From:	NSW Government
To:	Flood Inquiry
Subject:	Floods Inquiry
Date:	Friday, 20 May 2022 5:01:49 PM
Attachments:	NSW Flood Inquiry Submission - Disaster Health Response - Wolfgang Smith.pdf

Your details

Title	Mr
First name	Wolfgang
Last name	Smith
Email	
Postcode	2477

Submission details

I am making this submission as	A resident in a flood-affected area
Submission type	I am making a personal submission
Consent to make submission public	I give my consent for this submission to be made public

Share your experience or tell your story

Your story	I acted as a coordinator / liaison for the community-led health response across parts of the Northern Rivers during the February and March floods

Terms of Reference (optional)

The Inquiry welcomes submissions that address the particular matters identified in its Terms of Reference

1.2 Preparation and planning	Find attached document.
1.3 Response to floods	Find attached document.

Supporting documents or images

Attach files	• NSW Flood Inquiry Submission - Disaster Health Response - Wolfgang Smith.pdf

NSW Flood Inquiry Submission – Disaster Health Response

During the Norther Rivers flood disaster in February and March 2022, there were numerous failings in the official disaster response. In particular, in the crisis response area of health. My name is Wolfgang Smith. I live in Wollongbar, NSW. I am an Australian army veteran who served in Australia and on operations overseas as a communications and logistics specialist. I have a Bachelor of Psychology from Deakin University. I currently operate an NDIS disability and mental health support business in the Northern Rivers. During the February 2022 flooding event, I initially volunteered at Alstonville evacuation centre (AEC) to provide trauma-informed mental health support to evacuees. I ended up acting as a coordinator / liaison for the community-led health response across parts of the Northern Rivers during the February and March floods. I am currently part of a working group aiming to develop a community-led disaster response plan for future preparedness.

These crisis response failings were made evident to me via a range of sources. Firstly, through direct observation at numerous evacuation centres where there was an absence of a coordinated response from official departments. Next, through liaising with key community leaders and volunteer health service providers who communicated a replication of experience across the entire Northern Rivers area. Lastly, through interactions with management in the official disaster response network who were either unaware, unprepared, unwilling, or too under resourced to respond adequately.

Evidently, it was not simply the scale and severity of the flooding event that led to the failings in the official response. Indeed, one might argue that the definition of a disaster is when "systems are overwhelmed". However, a counter argument can be made for two reasons. First, during the initial February 2022 flood, any takeover from volunteers by official departments was glacial, uncoordinated, and scarce if it came at all. Second, and most

strikingly, the official response experienced in February was replicated during the subsequent flooding event in March 2022. This occurred despite that event being slower to evolve, less widespread, and less severe. Additionally, response services had extra flood resources and staff in-situ, a bolstered emergency services workforce, and additional support from Federal and State governments. Certainly, during the second flood, there was no legitimacy to a claim that the system was simply overwhelmed. The lack of an adequate crisis response was largely represented by three obvious themes:

1) Inherent failings in the State Emergency Management Plan (SEMP)

2) A poorly managed, fractured, and under-funded medical system

3) A lack of mental health and disability support

The immediate points of failure with the SEMP during both events can be identified against three common functions including, but not limited to: command, control, and communication.

The roles and responsibilities for servicing critical areas of the crisis response are not clearly understood by each department, leading to an over-reliance on some departments, an under-utilisation of more appropriate ones, and large gaps in overall response. Critical lines of communication both vertically and laterally in many cases is either one-directional or non-existent. Indeed, from all accounts external to and within, emergency response departments operate in fragmented silos. In addition, these departments waste crucial time in rigid, bureaucratic meta-management. As a result, the vital, time-sensitive information that needs to be gathered from and disseminated to flood-effected members of the community or volunteers helping them is not communicated effectively. The result is not only that known roles and responsibilities are being mismanaged by dedicated services. It is that there are roles and responsibilities required to address the needs of disaster-affected residents that are completely missed.

My role during the response phase of the crises was acting as a coordinator for the community-led health response. It was intended that this document would be supported by case studies gathered from the health service providers whose efforts I helped to coordinate: volunteer doctors, nurses, psychologists, community leaders, and others who worked tirelessly for weeks to meet the health, safety, and welfare needs of the flood evacuees. Without whom, the flood evacuees would have been left unclothed, hungry, insecure, and without the necessary acute and sub-acute medical and mental health care. Unfortunately, these people who gave so much of their time and energy during these crises are still recovering. They are trying to regain control of their own lives that they put on hold to help. Understandably, they are too tired to come home at the end of the day and write a submission to this inquiry. Poignantly, after witnessing the disaster-inquiry merry-go-round that happens after increasingly frequent natural disasters, from which few systemic failings appear to be learned from and addressed, the faith that this inquiry will be any different is low. However, the sad and bitter irony is that the learnings from these volunteers that could provide invaluable insight to affect positive, fundamental changes and improvements in the crisis response is lost. Essentially, the situation becomes a self-fulfilling prophecy. It is my intention to paint a picture of our collective experience and hopefully make sure these learnings are acted on.

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

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

In an attempt to rectify this issue and obtain key health POC details to facilitate communication and resource channels, I visited in person or made contact with multiple other evacuation centres in the region: Ballina, Alstonville, Goonellabah/Lismore (GSAC and SCU), Ocean Shores, Brunswick Heads, Murwillumbah, Mullumbimby, Evans Head, and Coraki. It became evident that all evacuation centres were operating in silos, doing the best

they could as they went. From all accounts, there were no official health templates, information sources, referral pathways, policies, procedures, lines of communication or key hierarchy of control etc. Medical administration volunteers were creating medical records documents from scratch to facilitate accurate and legal medical record keeping.

At the evacuation centres, the person identified as being "in charge" / main POC, either from a health or welfare perspective, were volunteer leaders. If they were present, the role of DCJ staff was ambiguous and perceived as a hinderance more than help. There was a palpable lack of competence, confidence, and leadership displayed by DCJ staff in the role of disaster welfare and centre management. If DCJ had any involvement it was in the welfare capacity alone. At no point were DCJ involved in the health response - this fact is very important due to issues with the command, control, and communication failures within the SEMP as indicated above.

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

The LHD involvement at many evacuation centres was initially limited to the supply of RATs for Covid-19 testing. At AEC, this arrived on Wednesday 9th March (nine days after flood), after an outbreak had occurred at SCU evacuation centre. The LHD's involvement at AEC increased to start paying one of the nurses who was already volunteering and assign one mental health nurse who subsequently only appeared for one half day. On the closing day of the evacuation centre (after almost two weeks in operation) the LHD sent one nurse for a couple of hours. This was after the lead GP – Dr Alex De Marco - and I had requested LHD staff earlier in the week to take over from volunteers facing burnout and needing to return to

their families and jobs. The representative from the LHD – Ms Rae Rafferty – was seemingly as helpful as she could be. Although, she explained that primary care needs were the responsibility of the PHN and the LHD was struggling with staff shortages. The mental health support at AEC was given by me, a retired psychologist (Mr John Noble), and some of his associates from Lifeline.

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

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

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

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

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

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

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

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

need with the list of volunteers. There was no mention of identifying people with a disability who might need assistance.

In the following days, Dr Alex De Marco and I spent countless hours on the phone relaying my concerns about the lack of a health response that was leaving flood-affected residents vulnerable. Eventually, after working our way up the health chain to find a solution, our concerns were raised to the highest levels in the LHD – Director of Disaster Response (Ms Katherine Duffy) – and the PHN – Director of Operations (Mr Luke Elias). In response, a mental health team and the street clinic van visited SCU, a doctor and paramedic swapped out the volunteer doctor in Coraki, and a mental health nurse visited Coraki evacuation centre. Frustratingly, however, after all this effort to achieve some form of an official health response in Coraki, neither DCJ, the council, or State Emergency Service (SES) communicated the health presence to residents of the area. I had to do it via social media community groups.

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

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

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

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

Ultimately, across the region during both crises an adequate health response was not provided due to the invisibility of the need and poor governance. The HealthFAC expected DCJ to do a needs assessment and request services. The LHD and PHN don't provide

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

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

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

the lessons learned here to ensure the protection of life and foster wellbeing in inevitable future disasters.

Wolfgang Smith