grossly undervalued. What price do we put on our health? The life long effects of shift work and broken sleep are well documented by the medical profession. This will further compound the detriment to our health and emotional wellbeing. Personally, I value me health much more than $10,000 per year. Even if the offer was 100% pay increase I would still scrutinise it.

So in summary, I believe we should flat-out refuse to take on MFR. Even if the media try to shame us, so be it. We don't need public support. Sure, having the public like us gives us a warm and fuzzy feeling. But my priority is firstly to my physical and emotional wellbeing and that of my family.

Subject: No thank you
Date: 1 July 2015 2:04:10 pm AEST

To whom it may concern,

I wish to advise the sub committee of my opinion of MFR and my stance of the issue.

I believe it's not our role nor our place to take on this extra work, regardless of any remuneration no matter how much it is. I did not join the Fire Brigade to perform Ambulance work on a regular basis. In my station area there is numerous nursing homes and an ageing population. Whilst I don't mind extra calls, I'd rather they be for our current core role and not "extra" ambulance work.

If there was a vote on this tomorrow my answer would be no thank you. If the vote was in 12mths time I would answer no thank you. If there was ever a vote my answer will be NO Thank You.

Date: 1 July 2015 4:24:37 pm AEST
Subject: MFR

Howdy MFR Committee

I fully support the view of Dave Castle and Marty Paddon, at *(station deleted)* we all share the same concerns, and is great to know we have representation on the committee with Firies that are looking at the big picture.

1. Levels of training
2. Fire Fighter Welfare
3. Renumeration
4. Industrially with our peers in the Ambos

All four need to be thoroughly considered
Regional and Country Areas will pose big issues with resources being very limited as it is.

Thanks for your efforts

On Fri, Jul 3, 2015 at 5:38 PM, XXX, wrote:

Dear Committee,

Thanks for the opportunity to submit my thoughts on MFR as part of our core role in the community.

I will preface this by saying that I was only recently made aware of this opportunity when working with Martin Paddon. I believe there would be many other firefighters interested in contributing if perhaps you approached the department about putting a notice on the intranet site or if you used facilities like the station fax explaining why you need input on this important issue from the rank and file.

I would like to submit my thoughts in three parts around MFR: The question itself, the discussion and the concept of MFR.

The Question

To the question itself: - 'Should we take on MFR?'

Within the question lies the problem - 'What is MFR'. We need to know what will MFR look like in FRNSW? What kind of jobs we will be called to and what kind of training and maintenance of skills will we receive.

The Discussion

I would imagine that normally the department proposes to answer this question by presenting a model to the FBEU for serious consideration. If this is not the case, then it is perhaps fair for FBEU to propose the model to FRNSW instead which will also include industrial considerations. This of course will be perceived by some that it is the proverbial "tail wagging the dog" but if the department doesn't give us any choice then very little blame can rest on the FBEU.

Basically, we need to know what we're talking about and discussing as I imagine there are many models and ways to operate within the MFR framework.

The Concept

I support the concept of MFR in general. However I do want to be compensated monetarily for it. I also want the training and skills maintenance to be adequate to the task. If the model is to be similar to the MFBs in Victoria, I would expect the same level of training. I would also expect a much higher level of support as the anecdotal evidence suggests that we as the operational staff will face a much higher exposure to fatalities, trauma and stress. Like all of our incidents I want to face them being well prepared, properly tooled and supported after the event.

In summary I want us an organisation to be well trained and well paid for the additional work but before that we really need to know what we model we are considering.

I hope this helps,

Subject: MFR
Date: 7 July 2015 1:23:07 pm AEST

Hi committee members,

To all of you, thanks for putting your hands up and being part of the process.

Firstly, my overriding concern with us doing MFR is the effect that standing around watching people die will have on us all. It's all very well to say that we deal with dying people at MVAs and fires, and to some extent that's true, but generally we are not having a direct interaction with the casualty as we are busy doing other stuff, usually dealing with the rescue or putting the fire out. It's the Ambos that deal with the casualty, as a rule. We are usually a bit removed from that, even when cutting people out of cars. If MFR comes in, it will be us, front and centre – nowhere to hide. Is the Dept at all concerned about increased stress being placed on us?

How would you feel turning up to some little kid whose been pulled out of a backyard swimming pool, already dead, but having to work on him till the ambos arrive. With family members screaming and crying, yelling at us to "do something'.

Secondly, I get the spin that the Dept are putting on this, the whole "wouldn't you rather have somebody turn up who has a bit of first aid knowledge, a bit of gear, rather than have nobody turn up". Most people would answer yes to that – my answer would be "of course I would, but I want that person to be an Ambo". And as is always the case, the blokes spruiking this to us (we've had an Inspector, Super and Chief Super visit us in the last month talking it up, all saying "I'd do it!") are all people that won't have to do it.

Thirdly, one of my concerns about the introduction of MFR is the possibility that the Dept. will want to tie this in with other industrial issues – specifically, the 24 hr roster. I can see the Dept saying "you guys seem pretty keen on the 24 hr roster, we're pretty keen on getting MFR up and running, let's see how badly you want the 24 hr roster".

Finally, the Commissioner has talked about it being voluntary and of the you-beaut training that we'll get, but so far the only up-scaled training we've had was a three hour visit from an ambo, and our (relieving) Inspector thought so much of the training that he wouldn't even allow us to go offline for it! We had a couple of calls during the training, in the end the Ambo gave up.

I don't know too many fireys that are keen on this – I just hope that if (when?) this comes in we have some control over it.

Good luck with it all, and again thanks for putting in your own time.

Date: 8 July 2015 1:06:56 pm AEST
Subject: Meeting HSU and AMSPA

MFR Sub-committee,

From the union forum, someone suggested meeting with HSU and this prompted me to

remember I attended a SCoM meeting when an AMSPA rep chatted to everyone.

Jim or Sully may be able to help with a copy of the minutes?

My post from the forum...

But I do think that meeting with HSU and AMSPA? (the other industrial association that covers some ambo's) would be a good idea.

Not sure if the sub-committee has seen or had access to minutes of SCoM meetings? But I attended a SCoM meeting about 3 years ago, maybe 2 years, when a member of AMSPA attended the SCoM meeting. It may be worthwhile chasing up a copy of those minutes to have a read, if that hasn't happened already.

Subject: MFR tankers
Date: 8 July 2015 3:05:54 pm AEST

Here's an idea.

Could we approach the department with the following.

Get 10 more tankers and 80 firefighters

- crews could be used for MFR with tanker.
- crews could be used to drive an ambulance with a paramedic when a code red (or what ever it is called when all crews are tied up and other operational staff are recalled to man ambulances)
- crews could be used for surge capacity during bushfire and storms.
- crews could be used for relieving as required.

No MFR for the majority.
No 12.5%.
80 new firefighters.

Surely this would help when 13 cars are off the road in Sydney due to staffing issues.
Surely it would have less operational and training issues.
Surely this is too simple an idea.

Subject: MFR
Date: 10 July 2015 11:06:19 am AEST

Dear Mark,

As requested I would like to forward my opinions regarding MFR.

PAY

I feel that the Union are on track with the % pay rise attached to potentially taking on MFR.

10% + would be acceptable monetary compensation for all aspects related to taking on a portion of the work previously covered by NSW Ambulance service.

TRAINING

An increase to the current level of MFR training and equipment. This would allow all fire fighters to maximize their impact on scene and minimize any negative effects of trauma caused by attending more medical emergencies.

Along side the increase to base MFR training and equipment I would propose optional NSW Fire and Rescue funded external training scheme with NSW Ambulance service on our days off. This training would allow any fire fighter who chose/applied to do the course/s being qualified as a paramedic or similar. The training and associated costs would be paid for by NSW Fire and Rescue (If payment was required under a potential government funded scheme) but no hourly rate would be paid to the Fire Fighter whilst studying (similar to attending University or TAFE). This free to study scheme would qualify a Fire Fighter with a nationally recognized qualification and a NSW Fire and Rescue allowance (MFR+) on completion, similar to Rescue, Hazmat or Bronto.

Training structure for the Medical Industry is already in place and choosing the most relevant modular courses to attend accumulating in the MFR+ qualification should be a process in consolation with the NSW ambulance service.

If the MFR role out commences then data will be gathered over time in relation to MFR calls per station and the nature of these calls. MFR+ stations could be developed under the same structure as Specialist Appliance Stations. This would allow NSW Fire and Rescue to effectively meet community needs whilst providing another career development pathway for Fire Fighters and Station Officers.

If NSW Fire and Rescue are serious about making an impact on the health and wellbeing of the community, relieving pressures currently faced by the NSW Ambulance service, protecting and educating Fire Fighters whilst maximizing the human resource already employed then bold steps need to be taken to supply a high level of medical service for the community that is after all funded by the community.

As mentioned in our meeting at COS last week, I would also propose that the Union canvas opinion via an online form with tick boxes and an additional comments section via email. Gathering information in any form is a difficult process therefore different avenues for 2 way communication should be explored. Thank you again for your time last week, I appreciated the Q&A opportunity with Wez, Jim and yourself.

I look forward to your response and I'm willing to help in any way.

Subject: MFR issues etc
Date: 10 July 2015 1:21:47 pm AEST

Good afternoon.

After meeting this morning chaired by Dave Castle and Trevor Ross I would like to submit some of my concerns add a few questions for the department to answer (am I dreaming) Recently I returned from 8 years in the E&T directorate and remain sceptical on if and how the department could or will implement MFR as part of our core roles.

What training and at what level of qualification would be required, what would be the departments "skills maintenance" for the qualification.

Would it be a case of all in or just designated locations performing MFR.

What if certain members did not want to be a part of the MFR, what and where would these members go to.

Would we be doing all 1A responses or just the overflow from the ambulance service.

Under 1A responses there are a number of areas I believe are well outside our skill sets...suicide, drug overdose and drowning's.

I am of the opinion that much of the training would be set up as E learning. What part or percentage of the training would be assessed and face to face.

What are the consequences if a member does not complete the required training.
What support would there be for members after attending a serious incident where individuals or the whole crew are suffering some effects.

We all know that the department can't even keep up with the BLS training for all members, as set by the government. How do they believe they can conduct and fund the new and updated training and maintenance of qualifications.

Additional payment to carry out this role is way down the list of concerns by members. This was very clear from the meeting held at 86 station this morning. A figure of 12.5% pay rise was mentioned. My belief is that this number be maintained if discussions continue with the department. This should only be given to personnel doing the training AND providing the service....NOT senior officers and admin personnel and NOT Operational Support staff.....none of these would be delivering to the public.

That's my say....and I say NO to MFR.

Subject: My thoughts on MFR
Date: 10 July 2015 9:12:06 pm AEST

To Whom It May Concern,

The purpose of this email is to provide some feed back in regards to my thoughts and feelings toward MFR.

As Firefighters we show a strong sense of community commitment. We see danger, we act, be it a warning to someone, be it physically putting ourselves in harms way to help and or protect someone and often something. This often commences with a rush of adrenaline, for some anxiety, for others excitement. Some all three. Having been with the service since 1993 I feel I can say I have experienced my fair share of these emotions. I'm sure that there are many that have also had to deal with some of the worst emotions as I have as well. Shock, Dread, Fear, Despair to name but a few. Sure we have moments of elation which is our ultimate goal. Get the job done, do it well as a team and get home safely, "save the day" so to speak.

There is a point I wish to make here. I, as most others, joined the fire service for what is was and still is. A Fire and Rescue Service. We are trained to act smart, as quickly as possible and under immense stress and pressure. To put it bluntly "when someone is in the shit, we have to dive into the shit willingly to get them, and now us as well, out of the shit". It has been and must be continually acknowledged that this has and will continue to have adverse effects on us in many various ways. Thankfully this doesn't happen everyday nor every shift. If it did we would all be a sorry worn out mob indeed. To sum this up we are at the pointy end of the stick

when it comes to protecting life and property. When it all hits the fan, we go in with all the emotions raging through our system.

Now lets add MFR to the picture.

As we all acknowledge the Ambulance service is stretched to the limit. So the MFR plan is for us, FRNSW, to alleviate this deficiency in Government service by attending life threateningsituations.

Herein lies the problem. Firstly I didn't join the Fire and rescue service to deal with dieing people on a daily basis. Argue all they want that potentially we deal with this anyway. Yes, but not every working day. I wonder how many of the people trying to make these decisions have had to deal with these situations, with little or no emergency medical training. I have felt the despair when trying to resuscitate with no success. The suicides I have attended, to name but a couple of situations. To be doing this often I feel will have grave consequences to us as First Responders. We are being treated as pawns on a chess table. We know we are not trained to handle these situations. BLS is exactly that, BASIC. And to back this up the tools, the training and maintenance of training is not even basic. My BLS had lapsed for over 5 years and I attended on my days off to be re-accredited. Note I said re-accredited. There is a big difference with being confident and skilled to being simply "re-accredited".

We as firefighters naturally respond to calls with a strong sense of urgency. All the emotions I already mentioned and for some of us the experiences (some good and some not so good) that we have also experienced in our private lives, are always with us. These experiences all add to that "jar" that fills up. People who decide to become Ambulance officers are trained for what they do, giving medical aid and assistance. MFR is not our specialty, it is the specialty of the Ambulance service.

I feel that taking on MFR would be a demoralising addition to our daily duties. We are not prepared, and as the training history of the service has continually proven, will never be prepared. To have an Ambulance officer come and teach us first aid for a few hours does not prepare us for the situations that arise. We are not prepared mentally, nor skilled to have the confidence and ability to do the job well.

Now on a mental health issue. The brigade is now acknowledging mental health. Acknowledgement is one thing. Action...well thats something else. Peer support is fine, as a band aid. It might get you through the night. But the next day it all comes back. I know, I've been there. When you go to your doctor who then refers you to a Psychiatrist for treatment you then do the right thing and notify the brigade. The response I got (from the brigade mental health guy at the time) when I had this experience was this.... "no you don't need to see a Psychiatrist, all you need is support". This bloke had no idea who I was or what I and a fellow firefighter had experienced. You call that support? I called it Bullshit then and to this day my thoughts haven't changed.

All I can say is thank heavens for Dawn and Lindsay Smith the Brigade Chaplains. I don't know where I would be today if it wasn't for them.

So, as far as I am concerned FRNSW is **not and will never** be ready to:

1) Delivery the correct and adequate training that is required for us to commit to the MFR role. The track record proves this.

2) Manage the mental health issues that will inevitably arise and leave fire fighters long lasting damage.

and

3) I WILL NOT sacrifice my mental and emotional well-being in order for the government to use a band-aid system to patch up the health departments lack of management and competence.

I will not, nor wish any other Fire Fighter be put in a situation that jeopardize the quality of their life and the quality of their family's lives in the name of a "Patch-Up".

Subject: Concerns about MFR
Date: 12 July 2015 9:25:52 am AEST

My main concern is that I am a firefighter and have no intentions of being a paramedic. I am worried that the scope of MFR will change in the future where our original turn outs are apparently categorized as a 1A will be expanded into calls that we are not qualified to handle. I am also worried that the promised co-turn outs with ambos will not happen.

I have concerns that the Coroner will one day turn around and say 'You did your best and you are covered for that but I don't think your best was good enough'. We are firies and we accept our actions as we have trained years for that but to be put in a position where we are responded to a call which apparently a 1A covers more then just heart attacks is not acceptable.

Date: 12 July 2015 3:59:22 pm AEST
Subject: MFR Feedback

G'day MFR Committee Folks,

From the outset, I would like to make it clear that I am not interested in seeing FRNSW take on MFR. I personally don't want to perform this role. Please don't take offence to the wording of this document, it's something I feel quite passionate about and I may get a little carried away.

I have a number of reasons for being against MFR:

1. I didn't join the brigade to be an ambo (pseudo-ambo is probably more apt). To qualify that statement, I am not against rendering first aid where I can at an incident or if Joe Public takes a spill in the street outside the station. As a matter of fact, a few years ago we had a gentleman have a cardiac arrest across the road from the station. We attended to him as best we could by assessing that he had no signs of life, so we commenced CPR and administered shocks from the AED as dictated by the device. We worked on him until the ambos arrived, where we continued to assist until they transported him to the hospital. He never regained consciousness. I think all firies are happy to assist where we can, but that's not a reason to abuse this goodwill by having the department lump ambulance work on us.
2. I believe we don't have sufficient skills or equipment to be performing this role. Let's say hypothetically my wife collapses. I call for an ambulance. No offence to any firie, but I don't want firies turning up if I call for an ambulance, I want paramedics to come and give her the pre-medical help that she needs. And you know what, if they can't help her, the next stop is the hospital where they (hopefully) can sort her out. This leads to my next point -

3. If we take this on, do we just become another step in the process before the patient receives the help they really need? If people are really that crook that they need chest pumping and Defibbing, they are going to need to go to the hospital afterwards. We can't do that - we can't transport patients to the hospital. So again, we are not properly equipped to perform this role - the role of a paramedic.
4. If there is government money to fund us in doing MFR, maybe it should be given to the hospitals to help with the trolley block issue, or give it to the ambos to fund more ambos. If there isn't money to fund us (in the form of extra training and a suitable allowance to compensate for the extra skills that we need and the extra stresses we will be under), then I'm even less than not interested.
5. What proportion of the work is going to be legitimate? I know that is a "how long is a piece of string" type rhetorical question, but working in the western suburbs, and speaking to ambos and police at jobs, we know there are "frequent flyers" who know how to use the system to their advantage. We know there are people who know how to get a ride in the ambulance, to get some pain medication, to just be a general nuisance. How long will we be tied up at these nuisance calls? When the ambos hear it's a nothing call, are they still going to come with great haste to relieve us? Then the question needs to be asked: do I, as a first aider, have the training to determine whether the person is on the verge of a chest grabber, or if they just have some severe indigestion? I know who would have a better idea, the paramedic who has done their uni course and understands the functions of the human body a bit better than myself.
6. Who is performing OUR CORE ROLE (putting out fires, doing rescues for those of us at rescue stations, attending HAZMAT incidents for those that do that) while we are at these MFR calls? What will the public perception of firies become if we do start doing this work, and Joe Blogg's house burns down because we were stuck with some guy who had a dodgy kebab last night?
7. Lastly, but probably most importantly, what will the mental health impacts be from taking on this work? Occasionally I think back to what we did working on that guy across from the station and think "could we have done something better, or different, that might have changed the outcome?" I always tell myself that we did the best we could on the day. Which begs the question: Do I want more of those sorts of circumstances playing on my mind if I can avoid it? Being at a rescue station, we do our fair share of nasty, shitty work. I accept that, it's what I signed up for when I said I would do rescue. But the fact is, I don't think anyone wants their "bucket" of nasty jobs to fill up any quicker than it has to by adding MFR work into the mix.

Subject: MFR Sub Committee Meeting
Date: 13 July 2015 2:00:42 pm AEST

G'day Comrades,

Thanks for representing our union on such an important issue.

I have spoken passionately for the positive engagement on this role in the community for the FBEU.

I have significant experience on this topic and I have in-depth knowledge from the health perspective to share with you.

I would like the opportunity to attend you next meeting if this is possible as I would be more succinct in delivering face to face on this topic.

However, if this is not possible could you give me some guidelines to present to you as my experience is incredibly diverse with NSW Health, In-hospital and pre-hospital, as well as both

public and private health institutions. This information is underpinned by my involvement in the FBEU on a range of topics inclusive of the last major E&T restructure.

Subject: mfr
Date: 13 July 2015 4:55:02 pm AEST

Dear Committee members,

I am writing to you as suggested by the union in its latest sitrep. regarding medical first response.

I commend your efforts to get out to as many stations as possible to hear viewpoints on medical first response (MFR), and to update us on your views and those of other members.

I have not attended a meeting on this issue specifically but wish to make my point to you.

I believe medical first response should be conducted by those with the training and the equipment to do so; the organisation that is best capable to serve the people of NSW in this area. The organisation where the members chose to do this type of work. That organisation is the ambulance service, not FRNSW.

I think we are cheating both the people of NSW and ourselves if we use fire fighters to undertake medical first response. The people of NSW want, expect and deserve an ambulance when they call for one. I understand there is an issue with ambulance availability. Much of this is do to the health system using them to transport patients in non emergency situations, and with them sitting for hours at hospitals being used as temporary beds. If we need more ambulance staff then put them on, Don't use firies as ambos. We are not ambos. Fix the system properly, don't quick fix it. What next: the local mechanic is short staffed. We carry tools, so do we become mechanics for the day?? Once we start where does it end?

Heaven forbid if any one of us had a medical emergency, we want an ambulance turning up, not firies. Firies who only carry best intentions, a first aid kit and a defibrillator (wasn't the defibrillator put on our appliances for our own use?). We can't transport patients. We should not be used in this way. It is wrong both for the people of NSW and for us. Just because it happens elsewhere in the world doesn't make it best practice. It makes it a cheap inferior alternative. It occurs in many countries with huge financial problems and broken health systems. Doesn't make it right.

If we do MFR we will sit there and watch people die while holding their hands and giving them oxygen, while family members cry, scream and beg us to do something. What mental cost will this have on our members? I am very concerned for fire fighters mental well being if we take on MFR. I am sure post- traumatic stress is already a huge cost to the organisation, get ready for this figure to sky rocket if we do medical first response. Members chose to be fire fighters, not ambulance officers. They are very different occupations requiring different mental attributes. While firies are incredibly skilled and adept at many things I fear many will not cope with the stress of this type of work.

I do not want to do medical first response. It was not a part of the job I joined. Some allowance or pay rise dangled as a carrot will seem paltry compared the the stress related costs that will come with MFR. A great part of our job is that we look after each other. I don't think we will be looked after adequately if we do this.

I thank you for reading my viewpoint on this issue.

Subject: MFR
Date: 13 July 2015 7:55:07 pm AEST

Here's a copy of my post on the topic. The feelings on my shift are generally "we'll do it I suppose",& "it's inevitable". I don't agree & they do see my 'industrial' argument.

Posted on FBEU forum 13/07:

After some consideration & for my 2 cents worth on M(E)(C)FR, in what ever form it is thought up.

I see this as either having moral implications or industrial implications. I think we need to decide which we are going with. Conscientiously (big word) I see the reasoning behind why we should end up doing it, formally. That's me implying we help Ambos when they ask for it anyway. We all (well nearly all) have some inkling to help people in need. I would hate to think someone believes I won't do it because I don't care.

Industrially thinking, you're kidding. This is propping up a failing government department pure & simple. Can we draw on the health Services budget? Aren't our pollies supposed to fix that sort of problem?

This whole 'FR farce, is a band aid fix for the Dept of Health Services short comings (Ambulance Service NSW budget). In the interest of our community (that's all of us by the way) should we not make that Department (one of OUR governments departments) responsible for their short comings instead of handing the problem over to us, possibly capable, maybe not so keen firefighters.

Let's be the catalyst for change not a crutch for incompetence.

If this is a ploy to merge the 2 services, as occurs in other jurisdictions, then get them to say so. Maybe that would be a good fix in the best interests of the community. Otherwise stick it up their arse & make them fix their own problems. Respectfully, I'd prefer a trained Paramedic working on my heart over my baggy arsed friend next to me…

For whatever record there is, I don't mind helping keep someone alive to die another day but I don't want to be part of a band aid fix to an industrial situation, in this sophisticated society of ours.

Subject: MFR and associated issues
Date: 14 July 2015 8:47:25 am AEST

Hi FBEU MFR team

I recently read the piece in the SITREP about MFR and of course it has been the topic of much discussion in the mess room.

Just prior to the last election Jim Casey attended *(station deleted)* on the campaign trail and the issue of MFR was raised. I spoke to Jim in front of the meeting and stated we should be getting fire, rescue and hazmat issues sorted statewide before we take on MFR, although I am not opposed to MFR if done correctly. Jim stated he would look at following up my suggestion and would employ a dedicated person to drive the issue of FRNSW taking on more fire district area on the interface and being better utilized as a paid fire service and sorting the mess that

is rescue in NSW and making sure FRNSW is responded to all hazmat jobs...which at present we are not...read RFS.

If we are to take on MFR lets use the opportunity to bargain for our job security in our core roles which are being constantly undermined by other services.

So my suggestion is the union secretary should follow up on our discussion and get the core roles of FRNSW fully embedded as our work!! Then when that is complete consider taking on MFR with appropriate remuneration, training and support.

Subject: MFR
Date: 14 July 2015 9:59:46 am AEST

Dear committee members,

Thank you for taking the time out of your own lives to be a part of this sub-committee.

My own thoughts on MFR...

I do not want to be doing it. Its not that i do not want to help people, i do not believe we are the ideal service, our initial and ongoing training is grossly insufficient, our critical incident support would have insufficient trained staff to deal with the potential workload, and appliance crewing does not suit undertaking MFR and having an appliance of four personnel being tied up and potentially neglecting our core roles.

My main concern with not taking it on, however, is that we are currently unable to justify (to the bean counters, penny pinchers, and pen pushers) our workload for the hours spent on shift and even though everyone pretty much knows that, noone ever wants to admit it.

So if we truly do not want to take on MFR (or at least not take on MFR without a reasonable pay increase) then we need to be able to justify our work hours and how this would impact on our current workloads.

Feel free to contact me to discuss further.

Subject: opposition to MFR
Date: 14 July 2015 10:52:15 am AEST

hi comrades

noting in the last sitrep 24/15 requesting feedback about imminent recommendations from the union sub committee regarding MFR

please be advised that the feeling of myself and many around me toward MFR remains unchanged at strongly against, we were advised by the union at the sgm in the trades building that anything less than 12% will be rejected, we were advised if we were against it in principle to vote along this line also, as was raised by john henry on behalf of concerns from his region, i expect the union to uphold this and not fold under pressure from the department or package it up in some cost packaged sweetheart deal for anything else in an effort to get it across the line.

when the time comes i expect the union to act morally and put it to the members as a stand

alone item with all the details available so the membership can make a single informed decision regarding the erosion of work conditions and the pay that will be offered in effect of this.

could the sub committee please acknowledge receipt of this objection by means of a return email.

Date: 16 July 2015 1:53:44 pm AEST
Subject: MFR

FYI,

Firstly let me start by saying i could not be more against MFR/CFR/EFR any FR. My reasons are two fold-

1.Politically- I believe this is both the root of the problem and also wear this issue should start/end and be fought out. The problem or need that arises to the extent that 4x FF need to jump on a Heavy vehicle and attend a Medical call because ambulance response in the GSA let alone country areas is so poor is a NSW disgrace. As aussies we try and tell everyone who will listen internationally how great we are and how lucky we are. Hypocritical much, when we cannot even provide timely life saving medical assistance. Ambulance officers want to be on the road doing their core jobs they signed up for just as Fire Fighters do. The need for us to step in comes from them being tied up to offload patients at ED's.(just last night 8/13 rostered ambulance tied up at RPA due to bed block). The responsible way for fire fighters as trade unionist and community members is to fight alongside the HSU to publicise this issue and turn the pressure back on governments to spend the money to fix the health system. I was recently told by a member of the sub committee (para phrasing whole discussion)that health is a 5 billion dollar problem and we are much cheaper, since when should this dictate our compliance in reducing the outcomes for patients who need ambulance/ hospitalisation within the shortest possible time. At the very best we would be a bandaid solution, considering we do not transport and will not under any MFR system we dont meet the main outcome most of these patients need which is high level care and hospital. the only bandaid offered should be more ambo's or bed managers in waiting rooms. lets join forces and turn the rhetoric away from "FF dont want to help people" and educate the electorates about the disgraceful state of our health system and ambulance service.

2.Type of Work- Whilst the call type are still to be negotiated, one is to assume that we would attend the worst calls ie the most life threatening. Let me tell you there is a huge difference doing first aid as a by product of a call, compared to daily entering peoples homes/workplaces as the responsible agency at least until relieved. Constantly dealing with the sights, smells and distraught family and co workers takes its toll and you definitely dread getting a call especially late At night. I have seen my fair share of bad stuff as a FF but it pales in comparison to medical responders. It also is not why any of us joined to be FF its not part of our history or legacy. People will argue its done in Nth America and other states, that is just part of their roles now and will never be given back, but thats no reason for us to do it just cause others are. We need to steer the argument away from we could have saved them or MFB have so many saves because the ambos could have also saved those people if available.

In summary i believe socially it is vital that we educate the electorates correctly on this issue and fight with ambos on the front foot. This is not what we signed up for and we are not yet at that impass were we need to find more work to justify our jobs and if we are then lets find better work for us to do i can think of a heap of jobs we could do before this. We would not expect an ambo or a police officer to put out a fire, The police would not respond us to a break inn next door to the station and we should not be doing medical calls.

I hope this sub committee is as unbiased as sold to the members and we are not only trying to nut out how we are going to do MFR but spending equal time on how we are going to fight against it.

I have experience both teaching BLS and working as a fire first responder and as an RO talking with the membership i can tell you the majority are against MFR.

On Thu, Jul 16, 2015 at 9:09 PM, XXX wrote:

MFR Committee

We're unsure of the input you require but wish to submit the opinion of MFR on behalf of *(station deleted)*, D Platoon.

It is our opinion that any form of MFR taken on by FRNSW would only be a short term fix for the underlying issues with the current ambulance system. Whether it be bed block, staff shortages, or other problems have led to this situation. Whilst there appears to be little focus on fixing the real issues, our assistance in propping up the system would all but guarantee that no effort would go towards a proper fix. Given that their current system is in decline, how long before our prop is not enough and we or someone else needs to come to their aid?

It goes without saying (although we are saying it now) that when we're sick and in need of proper care, it is well trained and seasoned paramedics that are required and not firefighters with basic first aid skills.

We are concerned that there will be an automatic assumption that all FRNSW members are suitable to work as medical first responders. We now know that there are specific psychometric requirements for persons to be classed as suitable for certain occupations and roles. The Brigade might be putting members at risk of permanent psychological damage not to mention the risk to the patients. This proposal is fraught with danger.

In summary this crew does not believe that we are a solution to the problem but a very temporary fix and that MFR for FRNSW is a short sighted ideology.

On Sun, Jul 19, 2015 at 7:17 PM, XXX wrote:

Country perspective-

Through my experience as a country permanent, ex Ambulance Officer, with a wife who works in XXX Emergency Dept and next door neighbour a good mate and Ambulance Paramedic, I believe i have a good knowledge of how the country Ambulance system works.

Basically, the Ambulance crew turns up to station, picks up Ambulance and then proceeds to cover and respond to patients throughout a huge region-Grafton up to QLD border and beyond an area that can take over 3 hrs. to drive. They float throughout region trying desperately to cover a huge area leaving at times big gaps in response times. The Ambulance coverage up here is so poor its quite frankly criminal.

For stats on SOME waiting periods for Firefighters sending code 3s to first aid -(204 retained) CFR station until Ambulance arrival please check BOSS.

If we do CFR, MFR whatever acronym we use, we will be going to life threatening cases. We will not be able to" load and go-"the Ambulance service term for stabilising and keeping PTs alive, whilst en-route to hospital with absolutely minimal scene time under lights and sirens. INSTEAD- we will be doing the opposite.

Fire crew will be sitting with a PT with life threatening injuries, in a bedroom or on the side of road etc waiting for an Ambulance that potentially comes from 30 or more minutes away.

I realise this email is more emotive than statistical, but I assume you guys are looking at Ambulance and Retained response times in this region-Far Nth Coast RN2.

Please... the FF s on this committee- unless you have worked as an AMBULANCE OFFICER prior to your current career in Fire and Rescue ,I am sorry and mean no offence -
But -you guys have no real idea of consistent traumatic exposure to PTs with life threatening conditions. The HUGE emotional toll their situation and their families reactions- Grief, horror, states of emotional anguish that imprint on your mind sometimes long term, leaves is enormous.

For country permanents make no mistake- we will be sitting, with the minutes turning into half an hour or more, waiting for an Ambulance to arrive, trying our best soaking in the worst day of many peoples lives simply because of an underfunded Ambulance service.

We will not be helping- we will be allowing a stretched Ambulance service to be further dismantled.

I wrote this email because I felt I had to at least try and stop this dangerous plan been implemented.

On Sun, Jul 19, 2015 at 8:48 AM, XXX wrote:

hello fellas

I did not join the fire brigade to be an ambo. By all means we are capable of dealing with some medical situations that arise at house fires etc because we are already there and are obligated to do so. I am extremely skeptical of the Brigade hierarchy telling us it is all for our future benefit ie keeping our jobs because of diminishing call numbers as our population hits 5 million in Sydney alone. The government is looking for a cheap fix for our ailing medical services. How many people will we not be saving the life of with our basic skills.

If they are going to bring it in regardless then make it cost them more than they thought, and why not have firies who are keen to do this like our rescue and hazmat people are by having designated stations to give better and faster turn outs to these medical situations and pay the appropriate allowances .

Will it not tie up our firefighting resources when we are at these jobs waiting for ambos who may not be in such a hurry to get there because the firies can look after it for a while.

On Fri, Jul 17, 2015 at 7:14 PM, XXX wrote:

Fellow Firefighters,

A justified view on MFR that is shared by many experienced Firefighters.

I don't think anybody disagrees with the principle of MFR, however experienced Firefighters fear that if the problems of the health system are not fixed, then the wait for an ambulance to come clear will not be any shorter. If anything it could be longer as help will already be on the scene and other cases may end up taking that priority instead. In fact, on paper, stats will probably be used to show that assistance (FRNSW) was on scene quickly and therefore there is no problem at all (despite patients waiting dangerously excessive times for Ambulances).

FRNSW is not equipped or trained to deal with MFR, and if we are to take it on we need a massive increase in payment and training, as well as an opt out clause for pre existing members.

There also needs to be a rock solid guarantee from the Ambulance Service that they will still respond immediately without delay. At the moment, if FRNSW is already in attendance then the call becomes a lower priority to ASNSW. Here's a real life example :-

My crew and I attended an incident where a pregnant woman had fallen over on a foot path, dropping her baby onto a the concrete footpath. The mother had leg injuries so my fellow crew members did what little they could with the basic first aid kit we are provided with.

I held the injured baby, who had serious head injuries.

An updated message was sent to Comms describing the seriousness of the situation and asked for immediate attendance of an ambulance. Comms operators continued to hear my pleas for an ambulance over the next hour. That's right, ONE HOUR!!

I held that little baby in my arms, her eyes rolling around in her head,trying to keep her warm whilst lapsing in and out of consciousness, for ONE HOUR! ONE HOUR!! Please think about that and consider that.

When the ambulance eventually arrived, from the Ambulance station that was less than 2km away, it was under normal road conditions - no lights and sirens. We asked why. The answer "because the Fire Brigade was already here Control made you a lower priority. We had no idea this was so serious".

I ask the members of the MFR committee to please take some time to think about and reflect on the above incident.

Imagine that you were the one holding that baby, it's head injuries causing its eyes to roll around uncontrollably in her little head as she lapsed in and out of consciousness.

Imagine if it were your baby child as I had to whilst I held her.

What would you have done?

If I had known that ASNSW would take an hour to get there I would have put her in the pumper and taken her to hospital myself. The first hospital was about 3 minutes away, the second about ten minutes away under lights and siren. Imagine standing there, holding that beautiful little baby girl for ONE WHOLE HOUR whilst her poor injured mother lay on the ground unable to move, fearing for her unborn child and asking if her beautiful little baby girl was alright.

This did not happen in a rural area, it happened on the Central Coast, 1 hours drive from the Sydney CBD.

I believe this little girl later died in hospital. If by some chance she didn't, she would be suffering severe brain injury and impairment that will probably last the rest of her life. We don't know, there was no follow up. There was also no follow up from FRNSW. No phone call from the Employee assistance program, no critical incident debriefing. No reply from Senior Officers after emails were sent outlining what had happened, in an effort to prevent such a tragedy happening again. Nothing.

If FRNSW had not attended that call then ASNSW would have responded immediately and transported both mother and child immediately to Hospital for specialist medical care and treatment. ***The attendance of FRNSW actually contributed to, and increased the severity of injuries to the patients.***

People will stand around in Head Office backslapping each other about what a great concept MFR / CFR / EFR is, and how great FRNSW's systems, Critical Incident Debriefing and Employee assistance programs are but the reality is that they have no idea. ABSOLUTELY NO IDEA WHATSOEVER! They need to stop watching reruns of American firefighter tv shows and get out into the real world. Firefighters cannot fix the problems of the Health Dept.

Date: 20 July 2015 11:04:04 am AEST
Subject: MFR

Comrades, thanks for putting your hand up & accepting the role on the MFR committee.

The following points are probably nothing new to you & you've probably had a lot of members voice similar sentiments. In principle I don't have a problem with MFR if done properly. However after 29 years in FRNSW I think it's an absolute given that management & the state government will want to do it the cheap & nasty way.

I am stationed at Tweed Heads & a lack of access to training has always been an issue for regional firies. At my station at the moment there are numerous members who's BLS, rescue, hazmat quals have lapsed, some for over a year. It's a big investment to maintain skills & qualifications & it is obviously not a high priority for the dept.

When you look at overseas departments who have the medical role the percentage of medical calls far outweighs fire calls. The added load, even for 12.5% will significantly change how we do things. I see this leading to burn out of members & an increase in the amount of members developing mental health issues.

Regional ambos are flat out, Tweed Heads ASNSW is the busiest station outside the GSa. They talk about the short comings with their system & they're ideas to fix it. FRNSW doing this role isn't one of them. They have regulars who know that by saying they have chest pains or trouble breathing gets them an ambulance fast. If a fire truck turns up & a message is sent that the patient is stable but needs transporting then it won't be a high priority job & we will be left to baby sit the patient till a car is freed up.

If the government were to bite the bullet & merge ASNSW with FRNSW & privatise patient transport, which is generally how it works overseas, this could be a reasonable idea. The money they need to spend giving us this role would be better spent fixing the public health system to eliminate ramping at hospitals. Get the ambos freed up & back on road quicker.

Subject: Support for EFR/MFR
Date: 21 July 2015 10:16:44 pm AEST

Lady and Gents,

I provide this response to the sub-committee as it is my experience in all matters requesting consultation and feedback, that those who support a request tend not to jump online and write ‘hey, I think this is a good idea!’ Those who oppose however, cannot wait to respond any number of times, in any number of ways.

So this is my submission to say that I am a supporter of an expanded role for firefighters into a medical/emergency first responder role. My position is both professional and ethically based, and in my opinion is shared by many more members who are (sadly) less pro-active on this issue.

Ethically, our role as a provider of emergency services to the community means that we have an obligation and capacity to help when it is needed. I cannot justify (on any level) sitting in a fire station waiting for the next call, when someone close by requires a relatively simple but deliberate intervention, to have any chance of surviving. We do have the capacity to provide this work and I would happily attend 100 EFR calls over 1 pre-school baby-sitting exercise, on any given shift. Additionally, it is my experience that on least one (possibly two??) occasions that I am confident that if the nearest fire station had been responded, the patient would have survived.

Professionally, our role needs to adapt to the changing needs of the community. Some areas of our core business are expanding while others are in decline. The phrase “what we are prepared to do” won’t wash with todays taxpayer and we need to be adaptive and pro-active, non of which means selling ourselves out, or short.

What I am about to suggest is not my original idea, and I hope the person who floated the concept to me will involve themselves to explain further. We should take on EFR for no additional money for a period of 18 months. We should demand the level of training that the sub-committee agree’s is required, prior to commencing the role. We need to show the value we provide the community (and govt) and develop some hard data on what we achieve, save, lose, gain whatever. Only at that point will we have something tangiable to negotiate for pay rises, based instead on real value without the need to give anything away.

It is a simplistic explanation of something that requires vision (and little self belief) and will take a targeted and deliberate pitch to convince the membership. One thing for certain however, the membership won’t again accept hidden or unexplainable tradeoffs to achieve a single item agenda.

Thank you for your efforts to date on this matter

Date: 21 July 2015 10:18:16 pm AEST
Subject: MFR

G'day MFR Sub Committee,

Why are we even discussing the possibility of Firefighters performing Medical First Response! FRNSW struggle to keep training up to date as it is let alone the (ongoing)training of MFR. I haven't spoken to one firie that wants to do it. We already have people who joined an organisation with the sole purpose, and understanding, of being the first line of medical assistance. They're called Ambulance Officers. They signed up for it knowing what the job entailed and they accept it. I joined the 'Fire Brigade' not the Ambulance Service. It's simple, hire more Ambulance Officers or free them up from waiting around at Emergency Departments

for hours on end. If something happened to my family, I want an Ambulance Officer knocking on my front door, not a firie.

Subject: MFR Feedback
Date: 22 July 2015 12:49:26 pm AEST

MFR Sub-committee

My crew and myself at *(station deleted)* have been discussing Fire and Rescue NSW taking on a MFR role and unanimously have decided that we would not take on the role if it was voluntary and the same stance even in the unlikely offer of a pay rise. So the reasons listed are my personal feelings as to my strong NO vote for MFR.

1. PTSD would be a certain legacy of MFR and I have had a lot to do with friends in the Police and Ambulance services and those services seem to spend more resources on trying to dodge their responsibilities to these victims than trying to help them. Also in our service there is a feeling that if you put your hand up for help it would probably mean you would never ride a fire truck again. So I believe that exposing our firefighters to constant death and the feeling of helplessness is a cost that has to be acknowledged otherwise TOLing will start again and it will be 'our' fault once more.

2. The Ambulance Paramedic that came to our station last week to tick us off as ready to start MFR stated herself that if CPR is no commenced within the first five minutes of a non responsive victim CPR is a waste of time, she also stated that over a nine year period she only had one successful resuscitation that led to the victim walking out of hospital, to add to that our pampers would not be out of the station in that time due to the time it takes to receive the 000 call, determine that it is a 1A then pass it to our operators etc thus exposing our firefighters to situations of very little chance of ever reviving a victim, which generates an even better chance of PTSD. The paramedic herself is an educator with the AMB because she had had enough of seeing the deaths and remembering every event and stated that the effects are accumulative to breaking point.

3. I believe we have not had sufficient training to even start MFR as we have not had any training at all on dealing with the families of the victims who could be anything from violent to extremely distraught, which once again leads to PTSD triggers. The victims families etc would be expecting and ambulance with drugs etc to sustain life and even to transport a victim but we have nothing as well as then being left with the families etc as their loved one is carted away once an AMB gets there.

4. If the situation is not heart attack etc related, it could be a gunshot, hanging or other type of suicide, we would not have addition training and knowledge to deal with these situations. We would also be called to drug overdoses and illnesses that require treatment other than CPR we are not able to deal with these situations. The statistics show that in a large percentage of cases we would not be able to help a dying victim and that would not be the expectations of the onlookers and families etc

5. The effects on our psychological well being would be worse than not attending at all by arriving to a hopeless situation that statistics and experts suggest that our efforts are for no positive result.

6. It seems like FRNSW taking on MFR is a bandaid solution to fixing a broken AMB system so money, resources and political priorities should be directed at the Service that deals with medical emergencies.

7. Up until now the FB has had policies and procedures in place so that our safety and well being is our priority and by taking on MFR we are asking our crews to expose themselves to potential if not certain harm especially in the shape of PTSD.

In summing up I am definitely against Fire and Rescue taking on a MFR role as it will cost the Brigade more than just money!

On Tue, Jul 21, 2015 at 10:18 PM, XXX wrote:

G'day MFR Sub Committee,

Why are we even discussing the possibility of Firefighters performing Medical First Response!

FRNSW struggle to keep training up to date as it is let alone the (ongoing) training of MFR. I haven't spoken to one firie that wants to do it. We already have people who joined an organisation with the sole purpose, and understanding, of being the first line of medical assistance. They're called Ambulance Officers. They signed up for it knowing what the job entailed and they accept it. I joined the 'Fire Brigade' not the Ambulance Service. It's simple, hire more Ambulance Officers or free them up from waiting around at Emergency Departments for hours on end. If something happened to my family, I want an Ambulance Officer knocking on my front door, not a firie.

Subject: MFR Negotiations
Date: 23 July 2015 2:33:32 pm AEST

Hi guys,

I had a thought the other day regarding the remuneration debate surrounding MFR etc.

When I was a paramedic, we were able to salary package mortgage repayments. Something to do with the ASNSW being a public benefit institution (I think). This ended up saving me a fortune each year in tax paid. The random thought I had was whether or not this benefit would apply to us if we take on MFR, seeing as we would then be performing a health service? If so, could this be used in negotiating a dollar deal with the government?

Subject: Nearest Defibrillator
Date: 24 July 2015 12:59:27 pm AEST

Just wanted to ask a question about MFR and if it is targeted at Fire Brigade specifically or whether it is being sold to us as getting the nearest defibrillator to the casualty. Looking at all the other services that also carry them I’m wondering if they are also coming on board.

For example, a confirmed non breathing unconscious patient and the ambulance service is obviously responded as first priority but then to cover that “gap” until they arrive is it going to be the nearest appliance with a defib? Fire truck/senior officer and also nearest police unit or Surf Life Saving vehicle (if its nearby) and its just whomever gets there first does what they can until the ambos get there.

Just a thought about if this really is targeted at assisting the community as best as possible.

Subject: concern at the quality of our training
Date: 29 July 2015 9:03:22 pm AEST

hi guys

just a quick email to raise a concern that myself and my crew and the visiting crews to our station had during a first aid course today. Before i start i want to point out that in no way are we disappointed with the trainer that we had today and are well aware that she is limited by the constraints placed upon her by the department. She did a great job considering the limited resources that are afforded to her, and in the bigger picture, us.

Situation: today at 88 we had a first aid course with our crew, 87s crew, 93s crew, 7s crew, 2 light duty personnel and an outduty from city of sydney who was out of date. 8 station was supposed to also attend but didnt make it. 19 persons by my headcount although i think 1 guy sat out as he was had done the course recently. For any of you that have been out the 88 station, you will know that it is completely inappropriate and ill equipped to train this many people. We had 1 trainer. we held it in the tv room. We as a group felt that the quality of training was effected because of this situation. The content was also the same as what has been being taught by the visiting ambulance trainers, which made it obvious that there is little communication between these seconded ambulance trainers and the BLS trainers.

The reason for my email is to raise a concern about the quality of the training that is being delivered to us by the department with the impending decisions coming up regarding MFR, and it is very concerning that only 1 BLS trainer is doing the rounds at the moment, you would think that they would be a little more fair dinkum about such an important role that we need training in.

Cheers guys.

Subject: mfr concerns
Date: 29 July 2015 4:08:28 pm AEST

Hi,

I am writing to voice some concerns over the MFR issue.

Recently, Duty Commanders have been coming around to stations for informal talks regarding MFR and its benefits, without providing any information or detail. All this has succeeded in doing is creating a rumour frenzy regarding MFR.

I would like to see some key points addressed in regards to;
* training, and follow up training. hard enough keeping our first aid up to date
* what support is available for people suffering from stress and trauma resulting from MFR
* is MFR voluntary, and what happens to the people not wanting to do it
* should it be voted on as a payrise, or an allowance for the MFR operators only

My wife is a nurse at (*hospital name removed)* Hospital, and is constantly telling me how ambulances are piled up waiting to offload patients, but can't because there is no bed availability due to not enough nursing staff.

Are we going to be used as a cheap alternative to propping up a poor health service.

Wouldn't any funding be better spent on the ambulance and health service.
I think it would be a good idea to clarify our position on a lot of the issues facing MFR and to keep the rank and file updated, so we don't all become victims of the rumour machine.

Sent: Thursday, 30 July 2015 12:17 AM
Subject: Dealing with no signs of life

Gents

With the pending decisions and ongoing discussion regarding MFR I would like to put forward an issue for consideration.

Trevor's rescue experience may be able to shed some light on this issue.

(station deleted) went to a medical access emergency a week ago. On arrival no other services were in attendance. We made entry and found the casualty on her back and on first examination she appeared deceased. She had vomit on the cheek, had soiled herself, was very cold to touch and had an overall appearance of slight flattening as you would expect when the body relaxes and the fluids pool to lower areas. She had been there for a couple of days perhaps.

When the ambulance paramedic arrived he made the call that she was dead from the doorway, no further assessment was made.

We can make no such determination as firefighters.

With MFR we will be sent to incidents specifically because the casualty shows no signs of life and we must treat any casualty that shows ‘no signs of life’ as if they can be revived. Unless the event is witnessed it is very likely that the incident will be reported some time after resuscitation of the casualty was possible.

This would put firefighters in the unenviable position of attempting to resuscitate a corpse for an extended time.

My question is: With the exception of obvious physical evidence that the casualty must be dead, at what stage do we not treat, having made the assessment that the casualty has died? I posed the question to fire crews yesterday and they were of the impression that you have to ‘get to work’, which is fine. But if we are filling the gaps for unavailable ambulances at what stage will these crews make the call that they are wasting their time?

An Inspector suggested that I make an assessment on arrival. I am not comfortable with this either. Based on what training would I make this call with confidence?

I advised my crew at the incident that the casualty was probably dead but we needed to get to work and it would be good practice.

I wasn’t comfortable with this but I am not in a position to declare the person dead. I returned to the appliance to send a message and when I returned they had made the call and not initiated treatment. The ambulance paramedic arrived at this time.

Considering that they were expected to check the airway, breathing, start compressions then cut away the casualty’s shirt to initiate AED operations, they felt very uncomfortable with my instruction, which is understandable. The AED would not find a shockable rhythm and would advise the crew to continue chest compression. Again, at some stage, when no ambulance

attends we would also feel that we were wasting our time but had to continue....for how long?

Both the Duty Commander and CIS team member contacted me to provide support for my junior crew following the incident. We debriefed a couple of shifts later which revealed that the issue that caused the most anguish for the crew related to this 'to treat or not to treat' issue.

I consider that MFR will expose firefighters frequently to particularly stressful situations through intimate interaction with casualties and their grieving families.

The issue outlined above is a difficult one which needs careful consideration and we would appreciate clarification.

On Wed, Jul 29, 2015 at 3:59 PM, XXX wrote:

Dear MFR Committee,

In light of the increased speculation of what might or might not happen regarding the possible introduction of MFR in FRNSW I would like to offer the following observations and questions.

The current standard of training in BLS may be adequate for the role we have at present, however in my opinion the refresher training is too infrequent to ensure proper skills maintenance.

Add to this, at any given time there are numerous personnel who are overdue on their BLS refresher.

Given the anticipated increase in our roles and responsibilities from MFR, what if any proposal has been put forward by the department to address the increased medical training that will be required?

What systems will be put in place to address the increase in stress related injuries ? Or is the belief that the current arrangements are adequate?

What arrangements will be made for members who do not wish to participate?

It's hard not think MFR is a stop gap and cheap measure to prop up a poorly funded Ambulance service. We must have firm guidelines which clearly define our roles and limitations, anything less will be viewed with suspicion.

On another point it seems the only source of regular information is via Duty Commanders as mess room chats. While this is welcome and worthwhile it is not enough to give a clear picture of what MFR means for us.

It is difficult at best to make any informed judgment on any proposal when so little information has been put forward for analysis.

A Fact sheet for example which outlines the major questions and answers would be a good start if there is to be an informed debate which could ultimately be voted on.

Finally any remuneration for the increased workload, skills, responsibilities and pressures must be paid only to those who participate, be it an allowance or other means of payment it is important that whatever money is available is directed only to the personnel who are directly involved in MFR.

Submitted by hand

1. Response Protocols

- Ambulance prioritises calls. eg Minor injury gets bumped down the list as more urgent calls come in. On a busy shift it may mean significant times for FRNSW.

- Can SO 'Render safe'? ie its obvious the injury is not serious so can crew leave?

- Will FRNSW alter its protocols? Ie House fire comes in en-route to MFR call, will pump be re-assigned to its core business?

- Public will take advantage of fast response of FRNSW and 'over call' the injury. Can SO 'render safe' as above or call malicious false alarm in which case can a Charlie be applied as per AFA's?

2. Suggested pay negotiation

No upfront pay deal. Pay increase then tied to increase in workload. eg FRNSW has 10% increase workload = 1% for 1% = 10% pay increase. Percentage negotiation and signed off before commencement of MFR.

3. Vicarious liability/good faith

What is the situation?
Training issues
Certification etc.

** End **

Fire & Rescue NSW

Memorandum

Safety Management
PO Box A249, Sydney South NSW 1232

To:	First Responder Consultation Working Group
From	Megan Smith, Health & Safety
Subject:	Medical First Responder Risk Assessment
Date:	25 June 2013

Background
In considering the potential impact to FRNSW and fire fighters for the proposed Medical First Response capability, the Health and Safety Branch evaluated the potential risks to health and safety.

Medical First Response will involve FRNSW fire fighters providing emergency medical care to patients who are unconscious and not breathing until ambulance officers arrive.

This report does not evaluate risks other than health and safety and should be considered in conjunction with a holistic approach to risk management.

Assessment
The assessment included:

1. Identifying hazards and risks associated with Medical First Responders (MFR)
2. Evaluate controls
    a. Identifying current industry standard controls[1]
    b. Existing FRNSW controls
    c. Recommended controls to further manage the risks to the health and safety.

1. Medical first responder hazards

Responding to incidents where patients are unconscious or not breathing can often be associated with a traumatic event or provide possible precursors to occupational stressors.

Potential hazards present at a medical first response incident are expected to be similar or heightened to those encountered by fire fighters at some stage in their current roles. Additionally, what could previously be seen as an infrequent role, will now become a primary function. There will be a significant increase in the likelihood of exposure to these risks when performing the role of medical first responder.

[1] Referenced from Workplace Health & Safety Queensland, Safe Work Australia, Canadian Centre for Occupational Health & Safety, and National Institute of Occupational Safety & Health regarding standard controls for paramedics and ambulance workers.

With an expected higher incident response, particularly with the circumstances of the incident, the risk areas which have been identified as most significant include:

- occupational stress
- biological hazards
- hazardous manual tasks

Occupational stress

Traumatic incidents or circumstances associated with the MFR role have the potential to affect the mental health and wellbeing of our workers. Potential stressors include the pressures associated with the job demands, the potentially confronting circumstances of the incident, and the external factors (ie people and environment) placing additional strain on MFRs.

Job demands	Incident circumstances	External factors
▪ working with patients who are deceased or near death ▪ traumatic injuries ▪ sense of urgency of the role ▪ perceived successes and failures ▪ competency ▪ confidence in abilities to perform role	▪ suicide ▪ SIDS victim ▪ patients known to workers ▪ children ▪ exceptionally traumatic injuries	▪ grieving individuals ▪ those individuals known to workers ▪ hostile environments ▪ cultural or religious differences ▪ pressure from individuals or groups ▪ resistance to service delivery

Biological hazards

The biological hazards identified relate to transmission of infection and disease. Providing treatment as an MFR will involve contact with a patient without knowing their medical history.

The transmission of infection and disease relies upon the virus or bacteria having a source, a susceptible host and a method to spread. The most likely routes of transmission while performing the MFR role will be:

- blood borne – in blood or body fluids (urine, vomit, wound drainage)
- contact – person to person or via contaminated articles or equipment
- droplet or airborne (sneezing, coughing, talking or fine particles in air or dust containing the bacteria or virus)
- syringes and sharps

Hazardous manual tasks

The job demands of the MFR role require a physical component to successfully administer the required treatment to the patient. The nature of the circumstances may not allow the patient to be moved and/or the location of the incident may restrict the posture of the responder while performing the role.

Hazardous manual tasks identified as risks for MFRs include:

- CPR compressions (repetitive and requires high physical exertion)
- prolonged tasks
- moving or lifting patients
- moving or lifting bariatric patients
- working in sustained or awkward positions

Other hazards
The following table outlines additional hazards identified in assuming the MFR role.

Hazard	Contributing factors
Needle stick and sharps	Route of transmission of disease, drug exposure, etc
Unprepared response	Responding to incidents outside capability/training, not getting enough information regarding incident
Occupational violence	Aggression towards workers from external sources
Bullying and harassment	Emerging from internal sources
Fatigue	Demanding work schedule or job responsibilities, lack of rest, etc
Traffic	Loading and unloading patients and equipment in high traffic environments, traffic management
Slips, trips, falls	Landscape, weather, environment, location, lighting, debris, etc
Equipment and maintenance	Use, supply, instruction, maintenance, stowage, training
Animals	Pets, companions, working animals, etc becoming aggressive towards workers
Other emergencies/firefighter injury	Other emergency situations which are beyond our scope of control, emergency management

2. Controls

A review of industry standard controls and FRNSW resources determined that while FRNSW currently provides a certain level of protection against these health and safety risks, they will not be sufficient to support the expected increased incident response and exposure associated with the MFR role. As a result, it is recommended that additional control measures as outlined in the table in Appendix A are developed and implemented.

Recommended control measures include improving FRNSW's current documentation and training programs as well as developing further processes, programs and resources to manage the risks associated with the new role. This includes introducing new training as well as increased delivery of existing training, clear procedures outlining job roles and responsibilities, and establishing communication strategies with other agencies and the public to increase awareness.

3. Recommendations

1. Potential issues identified in this assessment are considered in the proposed introduction of FRNSW medical first responders.
2. Required treatments outlined in appendix A are considered and endorsed.
3. Allocation of the appropriate resources for the development of additional controls to manage the risks to health and safety associated with the role of medical first responder.

Appendix A

Industry Standard Controls	Current FRNSW Controls	Required Treatment
Biological exposure (bodily fluids, blood borne pathogens, etc)		

Information provided to workers about the transmission of disease and infection control	- Infection Control Manual
	- Information provided on the Health Promotion intranet page
	- Biological Hazards SOG 10.8, section 8.2
	- FRNSW Vaccination Program
	- Current PPE:
	  - gloves
	  - P2 masks
	  - goggles
	  - glasses
		1. Confirm adequacy of current vaccination program
		2. Develop comprehensive infection control training
		3. Review infection control PPE for
		  (a) adequate inventory and logistics, and
		  (b) stowage
		4. Provide after hours infection control support
		5. Finalise new Infection Control Manual

Use standard precautionary measures and procedures for all contact with blood and body fluids including: - hand washing & hygiene - PPE - appropriate handling and disposal of clinical waste (including sharps) - environmental cleaning - blood and body fluid spills - cleaning and/or sanitizing of reusable equipment and laundry		
Provide appropriate PPE for tasks and train workers how to fit, maintain and store correctly		
Using additional transmission based precaution where infection risks cannot be managed by standard precautions alone		
Provide adequate hand hygiene amenities including hand washing facilities and alcohol hand rub		
Provide an occupational immunisation program and encourage recommended vaccinations for workers		
Ensure communication channels exist to send and receive information about notifiable incidents		
Procedures for managing accidental blood and body fluid exposures		
Needle stick and sharps		
Develop safe systems of work for handling, use and disposal of sharps	- Infection Control Manual - Sharps containers	6. Biowaste disposal arrangement 7. Enhance needle stick and sharps training
Use sharps containers and store as close as possible to where sharps are used, if applicable		
Protocols for managing accidental needle stick injuries		
Occupational stressors (job demands, critical incidents, organisational change, relationships, etc)		
Identify and review job demands which may have a negative effect on the mental health of workers, including: - workload - work environment - role and responsibility clarification (clear understanding of their role and do not have conflicting roles)	- Wellbeing Intranet Page - Health, Fitness and Wellbeing Policy - Mental Health Policy (in draft) - Employee Assistance Program (EAP)	8. Proactive Occupational Stress training and Resilience training 9. Media Policy training 10. DNR Training 11. Public engagement 12. Increased delivery of critical

Industry Standard Controls	Current FRNSW Controls	Required Treatment
- a certain level resilience to type of work they are engaging in	- Critical Incident Support Program (CISP) - Mental Health Awareness Training - Critical Incident Stress Education	incident response & education 13. Increased Wellbeing and Peer Support Program capacity
Ensure organisational change is managed and communicated effectively throughout the organisation		
Provide training on how to cope with grief, traumatic situations and public interaction		
Provide and encourage the use of post-incident care, including debriefing, counselling, support or other resources, if necessary for critical or traumatic incidents		
Provide a mechanism for systematic 'check-in's for all workers involved in a critical incident		
Provide training and prepare workers to and have realistic expectations of the situations, circumstances, people, injuries, etc they may encounter		
Equip workers with resilience building techniques and training		
Promote positive and cohesive working relationships to avoid conflict and deal with unacceptable behaviour and boost morale		
Occupational Violence **(aggression towards workers from external sources)**		
Policies and procedures that address occupational stress and violence and enforce effective issue reporting & resolution	- Debriefs from Post Incident Management SOG 17.2 - EAP - CISP	14. Police Liaison 15. Occupational Violence training 16. Wellbeing referral, peer system capacity and after hours availability (third party) 17. Cultural awareness training
Understanding of what occupational violence entails		
Procedures in place for when situational violence occurs (police on the scene)		
Prepare for and prevent violence by consulting with workers (using their own experiences to highlight problems, issues or responses		
Encourage expression of feelings & concerns regarding violence		
Provide training in how to deal with aggressive or unpredictable behaviours		
Provide post-incident care, including trauma counselling and debriefing		
Unprepared Response **(Responding to incidents outside capability/training or individuals responding outside their competency, which increases occupational stress and risk)**		
Ensure workers are aware of the scope of their training	- Standard Operational Guidelines, policies and procedures	18. Clear response guidelines 19. Feedback loop to ambulance service regarding notifications outside of scope
Provide clear instructions which address the functions/tasks to be and not to be performed		
Ensure clear communication protocols exist to report situations in which workers respond to these situations and incidents		
Procedures which provide direction to workers when responding to incidents where the		

Industry Standard Controls	Current FRNSW Controls	Required Treatment
required care is beyond their capability and how to proceed		
Provide training to increase the skills of workers		
Bullying and harassment (from internal sources)		
Policies and procedures in place to address bullying & harassment	- Preventing and managing workplace bullying policy - Bullying and harassment prevention training - Respectful workplace training	20. Discuss bullying and harassment at training 21. Develop communication strategy for introduction of program
Provide a means to report and resolve issues		
Clear understanding of definitions of bullying and harassment		
Formal complaints, reports, notifications, etc, are investigated properly, promptly and without bias		
Provide post-incident care, including debriefing, counselling, support or other resources, if necessary		
Hazardous Manual tasks		
Clear instructions and appropriate training available to allow workers to safely perform the job.	- Incident Ground Rehabilitation SOG 18.3 - Health, Fitness & Wellbeing Policy (Fitness Program, Posture Program, Station Training Program)	22. Bariatric awareness training 23. Patient handling training 24. Introduce a voluntary Rehabilitation Functional Conditioning program 25. Finalise the Hazardous Manual Tasks policy and guidelines for publication 26. Investigate potential aids to assist with the movement of nonambulatory patients
For tasks requiring hard physical effort: - organise the work or task to reduce physical force necessary to lift, carry, move, hold or restrain items or people - do not fully lift a person other than a small child unassisted - use assistive devices, mechanical aids or another person to help		
For tasks requiring working in awkward positions: - where possible, organise the layout and design of the work area allow for the straightest forward facing position – avoid positions where workers are bent, slouched, twisted or turning and with arms close to the body, not reaching away or overhead - vary positions frequently, don't stand, sit, kneel or squat for long periods of time - when driving, adjust the seat as to maintain a good posture and so that there is comfortable access to vehicle controls		
For tasks which are highly repetitive and/or of long duration: - alternate tasks with others - ensure regular rest breaks are taken - regularly change positions or posture - pace yourself - when driving adjust the seat as to maintain a good posture with so that there is comfortable access to vehicle controls		
Use specialised vehicles and assistive equipment to support the management of complex cases		

Industry Standard Controls	Current FRNSW Controls	Required Treatment
Fatigue		
Ensure that workers: - communicate to supervisors if their work schedule is too demanding and/or stressful - are aware of the causes and effects of fatigue - take breaks when necessary and extra breaks in extreme conditions (ie weather, high stress jobs)	- Incident Ground Rehabilitation SOG 18.3 - Fatigue Management Policy	27. Finalisation of Fatigue management procedures
Use the rostering system as to prevent fatigue & rotate workers		
Follow fatigue management policies, procedures & guidelines to assist in preventing fatigue for workers		
Traffic		
Load and unload in safe conditions (use hazard warning devices or signage)	Safe Work on Roads SOG 13.2	28. Discuss traffic management (and differences between multiple appliance response and single appliance response) in training
On route to destination, inquire about the location (eg stairs, access, traffic, public, someone directing them, geography, etc)		
Slips, trips, falls		
Assess unfamiliar sites for hazards or risks before starting the task (size up)	- Existing size up processes (safe person concept) - Rescue accreditation - Ariel appliances - AS4821 footwear - Lighting capabilities	29. Discuss slips, trips and falls awareness and controls in training
Avoid steep slopes, especially when carrying heavy or awkward loads		
Clean spills quickly using appropriate cleaning methods		
Non slip boots with good tread		
Check for good lighting, or provide additional lighting , especially at crossing points, or where surface type, height or slope changes		
Equipment & Maintenance		
Workers are trained in using equipment necessary to perform task	- Recommended Practices for: - EMT Pack - Zoll AED Plus	30. Review BA Service capacity (24hrs/day) 31. Enhance equipment hazard training
Manufacturer's operating instructions are followed carefully		
Increase equipment consumables at station used for emergency medical response		
Load, unload, store & secure equipment in safe conditions and designate a safe load or unloading area		
All equipment maintained and in good working order		
Animals **(Pets or companion animals becoming aggressive)**		
Limit contact with animals which may be in the vicinity of the incident	- Animal Handling - infection protection: In Orders 2001/2 - Infection Control Manual	32. Enhance animal awareness training
Wear adequate PPE when there is a risk of contacting animals, their secretions or being bitten or scratched		
Wash hands thoroughly after coming in contact with animals		

Industry Standard Controls	Current FRNSW Controls	Required Treatment
Remove and clean/decontaminate any clothing or equipment which may have been in contact with animal secretions		
Other Firefighter Injury/Emergencies		
Emergency management procedures in place	- Rapid Intervention Teams SOG 18.2 - First aid in the workplace procedure - Management and investigation of safety incidents policy - Incident Ground Health Monitoring SOG 18.4	33. Discuss emergency procedures at training

IRC 123 of 2014 – Background discussion of Medical First Responder concept, without prejudice.

Filed by Fire & Rescue NSW, 18 August 2014.

1. Medical First Responder (MFR) is the co-response of firefighters and paramedics to life threatening medical incidents.

2. FRNSW permanent firefighters on the 10/14 roster in 24 hour staffed fire stations (120 stations) in metropolitan areas and major regional centres would co-respond with Ambulance Service NSW (ASNSW) paramedics to high-priority code 1A Life threatening medical emergencies. Firefighters much faster response times will likely arrive first to commence life saving treatment.

3. The critical medical calls are classified by ASNSW as category **1A.** These calls are the most urgent whereby a patient is not breathing and unconscious requiring immediate medical attention - without treatment the results will be life threatening. These include:
    - cardiac arrest
    - drowning
    - electrocution
    - drug overdose
    - life threatening bleeding.

    All these calls require immediate medical treatment of Cardio Pulmonary Resuscitation (CPR) and defibrillation plus any other life saving treatment such as stopping major bleeding.

4. When a medical emergency occurs people will call Ambulance 000. Ambulance communication centre will automatically notify FRNSW communication centre of category 1A calls. FRNSW centre will dispatch the nearest fire truck to the medical incident.

5. ASNSW will dispatch their resources to the medical incident.

6. ASNSW will always respond with FRNSW to Category 1A calls

7. Firefighters, with faster response times, will commence patient care such as:
    - provide CPR
    - early defibrillation
    - stop bleeding
    - stabilise patients.

8. MFR firefighters will perform these duties:
    - assess and secure the scene for any dangers
    - follow infection control procedures within the scene and with the patient, which will include the wearing of medical gloves, masks and glasses and decontamination procedures
    - undertake a patient assessment and assess any signs of injury or illness Treatment and assessment will be documented on a Patient Handover form with a copy to be provided to paramedics
    - commence treatment which will include utilising any skills, training and equipment for MFR

- brief paramedics on arrival on patient condition and treatment provided. firefighters will remain to assist with patient care as directed by paramedics and will provide on scene support such as;
  - scene protection
  - access
  - risk mitigation
  - lifting patients
  - dealing with grieving family members
  - crowd control.
- download on to a computer and send any data from the defibrillator as part of the patient handover and treatment, for use by paramedics and hospitals Appliances will need to be fitted with ToughPads to enable immediate data transfer
- submit any patient records to a FRNSW central record keeping database and any designated Health NSW database in accordance with current legislation
- ensure the maintenance of any medical equipment
- ensure the correct inventory of any medical equipment.

9. For firefighters to be eligible as a MFR it will be mandatory to have further vaccinations, in accordance to the Health NSW policy directive *Occupational Assessment, Screening and Vaccination Against Specified Infectious Diseases.*

10. Significant research and consultation with the Melbourne Metropolitan Fire Brigade and Ambulance Victoria has been undertaken to assess proposed operating model and associated risks.

The Trial Option?

11. A six month trial would confirm:
- faster response times in provision of critical care
- the number of type of incidents attended
- effects on other FRNSW core roles
- procedures and policies cover all aspects of MFR duties
- training sufficiently addresses the required capabilities and any areas for skill improvement
- consultation and feedback from firefighters
- that all aspects of program are managed effectively and to identify any areas for improvement
- a collaborative approach to patient welfare is achieved with FRNSW and ASNSW.

12. For the purposes of a trial, MFR will be on a voluntary basis for firefighters. Therefore firefighters in the proposed trial area will be given the opportunity to participate in the first instance.

13. In the case of sick or other short term leave minimum of two firefighters per platoon shift will be required for an active MFR crew.

14. To ensure the minimum coverage of MFR firefighters is attained, stations adjoining the trial area will also be given the opportunity to be trained on the provision they will fill vacancies as required within the trial area.

15. If the number of MFR firefighters within the trial and adjoining area is insufficient to fill required MFR firefighter positions, FRNSW will offer the positions to Sydney based firefighters to transfer and participate in the trial.

16. All station officers and firefighters within the trial area will be MFR firefighters.

17. Station officers and firefighters not participating will be transferred from the area in accordance with operational requirements**.**

18. The trial of MFR will be integrated into current operational requirements of FRNSW such as fire trucks attending:
- structure fire
- vehicle rescues
- large bush fires
- resource allocation.

19. In consultation with ASNSW and FBEU, a trial area in Sydney incorporating six full-time stations will be selected. This location will be selected based on the distribution of 2013/14 category 1A calls, geographical location, and corresponding fire and ambulance stations.

20. The trial will need to be a defined area as opposed to selected stations distributed throughout Sydney to enable integration with ASNSW computer aided dispatch (CAD) system. ASNSW CAD system does not recognise the same zones as FRNSW and will require FRNSW system configurations to enable this

21. The trial area will require approximately 160 station officers and firefighters trained. Fire Stations in adjoining areas to the trial area will also incorporate 160 station officers and firefighters of which 50% will be trained.

Training and Skills

22. In 2013 ASNSW provided a gap analysis of the current medical training provided to firefighters. As a result of that analysis two gaps were found:
- infection Control (draft in progress)
- patient documentation.

23. Firefighters would not require any additional practical medical skills and medical equipment however refreshment of existing training and boosting confidence will be put in place to address feedback received from firefighters.

24. Firefighters would utilise both existing skills and medical equipment.
- **Skills:**
  - HLTAFA 211A Provide Basic Emergency Life Support
  - HLTAFA 311 A Apply First Aid
  - HLTFA 404 C Apply Advanced Resuscitation Techniques.
- **Equipment**:
  - AED
  - oxygen resuscitation equipment
  - emergency medical treatment pack.

Background to Medical First Responder

25. Ambulance services worldwide have shown an increase in number of incidents and the response times due to factors such as:
- aging demographic
- budgetary restraints

- increase in population
- increase in traffic congestion.

26. ASNSW statistics on Category 1A (the most urgent calls) incidents are increasing as demonstrated in table one:

Year	Incidents
2011-12	7,220
2012-13	8,115

Table 1 – ASNSW Incident response statistics for 11/12 and 12/13

27. The chance of survival of a cardiac arrest victim is reduced by 7 to 10 % with every minute that passes without CPR and defibrillation. Rarely do attempts at resuscitation succeed after 10 minutes.

28. In 2009/2010 FRNSW recorded a median response time for metropolitan calls of 7 minutes 18 seconds, in comparison to ASNSW, with 10 minutes 18 seconds.

29. The Australian Resuscitation Council NSW Branch reported in 2013 that in 2009/2010 NSW recorded only a 10.2% survival rate of victims 90 days following an out of hospital cardiac arrest, a decrease in survival rates from 2005.
- Victoria reported improved survival rates during the same period.
- people in Melbourne, where there is a Medical First Responder Program, were shown to have a higher chance of surviving an 'out of hospital cardiac arrest' than people in Sydney

30. Chain of Survival, as described by the American Heart Association, involves:

- rapid access through a (000) communication system,
- bystander (CPR)
- early defibrillation with automated external defibrillation (AED)
- early advanced treatment by medical emergency first responders.

31. This characterises an effective emergency medical services (EMS) system capable of promptly recognising an unfolding emergency and providing victims with emergency medical care and the most favourable outcomes. (Djeto Assane, 2011 International Journal of Business Strategy, Vol 11 Number 3,2011 page 90).

32. It has been found that "chest compressions and ventilations, and early defibrillation are the only factors proven to increase the survival of patients with out-of-hospital cardiac arrest and are key elements in the chain of survival defined by the American Heart Association." (Eftestol, Petter and Steen, 2003; in Expert Review of Cardiovascular Therapy Aug 1 2003 page 203).

33. Areas within the United States, Canada, United Kingdom and Europe have implemented Medical First Responder Programs which utilise firefighters as first responders in medical emergencies due to a faster response times to incidents and capacity within normal daily workload to attend.

34. In 2012 Health Minister Jillian Skinner commissioned a report into the ASNSW and as a result the NSW *Government Reform Plan for NSW Ambulance* was published in December 2012. This reform plan committed to progress implementation of a MFR program and recommended that a model similar to the Melbourne model be adopted in NSW. This would see an improvement in response times and patient outcomes.

35. Following successful trials in 1999-2000 the Metropolitan Fire Brigade Melbourne and Ambulance Victoria formally adopted medical first responder, and was the first Australian state or Territory to adopt this approach in managing acute medical incidents. The acute medical incidents included:
- cardiac Arrests
- drowning
- electrocution
- life threatening bleeding
- or other incident where the patient was unconscious and not breathing.

36. Melbourne simultaneously dispatches a fire truck and an ambulance to a medical emergency.

37. Firefighters in the vast majority of calls arrive first and begin CPR (chest compressions) and defibrillation to restore a normal heart rhythm.

38. Within the first 7 years, response times of over 10 minutes to cardiac arrests in Melbourne decreased from 18 % to 2 % of events. Additionally research confirmed that earlier response times improved patient outcomes.

39. Fire departments worldwide, including FRNSW, have seen a decline in the number of structure fires due to:
- better built environment
- smoke detectors
- better educated public on fire safety.

Medical First Responder process for Melbourne Firefighters

40. All calls are triaged by the Ambulance Communication centre to determine the appropriate resource and the urgency of the call.

41. Melbourne firefighters are automatically dispatched to category 0 medical calls from Ambulance Victoria as a co-response.

42. Category 0 calls (NSW the terminology of these calls are category 1A) are the most urgent whereby a patient is not breathing and is unconscious such as:

- cardiac arrest
- drowning
- electrocution
- drug overdose
- life threatening bleeding.

43. All these calls require immediate medical treatment of CPR and defibrillation plus any other treatment such as, stopping bleeding.

44. Before the commencement of the project in 1999 Melbourne firefighters:

- did not receive any first aid training
- no oxygen resuscitation equipment
- no automatic defibrillators

Consequently Melbourne firefighters required an initial 9 days training + 1 hour / calendar month.

45. The skill base of a Melbourne firefighter was much lower than the current skill base of a NSW firefighter. NSW firefighters already have:

- first Aid Skills and qualifications
- training and equipment to administer oxygen
- automated external defibrillator (AED) training with AEDs on every appliance.

46. Melbourne firefighters received a 2.4% to 3.5% increase depending on rank and a flat increase of $1 per hour when MFR was introduced.

Current NSW situation

47. ASNSW 2012/13 50th percentile (median) response time for potentially life-threatening cases was **11.13 minutes.**

48. FRNSW 50th percentile (median) response times for **all** calls was **7.3 minutes.**

49. In Australia, the 50th percentile response time is a key measure for all Ambulance Services.

50. Lennox 2014 report http://esa.act.gov.au/wp-content/uploads/Lennox-14-Final-July-182014.pdf in the ACT Ambulance service reports that Canberra has the best Priority 1 response times at the 90th percentile (13.7 minutes) of all capital cities. Figures for other cities as follows:

- Sydney (20.6 minutes)
- Melbourne (19.5 minutes)
- Brisbane (14.9 minutes)
- Adelaide (15.4 minutes)
- Hobart (16.1 minutes).

FRNSW 90th percentile response time for 12/13 is 12.02 minutes

51. Response times for ASNSW has been increasing over the past 5 years.

52. ASNSW has 226 Stations.

53. FRNSW has 337 stations (120 Permanently staff 24hr/day, 217 other)

54. The number of Category 1A Calls as demonstrated in table two for ASNSW are:

Year	Incidents
2011-12	7,220
2012-13	8,115

Table 2 – ASNSW Incident response and transport statistics for 11/12 and 12/13

55. NSW Ambulance estimated that in 2013/14 there would be about 8500 emergency medical calls (code 1A) these calls would be spread across the entire geographical area of NSW.

56. In 2012/13 FRNSW crews responded to 133,611fire and other emergency incidents, an average of one incident every four minutes.

57. NSW Ambulance responds on average two Ambulances to each category 1A call, each ambulance dispatched is recorded as a response.

58. In 2010/11 the ASNSW provided over 1,149,820 total responses (both emergency and non-emergency) compared to 1,133,011 total responses in 2009/10. There were on average 3,150 responses per day - this is equivalent to a response every 27 seconds across a network of 226 ambulance stations.

59. This additional workload if calculated on total calls for FRNSW NSW 2012/13 would account for an increase of 6%.

60. The greater distribution of stations across NSW increases the capacity of firefighters to attend the scene of a critical incident faster than paramedics.

61. FRNSW is currently utilising existing skills and equipment in the following calls whereby firefighters attend to patients until the arrival of paramedics.

62. The medical assistance calls by firefighters (demonstrated in table three below) in will range from cardiac arrest, major injuries and general patient care whereby Ambulance response is delayed or Ambulance requires additional assistance.

	2008/09	2009/10	2010/11	2011/12	2012/13
Fires					
Structure fires	7 448	7 495	7 053	6 704	6 721
Other emergencies and incidents					
Non-fire rescue calls including animal rescues					
Motor vehicle accidents involving the extrication of victims	4 905	5 104	4 981	5 082	4 889
Other non-fire rescues including industrial and home rescues	2 506	2 621	2 788	2 959	2 867
Medical assistance	796	926	1 032	1 057	1 056

Table 3 - Number and Type of Incidents and Emergencies Attended

63. The skills, training and equipment used by firefighters has not changed since 2005 when FRNSW introduced Automatic Defibrillators and the Emergency Medical treatment pack.

Current Programs

64. FRNSW currently has the following support programs in place to assist firefighters:
- EAP (phone counseling, face to face counselling, well checks, manager assist and trauma assist)
- Peer Support Program (CIS, Mental Health Education, Peer Support)
- Chaplaincy services
- SANE Mindful Employer Program.

All other FRNSW mental health programs are currently in pilot phase and undergoing evaluation by both UNSW and Sydney University.

Current Situation:

65. In 2008 Permanent Firefighters Award FBEU argued a work value case successfully for the 'medicalisation' of firefighter roles.

66. The proposed model does not increase the skill level of firefighters over and above the 2008 Award. Firefighters are already trained and currently provide first aid when called to attend incidents such as:
- fires

- motor vehicle accidents
- other rescues.

67. All FRNSW appliances are equipped with AEDs and medical oxygen equipment.

68. Melbourne firefighters received between 2.4% to 3.5% increase (depending on rank) and a flat increase of $1 per hour when MFR was introduced.

Regulatory Impact

69. The Crown Solicitor's office has confirmed that firefighters can carry out Medical First Responder function without the need to change any Acts or Regulations including:
- driving under lights and sirens
- entry to Premises
- treatment
- patient documentation and record keeping.

Community First Responder (CFR) versus Medical First Responder (MFR)

70. CFR is a program run by ASNSW.

71. Partner organisations include:
- NSW Rural Fire Service
- NSW State Emergency Service
- Volunteer Rescue Association
- NSW Health
- FRNSW.

72. CFR stations are chosen due to distance from nearest Ambulance station and response time of > 30 minutes. This will normally tend to be retained firefighters.
- MFR stations will be all permanently staffed 24 hour stations

73. CFR firefighters co-respond to ALL ambulance calls and commence treating patients until arrival of paramedics.
- MFR co-responds to category 1A.

74. CFR firefighters are trained over 4 weekends/8 days in HLT21112 - Certificate II in Emergency Medical Service First Response.

75. CFR firefighters have monthly 2 hour training with paramedics and a yearly refresher, plus an intensive hand book which logs incidents and training.

76. CFR firefighters have a much higher clinical skill and knowledge base than MFR firefighters.

77. MFR firefighters will not require additional training only building of confidence.

78. CFR firefighters skills include the use of the following drugs:
- methoxyflurane
- anganine
- salbutamol
- panandol.

79. MFR firefighters will use existing skills and **NO** drugs.

80. CFR firefighters use the following additional equipment
- stethoscope
- blood pressure machine
- pulse oxymeter
- glucometer.

81. MFR firefighters will use **existing** equipment.

82. FRNSW CFR firefighters include:
- Alstonville
- Branxton
- Bundeena
- Bundanoon
- Tocumwal
- Uralla

83. FRNSW are reviewing the inclusion of three additional stations as CFR in 2015:
- Coolamon
- Henty
- Thredbo.

84. In 2013 CFR firefighters were granted a 7% increase in wages because of the additional skills and equipment.

85. CFR is utilised where there is no ambulance available in towns whilst MFR is utilised for a faster response where ambulances are available.

Attachment 5

Failure to use firefighters to fill NSW Ambulance Service shortfalls is 'costing lives'

August 30, 2015

James Robertson
Reporter
View more articles from James Robertson
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The Ambulance Service is under pressure to reduce waiting times. *Photo: Darren Pateman*

The state government's failure to fully implement a plan to send firefighters to treat critically ill patients in place of ambulances is costing lives, experts say.

A leaked briefing shows Health Minister Jillian Skinner and the state's most senior health and emergency services bureaucrats signed off two years ago on the proposal to use firefighters when ambulances cannot reach patients. The move was proposed as a stopgap measure to reduce ambulance response times, after a plan to have the services respond jointly to ill patients stalled because of the Fire Brigade Employees' Union's pay demands.

But Fairfax Media can reveal NSW Ambulance has referred fewer than 20 cases to firefighters in the past year. This comes despite at least four high-profile cases where patients have died from heart attacks while waiting 30 minutes for an ambulance – or much longer than the eight-minute benchmark.

The ambulance service is estimated to have received more than 8000 of the highest-grade emergency calls in the past year and 2000 cases of cardiac arrest, across NSW.

"There's no doubt people will be dying because there's no action on this plan," said Paul Middleton an associate professor of emergency medicine and chairman of Take Heart Australia. "It's very straightforward arithmetic: you get a 10 per cent decrease in survival for every minute that a patient is in cardiac arrest."

Fairfax Media revealed in July that a patient in Hurstville died from a stopped heart after a 30-minute wait for an ambulance.

Three fire stations in Hurstville and surrounding suburbs are equipped to respond to emergencies 24 hours a day. But the ambulance service has denied that a lack of resources caused the delay and is investigating the incident.

The ambulance service has come under strain recently, as paramedics are forced to stay with patients in hospital emergency departments. Extreme bed shortages in Sydney's south led to ambulance officers being told to bypass St George Hospital, a move they said could put patients at risk. Separately, the Ambulance Service downgraded sexual assault injuries to a lesser status of emergency, to ease demand.

Ambulances take a little less than 11 minutes to reach half of all emergency cases in Sydney – firefighters typically arrive three minutes quicker.

"Firefighters are trained in advanced first aid and all fire engines statewide are equipped with trauma kits, oxygen resuscitators, and automatic external defibrillators," said a spokeswoman for Fire and Rescue NSW.

Ambulance NSW acting executive director of service delivery said industrial disputes had delayed the introduction of a program of joint responses with firefighters.

"Four paramedics have provided training to more than 300 Fire and Rescue NSW firefighters [in the meantime]," he said. "We continue to work together to progress the proposed introduction."

Ms Skinner referred questions from Fairfax Media to the Ambulance Service. In 2012, she ordered the government to investigate the idea of using firefighters, as part of a plan to lower ambulance response times.

But a formal deal has stalled because of a dispute with the firefighters' union over their request for a 12 per cent pay rise to take on the work, according to the memo obtained by Fairfax Media.

As a proposed interim measure, the memo shows health bureaucrats would instead send firefighters to the most serious emergencies on an ad-hoc basis.

While demand for ambulances across NSW is increasingly rapidly, the number of times the fire brigade is called out is falling at about three per cent a year, due to factors such as better apartment sprinkler systems.

The plan to send firefighters to treat critically ill patients closely matches a model used in Melbourne for more than a decade, as well as in the United States, Canada and New Zealand.

"In Seattle [under a similar program], there's a 64 per cent survival rate for cardiac arrest, compared to ours of 10 per cent," said Associate Professor Paul Middleton, of the University of Sydney.

The Australian Medical Association recently expressed support for the plan but only if firefighters were not used with a view to replacing paramedics.

Attachment 6

Firefighters working with ambulance officers would save lives, experts say

December 14, 2014

Read later

James Robertson

Help: Firefighters could respond. *Photo: Quentin Jones*

A plan to have firefighters help the ambulance service respond to critically injured patient has been shelved by the Baird government over pay demands, despite medical experts saying it would save lives.

Under the proposal, firefighters would be sent as a stopgap when paramedics are delayed from reaching the most critically injured patients within a benchmark of eight minutes.

They would resuscitate patients, clear their airways or treat those in cardiac arrest with defibrillators only until paramedics arrived.

"It's a no-brainer," said professor Chris Semsarian, a cardiologist from the University of Sydney. "Every minute is vital when it comes to a cardiac arrest and the only thing that can save a person's life is an electric shock".

The Health Minister first ordered the government investigate the idea in 2012 as part of a plan to lower ambulance response times. But nothing has been said publicly since.

Documents obtained by *The Sun-Herald* under freedom-of-information law show plans for the policy are far advanced, but the government has shelved the idea because it has been unable to negotiate a pay deal with firefighters.

The logic behind the proposal is that firefighters carry defibrillators and respond faster than paramedics.

Ambulances take 10.8 minutes to reach half of all emergency cases in Sydney. Firefighters are more than three minutes quicker.

When measured against the time taken for 90 per cent of cases, Sydney's ambulance response times are the worst of any Australian city, according to the Productivity Commission.

While demand for ambulances is growing steadily, calls to firefighters fell about 3 per cent between 2010 and 2011.

The proposal to adopt the program went to cabinet last year, but a request for funding was blocked. A third round of negotiations for a trial of the program collapsed about two months ago.

The plans closely match a model used in Melbourne for more than a decade. Similar systems are in place in the US, Canada and New Zealand.

The Australian Medical Association initially had reservations about the policy in 2012.

But AMA NSW president, Dr Saxon Smith, has now expressed qualified support for having "advanced first aiders" respond when paramedics were not immediately available.

"But it's critical that this program doesn't replace ambulance services nor lead in any way to a reduction in ambulance services," Dr Smith said.

Jim Casey, the president of the Fire Brigade Employees' Union said the union was "open" to the program.

"But the government has made it crystal clear they refuse to pay for it," he said.

Fire and Rescue and the Ambulance service struck an agreement in January to call fire-fighters on an ad-hoc basis even without a formal policy. But *The Sun-Herald* understands it is very rarely invoked.

Some paramedics questioned why nearby firefighters were not paged in the case of hospital wardsman Brad Jones, who died choking in his Blue Mountains home while waiting 30 minutes for an ambulance.

It was revealed last week that Mr Jones' fate was likely sealed that morning, when on-duty paramedics were sent to cover shortages in Penrith, leaving an ambulance 40 kilometres away, in Springwood, to take the first call.

The Australian Paramedics' Association said it supported the idea of a program, but only if it was well funded and firefighters were trained, sent only to a select number of cases and never used in stead of paramedics.

Ambulance response times for emergency cases fell marginally last financial year by about 20 seconds, but this followed a re-classification of emergency cases last year, the Auditor-General noted.

A spokeswoman said that Fire Commissioner Greg Mullins is a "strong advocate" of a co-response program but "industrial issues remain unresolved".

West

Unions are 'potentially' putting lives at risk, says Fire and Rescue NSW Superintendent

March 10, 2015 11:03am

Alison Balding Mt Druitt-St Marys Standard

Example of a a defibrilator, which could save the life of someone in cardiac arrest.

THE project manager for a plan to send firefighters to medical emergencies says the industrial relations issues blocking it were "potentially" putting lives at risk.

RELATED: Shake up of emergency response labelled Band-Aid solution

Fire and Rescue NSW Superintendent Wayne Phillips said some of the industrial relation concerns seemed to confuse the First Responder Program proposed for Sydney with the Community First Responder Program used in isolated country towns.

"In those cases, firefighters are trained at a higher level so they can give pain relief and check glucose levels," Supt Phillips said.

"The First Responder Program is only about CPR."

With a defibrillator on every fire truck and quicker response times, he said it made sense to send firefighters to calls where a person was unconscious and not breathing "because minutes matter". This lifesaving service already happens across NSW on an ad-hoc basis, he said, but this program would formalise the process.

Supt Phillips said NSW needed this program because "it saves lives".

"New Zealand introduced this in December 2013 and, by July 2014, 47 people – who otherwise wouldn't have lived – were saved," he said.

Dunheved firefighter and Fire Brigade Employees Union Sydney outer west sub-branch secretary Trevor Ross wants to work out a program that is fair.

Dunheved firefighter and Fire Brigade Employees Union Sydney outer west sub-branch secretary Trevor Ross said Fire and Rescue NSW had never clearly explained their plan would limit the program to just cardiac arrests.

"They've never said it like that and from the union point of view, we want to sit down with them so we can agree on a model and money," Mr Ross said.

West

Shake-up of emergency services slammed as 'Band-Aid solution'

February 25, 2015 12:10pm

Alison Balding Mt Druitt-St Marys Standard

Firefighter Trevor Ross is concerned about a state government plan relating to firefighter's covering for ambulance officers in peak periods.

A PLAN that could see firefighters as the first response to medical emergencies in Sydney has been slammed as a "Band-Aid solution" to prop up a crippled NSW health system.

The move would result in firefighters being sent to jobs as the first responders in cases where an ambulance was unavailable.

Firefighters have raised concerns about not being guaranteed adequate training and a pay rise for the added responsibility.

Paramedics have also dismissed the plan and accused the government of ignoring the real issue of needing more feet on the ground.

Australian Paramedics Association president Wayne Flint, a paramedic of 33 years, said the First Responder Program was completely inadequate.

"Just as you wouldn't send a plumber to do an electrician's job, you shouldn't send a firefighter to do a paramedics job," Mr Flint said.

"Firefighters are not going to be able to provide the same skills and expertise required at a medical emergency.

SEE ALSO: FIRE AND RESCUE STATIONS ON THE MOVE

SEE ALSO: ALCOHOL AND DRUGS LEAD TO INCREASE IN CALLS FOR PARAMEDICS

"Paramedics are not allowed to treat patients without a certification to practice — what certification will be required of firefighters? Firefighters are already raising concerns over how they would cope."

NSW Minister for Police and Emergency Services Stuart Ayres said the program was recommended by the Government Reform Plan for the NSW Ambulance Service of NSW.

"Fire & Rescue NSW already participates in the Community First Responder program, which allows retained fire crews to respond to emergency medical calls, in selected regional areas," Mr Ayres said.

A FRNSW spokeswoman said all FRNSW firefighters were trained in advanced first aid, and all fire engines statewide were equipped with trauma kits, oxygen resuscitators, and automatic external defibrillators.

"FRNSW has substantially faster response times than NSW Ambulance because we have more stations and a lower response workload," she said.

"In 2012, the NSW Government decided that was an opportunity to adopt a system that operated in Melbourne, the USA, Europe, Canada, New Zealand and many other countries.

"The program would leverage the basic life support skills and rapid response of firefighters, with the advanced life support skills of NSW ambulance paramedics, to provide lifesaving treatment at life-threatening emergencies such as cardiac arrest and drowning incidents."

The spokeswoman said the program was not about firefighters being the preferred response to medical emergencies.

"It is a firefighter and paramedic co-response, focused on providing lifesaving intervention more quickly than is possible at present," she said.

The spokeswoman said the program was not about firefighters being the preferred response to medical emergencies.

"It is a firefighter and paramedic co-response, focused on providing lifesaving intervention more quickly than is possible at present," she said.

The spokeswoman said a trial of the program was meant to take place on Sydney's northern beaches and in south-western Sydney last year but was blocked by industrial issues raised by the Fire Brigade Employees' Union.

Union president Jim Casey said firefighters wanted a 12.5 per cent pay increase and a commitment from the government to provide adequate training before they would agree to the program.

"We are not trying to be ridiculous, they (State Government) are asking for a significant expansion in the role for firefighters and that needs to be remunerated," Mr Casey said.

"We have very real concerns that this isn't about helping patients out but is just a cheap and nasty way to make the response times look good so it appears they are meeting KPIs (key performance indicators)."

Dunheved firefighter and FBEU Sydney outer west sub-branch secretary Trevor Ross said he feared a spike in mental health issues if firefighters were sent to jobs they weren't adequately prepared for.

"A few half day training sessions with paramedics aren't going to cut it, firefighters need to be properly trained, supported and valued," Mr Ross said.

NSW Ambulance assistant commissioner David Dutton said a first responder program could improve early access to CPR and defibrillation for patients in cardiac arrest.

"In 2014 two NSW Ambulance paramedics were seconded full time to FRNSW to support the basic first aid skills of firefighters in line with current practice," Mr Dutton said.

He said another two paramedics would also start training firefighters for the program.

NSW Health Minister Jillian Skinner was unavailable to answer *The Standard's* questions yesterday but a spokeswoman from her office said the number of paramedics employed in NSW had been increased by 205 since the Baird Government came into power.