



Government of **Western Australia**
Department of **Health**

SHERP

State Health Emergency Response Plan

Version 1

Foreword

The WA health system is an important player in any emergency response in the State of Western Australia. Because of our expertise and specialist knowledge, the WA health system has been prescribed as a combat agency under the *Emergency Management Regulations 2006* with responsibility for providing health services. Historically, our roles and responsibilities have sometimes extended beyond our jurisdictional boundaries through the provision of medical assistance when disasters occur interstate or overseas.

The State Health Emergency Response Plan (SHERP) has been developed to replace the suite of subplans that previously underpinned the State Emergency Management Support Plan (Westplan) Health. The new amalgamated structure allows for a consolidated response mechanism that is supported by a series of functional annexes, and links into other State-level plans and Australian Government arrangements.

To facilitate this, pursuant to section 24 of the *Health Services Act 2016* the Director General has delegated his power to issue directions under section 28(1) *Health Services Act 2016* to relevant positions in the Department of Health for the purposes of preventing, preparing for, responding to, and recovering from emergencies, disasters and other disruptive events. In doing so, the Director General or delegates will be able to direct an entity within the WA health system, in accordance with the delegation and section 28 of the *Health Services Act 2016*. Entities within the WA health system must comply with such directions.

This plan provides a succinct, overarching response platform, which outlines how the WA health system, as a combat agency, will respond to any emergency or disaster within the jurisdiction of Western Australia. This plan may be activated in support of a hazard managed by another agency or in isolation to support the coordination of internal emergencies, or to support the response to a public health emergency. The plan provides the delegate of the Director General with the authority to coordinate all Health resources in order to minimise the health consequences that arise following a disaster or emergency.



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Authorisation

This plan has been endorsed as the single, strategic, State-level plan that outlines how the WA health system will respond to any emergency or disaster within the jurisdiction of Western Australia requiring a coordinated health response, including internal emergencies and disruptions.

Approved



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Date: 5 February 2018

Amendment certificate

Any amendments to this plan are subject to the approval of the WA Health Emergency Management Committee.

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1. Introduction

The State Health Emergency Response Plan (SHERP) outlines both the strategic intent and how the WA health system will respond to any emergency or disaster within the jurisdiction of Western Australia (WA). The plan provides a framework to enable the WA health system to fulfil its role as a combat agency in delivering the emergency management activity of health service provision, as prescribed in section 26 of the *Emergency Management Regulations 2006*.

Within the WA Health System, the State Health Coordinator is the Hazard Management Agency for Heatwave and accidental release of biological substances. The State Human Epidemic Controller is the Hazard Management Agency for Human Epidemic. The responsibilities and authorities of these roles are outlined in the *Emergency Management Act 2005*.

At all times, whether the response is in support of another Hazard Management Agency, as the Hazard Management Agency, or when dealing with internal emergencies, system wide coordination of state health resources is required to achieve an optimal response.

This plan may be escalated in support of a hazard managed by another agency or, in isolation, to support the coordination of internal WA health system incidents and public health emergencies. This plan, with its functional annexes, is a multi-hazard, comprehensive, scalable strategic document, which supports the State Emergency Management Plan (State EM Plan) and the Emergency Management Policy, and is supplemented by local and regional (district) health disaster response plans. This plan also provides linkages to relevant Australian Government plans, where a multi-jurisdictional response is required.

1.1 Aim

This plan outlines the strategies to manage a scalable and proportionate health response, with appropriate and timely interventions and allocation of resources, to minimise the health consequences of a disaster or emergency.

1.2 Strategic objectives

This plan's strategic objectives are to ensure a safe, effective, and coordinated Health response to an emergency or disaster by:

- describing how, when, and where Health resources are mobilised;
- outlining the operational framework and capabilities through the attached annexes;
- outlining the process of escalating and de-escalating the Health response;
- detailing high-level roles, delegations and authorities; and
- linking the WA health system's emergency response into broader state and national response and recovery frameworks and arrangements.

1.3 Hazard definition

The SHERP can be applied across the spectrum of prescribed and non-prescribed hazards, consistent with the *all hazards approach* to emergency management.

1.4 Scope

The SHERP may be activated in conjunction with, or in isolation from, the State Emergency Management Plan and associated hazard-specific Westplans.

This plan focuses on how the WA health system fulfils its combat agency responsibilities. The State arrangements for heatwave, human epidemic and biological hazards are covered under separate hazard-specific plans.

1.5 Emergency Management Policy and relevant legislation

The Emergency Management Policy establishes the WA health system's comprehensive approach to emergency management. As such, the SHERP should be read in conjunction with the Emergency Management Policy.

The SHERP is underpinned by the following State and Australian legislation:

- *Health (Miscellaneous Provisions) Act 1911 (WA)*
- *Health Services Act 2016 (WA)*
- *Public Health Act 2016 (WA)*
- *Emergency Management Act 2005 (WA)*
- *National Health Security Act 2007 (Commonwealth)*

This SHERP utilises a single activation and response framework that is supported by a number of functional annexes, which outline specific response capabilities. Upon activation of the response phase of this plan, a number of specific annexes may be triggered.

1.6 Related policies and plans

Australian Government

- Australian Government Disaster Response Plan (COMDISPLAN)
- [National Health Emergency Management Response Arrangements \(NatHealth Arrangements\) 2011](#)
- [Domestic Response Plan for Mass Casualty Incidents of National Consequence \(AUSTRUMAPLAN\) 2011](#)
- [Domestic Health Response Plan for Chemical, Biological, Radiological or Nuclear Incidents of National Consequence \(Health CBRNINC Plan\)](#)
- [Severe Burn Injury Annex to AUSTRUMAPLAN \(AUSBURNPLAN\) 2011](#)
- National Response Plan for Mass Casualty Incidents Involving Australians Overseas (OSMASCASPLAN)
- Australian Government Overseas Disaster Assistance Plan (AUSASSISTPLAN)
- Australian Government Plan for the Reception of Australian Citizens and Approved Foreign Nationals Evacuated from Overseas (COMRECEPLAN)

State

- [State Emergency Management Plan](#)
- [State Emergency Management Policy](#)
- [Hazard-specific Westplans](#)
- Emergency Management Policy
- Infectious Disease Emergency Management Plan (IDEMP)
- St John Ambulance (SJA) Emergency Management Plan (AmbPlan)
- Royal Flying Doctor Service (RFDS) Western Operations - Mass Casualty Plan

Regional (district)

- [WACHS – Emergency \(Disaster\) Management Arrangements Policy](#)
- WACHS regional health disaster plans (however titled)

Hospital (local)

- Hospital or health service provider disaster plans and emergency procedure documents (however titled).

2. Response

When an emergency or disaster occurs, the WA health system may be requested to fulfil its responsibilities under various legal instruments, including the *Emergency Management Regulations 2006*, *Health Services Act 2016* and *Public Health Act 2016*. This plan may also be escalated to coordinator the response to an internal emergency or disruption.

2.1 Standby phase

This SHERP is maintained in STANDBY phase as the default status.

2.2 Notification

The delegate of the Director General is to be formally notified of any actual or potential incident or emergency by telephoning **(08) 9222 4444** (24 hours).

2.3 Authority to escalate

Authority to escalate to the RESPONSE and STANDDOWN phases of this plan rests with the delegate of the Director General.

2.4 Triggers for escalation

Key triggers for the escalation of this plan to the RESPONSE phase may include, but are not limited to:

- a threatened, potential or actual occurrence of an incident in WA, which results in large numbers of casualties and requires resources beyond local or district capabilities;
- any incident or occurrence that results in a significant disruption to the delivery of key services;
- an actual or potential public health incident that may cause or contribute to serious adverse effects on the wider health and wellbeing of the community;
- notification by the National Incident Room (NIR) - Department of Health (Australian Government) of an interstate Mass Casualty Incident (MCI), which has resulted in the activation of the AUSTRAUMAPLAN and may require Health assistance;
- notification by the NIR of an international MCI that has resulted in the activation of OSMASCASSPLAN, which may require Health assistance;
- set triggers listed in the functional annexes (see annex triggers); and/or
- other circumstances, as deemed necessary by the Director Generals delegated officer.

To appreciate the scale of the incident, the ETHANE mnemonic may assist in providing a quick synopsis of the emergency or disaster:

- E – Exact location of incident
- T – Type of incident
- H – Hazards present
- A – Access to incident site
- N – Number and type of casualties
- E – Emergency services present and required

2.5 Incident coordination

The delegate of the Director General will command and coordinate the use of all Health resources within WA for the purpose of responding to, and recovering from, the impact and effects of a major incident or disaster. The delegate of the Director General exercises this authority through the State Health Incident Coordination Centre (SHICC).

To facilitate this, pursuant to section 24 of the Health Services Act 2016 the Director General has delegated his power to issues directions under section 28(1)(a) Health Services Act 2016 to relevant positions in the Department of Health for the purposes of coordinating a timely response to emergencies within the WA health system. In doing so, the Director General or delegates will be able to direct an entity within the WA health system, in accordance with the delegation and section 28 of the *Health Services Act 2016*, for the purpose of emergency management. Entities within the WA health system must comply with such directions.

2.6 Phases of escalation of SHERP

A summary of strategic actions are listed in each phase.

Phases of escalation

STANDBY PHASE (DEFAULT PHASE)

Synopsis of situation

- No emergency currently exists, or an incident has occurred that doesn't warrant a coordinated Health response

Strategic actions

- The SHICC remains in a state of readiness
- Monitoring of potential situations
- Normal business activities are undertaken
- Training and exercising
- Prevention and preparedness activities are undertaken.

RESPONSE PHASE

Synopsis of situation

- An emergency is imminent or has occurred.
- A coordinated Health response is required.

Strategic actions

- The delegate of the Director General assumes command of Health resources required.
- The SHICC is mobilised and gathers operational intelligence.
- Health Services and Hospitals deploy resources, assets and personnel in response to the incident, under the direction of the Director General's delegate.
- The SHICC liaises with key local, regional, and Australian Government stakeholders.
- Situational awareness is maintained by the SHICC through briefings and dissemination of situation reports.
- Specified responses are undertaken, as outlined in functional annexes
- The SHICC may seek assistance from the Australian Government or delegate operational responsibilities to regional or local health services, where appropriate.

STANDDOWN PHASE

Synopsis of situation

- The emergency has abated and a coordinated Health response is no longer required.

- All consequence management actions requiring State coordination have been completed (acknowledging recovery efforts will be occurring and potentially ongoing).

Strategic actions

- Deployed resources are recovered.
- Health services return to normal business processes.
- Recovery activities commence.

2.7 Post incident activities

Upon completion of the STANDDOWN phase, the delegate of the Director General will de-escalate the SHERP to STANDBY phase (noting that recovery efforts and hospital surge activities may still be continuing).

The following post incident activities are undertaken:

- debriefing activities;
- staff counselling and employee assistance, where appropriate;
- financial recovery and reconciliation;
- post incident analysis and identification of lessons learned;
- formal reporting to the Director General for Health, WA Health Emergency Management Committee, State Emergency Management Committee, Health Service Boards, and other relevant bodies; and
- updating of plans, processes and procedures, where appropriate.

2.8 Functional annexes

The delegate of the Director General can employ specific capabilities to respond to an emergency or disaster. Upon escalation of the SHERP to response phase, the delegate of the Director General will trigger the necessary annexes of this plan required to respond to the incident.

Annex A: Pre-hospital incident site coordination

Introduction

In large scale and remote area incidents, the delegate of the Director General may liaise with key partner agencies to provide emergency healthcare provision in the pre-hospital setting.

Key partners

St John Ambulance (SJA) Western Australia Ltd is the contracted State-wide provider of pre-hospital health care and is prescribed in the *Emergency Management Regulations 2006* as a combat agency for the emergency management activity of providing health services. SJA has articulated its emergency management arrangements in the Ambulance Emergency Management Plan (AmbPlan) 2014.

The Royal Flying Doctor Service (RFDS) - Western Operations is the contracted aeromedical transport provider to WACHS and plays a critical role in primary and secondary aeromedical retrievals.

Methodology

The WA health system utilises Major Incident Medical Management and Support (MIMMS) in its pre-hospital response.

Casualty distribution

In metropolitan incidents where ambulance transport is occurring prior to the SHICC becoming operational, the Ambulance Network Coordinator will determine casualty distribution. This role will transfer to the SHICC once it is activated.

Command

Metropolitan area

The decision as to whether a pre-hospital Health response is required is at the discretion of the Director General's delegate. This may be at the request of SJA. The mobilisation of a Health Response Team (HRT) is detailed in Annex C.

Remote site coordination

When an incident occurs in a remote area where there are no or insufficient senior clinicians on site, the delegate of the Director General may request RFDS to appoint an officer to undertake the role of Health Commander following discussion with the Regional Health Disaster Coordinator (RHDC). This may be a temporary appointment until a senior Health clinician arrives, or last throughout the duration of the incident until all casualties have been cleared from the incident site. The delegate of the Director General may request RFDS to deploy a liaison officer to the SHICC.

More information on the role of the Health Commander is listed in Annexes C and D.

Annex B: Liaison Officers

Introduction

A Liaison Officer (LO) is a critical enabler and facilitator between agencies in complex and large scale emergencies.

Role and responsibilities

The LO is the communication conduit between the Incident Controller and the WA health system (Health). Requesting agencies expect LOs to be delegated with full authority to make decisions on all matters affecting that agency's participation in the incident, including the committal of resources. As such, LOs should have sufficient seniority, well-developed negotiation skills, excellent knowledge of the health services they represent, and appropriate delegations to commit resources.

Elements of the LO's role and responsibilities may be performed by the Health Commander when a HRT is deployed to an incident site (see Annex C).

Key responsibilities of a LO include:

- establishing a communication conduit between Health and the requesting agency;
- collecting and disseminating operational intelligence on the incident to the SHICC and/or Regional Emergency Operations Centre (REOC);
- committing Health resources to support the response to the incident (noting that the LO may need to seek approval from the delegate of the Director General or RHDC);
- influencing, advocating, and negotiating with the Incident Controller about critical issues affecting Health assets, personnel and services; and
- identifying previously unknown health-related issues that require the attention of Health and the Incident Controller.

Authority to deploy

LOs usually deploy at the request of the Hazard Management Agency (HMA) that has overall responsibility for managing the incident.

In the Metropolitan Area and State-level incidents, the delegate of the Director General is responsible for authorising the deployment of a LO. In regional areas, this responsibility is devolved to the RHDC.

Prior to deploying, the LO should discuss with the authorising delegate about what level of resources can be committed.

Communication

The LO is to maintain a full log of communications, activities and decisions made. All information is to be transcribed into WebEOC and shared appropriately.

Supporting documents

- State EM Plan
- State Emergency Management Policy
- State Emergency Management Procedures

Annex C: Health Response Teams

Introduction

Health Response Teams (HRTs) are teams that can be deployed to an incident site to augment the pre-hospital response. The role of a HRT may vary; in the metropolitan area, a HRT may be requested by SJA to assist in providing treatment at a Casualty Clearing Post (CCP). In regional and remote areas the HRT may be the only health capability available, and may need to undertake triage, stabilising treatment, and transport. A specialist HRT may also be requested to perform specialist procedures, such as public health screening, or surgical intervention.

Authorising the deployment of a HRT

In the metropolitan area, any HRT deployment, including specialist teams, must be authorised by the Director General’s delegate. In regional areas, the deployment of a HRT to an incident site must be authorised by the RHDC.

Specialist teams (e.g. burn, trauma) may deploy as autonomous hybrid teams, or to augment HRT composition A, B or C teams.

Needs assessment

Following the occurrence on an incident, a brief needs assessment should be conducted to assess whether a HRT is required. As a minimum, the needs assessment should use the mnemonic ETHANE (see section 2.4 – Triggers for escalation). A more detailed needs assessment may need to be conducted for more complex and prolonged incidents.

HRT composition

The composition of the team is to be flexible to enable a context specific response. At all times, hospitals and health services are to provide a maximum HRT capability in line with their [Clinical Service Framework \(CSF\) 2014 - 2024](#) capability.

CSF level (disaster response capability)	Hospital / health service	Team	Composition / maximum deployable requirements
CSF Level 6	Metropolitan tertiary hospitals	Team A	Doctor x 2 Nurse x 4
	Princess Margaret Hospital Perth Children’s Hospital	Team B	Doctor x 2 Nurse x 3
CSF Level 5, 4, & 3	Metropolitan general hospitals with emergency departments, Regional Resource Centres, Rural and remote hospitals	Team C	Doctor x 1 Nurse x 2
Varies	Dependent on location, nature and magnitude of incident.	Specialist team	Assessed on a case-by-case basis.

Note: The above team compositions are the maximum deployable requirements; however, the HRT authorising delegate may request an abridged or hybrid team to deploy, depending upon the nature of the incident. Hospitals and health services should arrange staffing profiles to fulfil the maximum deployable requirements.

Specialised teams

Specialist teams may be deployed to provide specialist advice or treatment. Team composition may vary depending upon the nature and magnitude of the incident. Specialist teams may include:

- environmental health;
- burn;
- trauma; and/or
- other co-opted specialties, as deemed necessary to respond to an incident.

Environmental Health Team

An environmental health team may be deployed to provide advice or assistance to the HMA, local government or Health Service - Population Health Units. An environmental health team may also be deployed during a public health emergency. Advice, assistance and direction may be provided upon issues relating to:

- water safety (drinking water and recreational waters);
- food safety;
- human waste;
- vermin and vector control;
- hazardous materials management (e.g. asbestos); and
- chemical toxicology (non-clinical toxicology).

More information on the role of Environmental Health in an emergency can be found in Annex K.

Specialist burn team

Tertiary burn services are responsible for developing and maintaining a pool of specialist staff that are able to be deployed at short notice to an incident site to augment HRT A, B and C teams, or separately as hybrid specialist teams.

The composition of the specialist burn team will be decided at the time of the incident. The team should generally comprise burn/trauma expertise and members should be capable of performing burn triage, and initial burn management including resuscitation, analgesia, and dressings.

Specialist trauma teams

A specialist trauma team can be deployed to the incident site for the following circumstances:

- to perform field amputations on trapped victims; or
- to provide surgical management at the scene, due to the number of patients overwhelming the capacity to transport victims to hospital

Appointment of HRT Health Commander

The Health Commander is an operational position that is responsible for coordinating the HRT and reports to the delegate of the Director General via the SHICC in metropolitan Perth, or the RHDC via the REOC in WACHS regions. This role also liaises with other agencies.

The Health Commander is to be appointed prior to the departure of a HRT to an incident site by the appointing authority. The Health Commander role may fall to the RFDS Western Operations in remote and difficult to access locations, where there is no SJA or HRT presence, or alternatively where the HRT composition lacks appropriate seniority.

Appointment of other HRT positions for Team A and B

Where staffing permits, and in consultation with deploying hospitals and SHICC, the Health Commander is responsible for appointing the following positions:

- Senior Doctor (responsible for overseeing the CCP in conjunction with SJA); and
- Senior Nurse.

Where possible the Health Commander, Senior Doctor and Senior Nurse should be additional to the team composition. Consideration should be given to allocating a dedicated Communications Officer to the Health Commandeer, where resources permit.

The Senior Doctor and Senior Nurse are responsible for appropriately allocating staff to CCP and forward positions. This role may be performed by the Health Commander if no Senior Doctor or Senior Nurse is appointed.

Use of expectant category

The expectant category (MIMMS triage sort priority 4 - blue) may be invoked for casualties whose injuries are either so severe that they cannot survive, or the resources needed to treat them are unavailable without compromising the care of others. In Western Australia, the delegate of the Director General is the single approving authority for use of the expectant category.

Invoking the expectant category

To invoke the expectant category, approval must be sought from the delegate of the Director General. The use of the expectant category should be reviewed regularly during the incident and revoked once resources allow for all survivors to be adequately treated.

Communications

A clear line of communication must be established and maintained between the Health Commander and the SHICC (metropolitan area only) or REOC (WACHS areas only) to ensure command, control and coordination is maintained. The SHICC and REOC, or SHICC and relevant Hospital EOCs will maintain a clear line of communication with each other.

Prior to the departure of the HRT, the SHICC/REOC are responsible for ensuring a clear line of communications is established and maintained with the Health Commander. Communication platforms may include mobile telephone, satellite telephone, and/or Ultra High Frequency (UHF) radio through simplex channels or the Metropolitan Emergency Radio Network (MERN). Health Commanders should take at least two forms of communication, and ensure all devices are fully charged, with additional batteries, prior to departing to the scene.

Transport

SJA is generally responsible for transporting the HRT to and from the incident site, as articulated in AmbPlan WA 2014. Alternative forms of transport may be utilised in difficult access areas.

In some regional areas, the local hospital may operate the ambulance service, and will assume this responsibility.

Sustainability

HRTs should be used for short-term deployments. Where there is a requirement for a sustained pre-hospital response, the delegate of the Director General may consider using a WAMAT team (refer to Annex E).

As shift changes come into effect, a relieving shift may be required at the incident site. Where possible, the relieving HRT(s) should come from alternative hospital(s) to the HRT(s) initially deployed.

HRT personnel are only to deploy with appropriate Personal Protective Equipment and communications equipment.

Annex D: Mass casualty aeromedical transport

Introduction

A Mass Casualty Incident (MCI) in a remote or regional area may require the mobilisation of aeromedical resources to facilitate the transport of patients. Where the number of casualties exceed the availability of aeromedical assets, this Annex may be activated to facilitate and coordinate the retrievals.

Responsibility

Upon activation of this Annex, the RFDS Western Operations shall, in addition to their normal aeromedical transport duties, allocate a senior clinician to coordinate all aeromedical assets required and involved in the mass casualty aeromedical transport of patients from an incident site(s). The location of the incident, jurisdictional responsibility, and number of casualties will determine the type of aeromedical response required.

In remote and difficult access locations (such as Avon Valley and east of Kalgoorlie), the WA Police Air Wing will assume the coordination role for air assets (including aeromedical aircraft). In such circumstances, both RFDS and Police Air Wing may be requested to deploy Liaison Officers to the SHICC.

Strategies

In a MCI requiring the aeromedical transport of large numbers of casualties, it may be necessary to apply one or more of the following strategies:

- use a combination of rotary and fixed wing aircraft to move casualties;
- utilise aeromedical capabilities of other providers as listed and agreed to in existing Memoranda of Understanding;
- be cognisant of the limitations of the various aircraft, their crew, and the incident location, in the distribution of casualties. This may include distributing patients to Darwin for incidents in north-eastern WA;
- utilising South Australian resources for remote sites east of Kalgoorlie;
- establishing a temporary medical hub for initial triage and treatment, prior to transportation; and
- using land or marine vehicles to transfer medical personnel and casualties from the MCI to a suitable location where aircraft can land.

MCI exceeding WA aeromedical availability

Should the number of casualties overwhelm the available aeromedical resources in WA, it may be necessary to request assistance from the Australian Government. This may include a submission of a Defence Assistance to the Civil Community (DACC) request, through the State Emergency Coordinator.

Supporting documents

- RFDS Mass Casualty Plan (external document)

Annex E: WA Medical Assistance Team (WAMAT) response

Introduction

An Australian Medical Assistance Team (AUSMAT) is an official Australian Government multidisciplinary healthcare team deployed in response to national or international disasters where assistance is requested by the impacted government. AUSMATs are enablers under the [National Health Emergency Response Arrangements \(the NatHealth Arrangements\)](#).

The WA health system, along with other jurisdictions, maintains an AUSMAT volunteer base and deployable resources, which may be deployed as part of a national AUSMAT response, or by the delegate of the Director General within the state to assist in the response to a local disaster. When deployed within the state, this capability is known as the WA Medical Assistance Team (WAMAT)

Scope

AUSMAT/WAMAT deployments may occur:

- intrastate – under the auspices of the State Health Emergency Response Plan (this plan) (WAMAT);
- interstate – includes deployments to MCIs of national consequence as described in [AUSTRAUPLAN](#) and COMDISPLAN; or
- internationally – under [AUSASSISTPLAN](#) or OSMASCASPLAN.

Capability

AUSMAT/WAMAT has a deployable field clinic capable of providing early emergency medical care, and follow-up care for trauma cases, with additional capability including burns, paediatrics, and environmental health.

The preparation, pre-deployment, deployment and post-deployment arrangements for WA AUSMAT/WAMATs are described in the AUSMAT WA deployment Standard Operating Procedure (SOP).

Activation

For any WAMAT deployment, the delegate of the Director General is the authorising delegate.

Supporting documents

- [AUSMAT Handbook](#)
- AUSMAT/WAMAT deployment SOP

Annex F: Surge management

Introduction

Surge management is the ability of a hospital or health service to accommodate an influx of casualties and subsequent increase in demand for resources.

Scope

While surge management is context-specific, areas including the emergency department, imaging facilities, operating theatres, intensive care unit, and burn and trauma units are generally considered the focal points in a MCI. Such areas should plan for an increase of up to 200% in case load / census.

Strategies

Surge management involves the implementation of a series of strategies to augment or modify resource management and allocation during an incident. Strategies can be broadly categorised into four key components:

1. **staff** – strategies that increase the availability of suitably qualified staff.
2. **space** – strategies that allow for an increase in a facility's census and upscaling of activity.
3. **supplies** – strategies that increase the availability, or rationalise the provision, of consumables, pharmaceuticals, and specialist equipment.
4. **system** – the implementation of a system, such as a disaster plan, that documents strategies, roles, delegations, communication and information flows, SOPs, command and control, and continuity of operations.

Altered levels of care

In any disaster or major incident with large or overwhelming casualty numbers the strain of increased patient presentations in the hospital, combined with relatively fixed or decreased staff numbers, is likely to have a negative effect on patient care.

Activation and governance

Upon activation of this annex by the Director General's delegate, hospitals and health services will be authorised to make decisions to amend the level of care delivered to patients, as deemed appropriate for the incident and hospital.

Altered levels of care should be based upon pre-determined strategies authorised by the relevant hospital executive. This may include, but not be limited to:

- incrementally increasing patient-to-staff ratios;
- altering thresholds for clinical interventions (e.g.: blood transfusion, intubation);
- rationalising and prioritising imaging and laboratory requests; and
- implementing strategies to manage demand on the operating theatres (e.g. surgical triage, damage control surgery).

Supporting documents

- Surge management guidelines (to be drafted).

Annex G: Trauma response

Introduction

The trauma response will be contextualised to the number and type of casualties, and the appropriate level of care a facility can provide, as reflected in the [CSF \(2014 – 2024\)](#).

In normal operations, Royal Perth Hospital (RPH) as the adult State Trauma Centre, and Princess Margaret Hospital (PMH) / Perth Children's Hospital (PCH), as the paediatric State Trauma Centre, receive major trauma patients (Level 6 according to CSF).

In a MCI, patients may be distributed to hospitals according to triage category.

Patient distribution

Metropolitan trauma services

Major trauma patients (MIMMS disaster triage sort priority 1 and 2) will be distributed to:

- major trauma services (Level 6 on CSF).
- tertiary hospitals (Trauma Level 5 on CSF).

PMH/PCH and Fiona Stanley Hospital (FSH) deal with burn casualties. Neurosurgical trauma should be distributed to Sir Charles Gairdner Hospital (SCGH), RPH and PMH/PCH, from where the State Neurosurgery Services operate.

Minor to medium severity trauma patients (MIMMS disaster triage sort priority 3) distributed to:

- general hospitals (Level 4 on CSF).

Regional trauma services

Due to their remoteness, regional centres may receive all casualties relating to an incident. The following strategies may be employed:

Regional Resource Centres (Level 4 on CSF)

- Provide prompt assessment, resuscitation, stabilisation and, if necessary, emergency surgery, for a small number of seriously injured patients before transfer onto the Metro Trauma Service.
- These centres can provide definitive care to minor to moderate severity (disaster triage sort priority 3) trauma patients.

Regional, remote and rural (Level 3 on CSF)

Sites lack a surgical and or orthopaedic presence and cannot provide emergency surgery.

- participate in resuscitation of a moderate and major trauma patient, with rapid transfer on to the metropolitan trauma service.
- stabilise minor trauma patients and consider transferring out to Regional Resource Centre or metropolitan trauma service.

Annex H: Burn response

Introduction

In the event of a MCI involving burns, the delegate of the Director General may activate the Burns annex.

The burn response is reflected in the capabilities expressed in the [CSF \(2014 – 2024\)](#). PMH/ PCH provide the paediatric State Burn Service with FSH providing the adult State Burn Service.

Provision of specialist advice

In remote and regional areas, expert advice should be sought from the State adult and/or paediatric burn services for the initial care of mass burn casualties.

Burn capacity

In a mass burn casualty incident or disaster, a large influx of burn patients may overwhelm the normal capacity of specialist burns units. In circumstances where large numbers of burn patients are expected, burn units and Intensive Care Units (ICUs) should implement departmental surge management strategies to increase bed capacity.

Hospital	Dedicated burn beds	Pre-identified burn surge capacity (beds)	Ventilated ICU Beds	Pre-identified ICU surge Capacity
Fiona Stanley Hospital (adults)	10	26	30	10
Perth Children's Hospital (paediatrics)	8	16 (further beds may be negotiated)	10	10

Note: The above table reflects the capacity of the two tertiary burn units, and not the current occupancy. Following the occurrence of a MCI involving burns, FSH and PCH will complete a current and projected occupancy template to reflect their capability to receive burn patients.

Distribution of burn casualties

Burn patients should be distributed, managed, and cohorted at the facilities housing the State Burn Services. These facilities are to implement surge management strategies to accommodate all burn casualties from an incident. Where the facilities' surge capacity is exhausted, burn patients may be transferred to other tertiary burn facilities throughout Australasia under the auspices of [AUSBURNPLAN](#).

Triggers and thresholds

The following thresholds have been developed to be consistent with the AUSBURNPLAN thresholds.

Less than 5 severe burn patients

- Managed by local tertiary burn units using local resources, infrastructure and surge plans.

5 – 10 severe burn patients

- Activation of the SHERP burn annex.
- Patients are managed using State burn resources, infrastructure and surge plans.

10 – 20 severe burn patients

- Activation of the SHERP burn annex.
- In consultation with Director, State Burn Service, the delegate of the Director General may request activation of AUSBURNPLAN to request interstate patient transfer and/or assistance from interstate burn taskforce.

Greater than 20 burn patients

- Activation of the SHERP burn annex.
- Activation of AUSBURNPLAN as requested by the delegate of the Director General to facilitate interstate patient transfer and/or mobilisation of interstate burn taskforce.

Caveat: The above thresholds are based on the number of casualties with a Total Body Surface Area (TBSA) burn of 20% or more. The thresholds for activation of this plan, or requesting activation of AUSBURNPLAN, may vary depending upon a number of variables, including:

- the number of burn casualties;
- the age of the burn casualties (infant, paediatric, adult, elderly);
- the location of the incident (overseas, interstate, remote, regional, metropolitan area);
- the type, location and severity of burns (%TBSA, airway burns, circumferential);
- the current occupancy of tertiary burn units, intensive care units and pre-identified surge areas; and
- any other variable that has the potential to affect the WA health system's ability to respond to a disaster.

Deployment of specialist burn response teams

- Refer to Annexes C and E.

Annex I: Terrorist or criminal act

Introduction

In an emergency that results from a terrorist or criminal act, additional strategies may need to be implemented to ensure the safety of staff, patients and visitors, and the protection of critical infrastructure. Where a terrorist act is suspected, WA Police exercises overall command and control of the response. If the incident is not deemed to be a terrorist incident, it may be considered a criminal act.

It should be noted that it may not be immediately known that an emergency is the result of a terrorist act.

Response

The Health response to a terrorist act may include:

- activation of code black bravo – active shooter response plans;
- deployment of HRTs to incident site(s) (refer to Annex C), noting that access to the incident site may be severely limited;
- reception and treatment of casualties (refer to Annexes F and G);
- implementation of Chemical, Biological, Radiation, and Nuclear (CBRN) and Hazardous Material (HAZMAT) protocols (refer to Annex J);
- provision of mental health support (refer to Annex M);
- provision of specialist health advice to WA Police and other agencies; and/or
- provision of a Health liaison officer to WA Police and other agencies (refer to Annex B).

Security issues at health facilities

Additional security measures may be implemented in anticipation of, or in response to, a terrorist or criminal incident. In health facilities, this may include:

- restricted access and security cordoning;
- proof of identify measures for staff, patients and visitors accessing the premises; and
- inability to utilise certain clinical areas due to security concerns or contamination.

National Coordination

In the event of a terrorist or criminal act intrastate, interstate, or overseas, which results in large numbers of casualties, [AUSTRAUMAPLAN](#) may be activated to provide national coordination in respects to intelligence, advice, patient distribution, and resource management.

Other issues

Other issues that may arise in a terrorist-related incident include:

- media and political pressure that may distract Health staff from other roles; or
- business continuity issues arising from acute patient surge and security restrictions;

Annex J: CBRN/HAZMAT hospital response

Introduction

The WA health system plays a critical support role in treatment of casualties exposed to a CBRN or HAZMAT incident.

Delineation between CBRN and HAZMAT

CBRN and HAZMAT incidents can be delineated by the underlying motive behind the release of the agent. A CBRN event is associated with a deliberate release of a hazardous material whereas the HAZMAT incidents are usually considered accidental. Both CBRN and HAZMAT incidents are managed using the same principles: however, additional security and evidentiary considerations should be considered in CBRN incidents (refer to annex I).

Activation of this annex

Upon activation of this annex, hospitals involved in the response are to activate their CBRN / HAZMAT plans. This may entail:

- lockdown of facilities to protect staff, facilities and non-affected patients, relatives and visitors from contamination;
- provision of expert advice to the HMA (see Annex K);
- donning of appropriate Personal Protective Equipment (PPE);
- deploying a HRT to an incident site for treatment of decontaminated patients in the cold zone (refer to Annex C);
- decontamination of contaminated casualties arriving at hospitals (if not already undertaken prior to arrival at hospital);
- isolation of casualties who are at risk of causing further contagion or contamination, including communicable biological agents and off-gassing chemical agents;
- detection of the agent through symptomology or biological sampling and analysis;
- treatment of affected casualties, including symptomatic and definitive treatment;
- radiation monitoring of radiologically contaminated casualties; and/or
- cohort casualties in one hospital to preserve the integrity of other nearby hospitals.

Detection and treatment of the agent

Detection of the agent may be through physical detection systems, symptomology or biological sampling and analysis. Upon recognition of the agent, hospitals or health services are to immediately notify the Director General's delegate. In a large scale incident, the SHICC will notify other health services of the agent, PPE requirements, and treatment regimen.

Treatment regimens are to be based on expert advice from appropriate specialists, and in accordance with CBRN treatment protocols. This may include the delegate of the Director General authorising the deployment of special exemption antidotes.

Supporting documents and treatment guidelines

The following guidelines may be utilised to guide treatment during a CBRN / HAZMAT incident:

- [Australian Clinical Guidelines for Acute Exposures to Chemical Agents of Health Concern.](#)
- Protocols for hospital management of chemical, biological, radiological and explosive incidents (3rd Ed – July 2010).
- [Smallpox and Anthrax Preparedness, Response and Management Guidelines](#)
- [Communicable Disease Network Australia - Series of National Guidelines \(SoNGs\)](#)

Annex K: Environmental Health response

Introduction

The Environmental Health Directorate (EHD), Public Health Division, Department of Health is the principal regulatory and advisory body on environmental health in Western Australia. The EHD may be requested to provide specialist advice and assistance in a disaster or emergency where a hazard(s) poses an imminent threat to the health of humans and the environment.

Capability

A specialist environmental health HRT may be deployed in accordance with Annex C. The environmental health HRT may be deployed to the incident site or to an incident coordination centre to provide advice or assistance to the hazard management agency, local government authority or health service.

Scope of advice and assistance

Advice or assistance may be provided upon issues relating to:

- water safety (drinking water and recreational waters);
- food safety;
- radiation contamination;
- human waste;
- vermin and vector control;
- pesticide misapplications and toxicology (non-clinical); or
- hazardous materials (HAZMAT) contamination or release.

Authorisation

Any environmental health HRT deployed to an incident site must be authorised by the delegate of the Director General (metropolitan area) or RHDC (regional areas). The deployment may be at the request of the Chief Health Officer.

Any deployed environmental health HRT remains accountable to the authorising delegate.

Public health serious incident and emergency powers

Under Part 11 of the *Public Health Act 2016*, the Chief Health Officer may authorise the use of serious public health incident powers by authorised officers for the purposes of controlling or abating a serious public health risk.

When a public health state of emergency is declared by the Minister for Health under Part 12 of the *Public Health Act 2016*, the Chief Health Officer may authorise certain authorised officers and health professionals with specified public health emergency powers.

Supporting documents

An environmental health response may be requested under the auspices of the following documents:

- [Westplan HAZMAT](#)
- Westplan CBRN (restricted access)

Annex L: Management of the deceased

Introduction

Management of the deceased is one of the most difficult aspects of any disaster response and has the potential to impact upon all levels of government.

Management of the deceased

Management of deceased at the incident site is the responsibility of WA Police under the State Disaster Victim Identification (DVI) Plan.

Victims who die *en route* to, or at a health care facility should remain at the health facility until such time as WA Police can arrange transfer to the State Mortuary.

Depending on the number of fatalities, and the storage capacity of the State Mortuary, there may be a requirement for temporary mortuary facilities to be utilised. WA Police will organise temporary mortuary facilities and liaise with the SHICC accordingly.

Mass fatalities

The management of a significant number of fatalities, particularly within a short period of time, is challenging and requires strong interagency coordination and communication processes, as well as support and leadership from all levels of government.

The ultimate purpose in a mass fatality response is to recover, identify and effect final disposition of human remains in a timely, safe and respectful manner, whilst reasonably accommodating religious, cultural and societal expectations.

Activation

Upon activation of this annex, the WA health system will work with partner agencies, including WA Police, the State Coroner, the Metropolitan Cemeteries Board, and other agencies, to implement strategies to accommodate a rapid increase in the number of deceased.

The WA health system will undertake the following roles and responsibilities:

- legislative requirements for certification, including life extinct, cause of death and cremation;
- provision of transit certificates for the repatriation of cadavers and human remains;
- provision of post mortem services by PathWest;
- provision of expert public health advice for management of infectious/contaminated deceased persons; and
- development of relevant fact sheets (for example: health risks from dead bodies).

Supporting documents

This annex may be activated in conjunction with the State DVI Plan (WA Police).

Annex M: Mental health response

Introduction

In an emergency, a potentially large number of people may be exposed to a traumatic event, provoking an array of mental health issues. The Department of Communities (DoC) is the prescribed support organisation with responsibility for providing personal support in an emergency, including the initial psychological counselling. Where overwhelming and/or sustained numbers of people seek mental health assistance, which is beyond the resources of DoC, the delegate of the Director General may be requested by DoC to supplement their response by activating this annex.

Scope of response

DoC may ask the delegate of the Director General to provide additional mental health practitioners to augment the early provision of psychological support and crisis counselling. This may include screening for pre-existing mental health conditions, which may exacerbate presenting symptomology, or the provision of a referral or self-presentation pathway for people in acute crisis requiring emergency mental health assessments and treatments.

Furthermore, DoC may request mental health assistance without activating this annex, whereby patients are referred to local mental health services using normal referral channels.

People presenting with mental health issues should be managed within their own community by the local mental health service. Where the local service's surge capacity is exhausted, the regional/area mental health service is responsible for facilitating additional supports and resources to the local service.

Response capability

The response is dependent upon a needs assessment provided by the DoC. This may include the deployment of staff to the incident area to supplement existing mental health services, or provision of staff to support the initial psychological support provided by DoC.

Variable which may influence a mental health response

- The number people exposed / affected by a traumatic incident
- The age of the people adversely affected (infant, paediatric, adult, or elderly)
- The location of the people (e.g. remote, regional, metropolitan)
- The presence and capacity of on-site mental health services
- Any variable that potentially affects the DoC ability to provide a mental health response to the disaster

The delegate of the Director General should assess the variables of the incident and consult with the North Metropolitan Health Service Executive Director, Public Health and Ambulatory Care prior to making the decision to activate the plan.

Supporting Documents

This annex is supported by the State Mental Health Disaster Response SOPs, which provide detailed operational guidelines and procedures for providing a mental health response to a disaster.

Annex N: Media and public information

Intense media and public interest can be anticipated following an emergency or disaster.

Responsibility

Overall responsibility for responding to media requests and issuing media statements lies with the Director General's delegate. The coordination of media inquiries during an emergency is performed by the Department of Health - Communications Media Manager, or nominated delegate. The Communication Media Manager will specifically coordinate activities at a State level, including:

- providing up-to-date information to media outlets;
- coordinating social media messages;
- responding to media enquiries;
- providing media management and communication assistance to senior staff involved in an emergency;
- coordinating community announcements to be disseminated via media outlets;
- liaising with public relations staff across the health system;
- liaising with the Department of Premier and Cabinet Media Office;
- liaising with media and public relations staff from other government and non-government agencies involved in any emergency event (e.g. WA Police, Department of Fire and Emergency Services, SJA, RFDS, etc.); and
- ensuring close communication is maintained with key stakeholders throughout the emergency, including via the Public Information Reference Group.

Media process during an emergency

- All Hospital Incident Commanders (metropolitan area) or RHDCs (WACHS) must advise Communications Directorate (**9222 4333** - 24 hours) as soon as they become aware of a significant emergency or disaster.
- The delegate of the Director General is responsible for the provision of emergency public information for the WA health system.
- Preparation of WA health system media statements, including social media, and coordination of media inquiries during an emergency lies with Department of Health's Media Manager or nominated delegate.
- All media responses and spokespeople must be approved by the Director General's delegate.

Hospital, health service and regional public relations

- All official contact, queries with and comment to the media during a major health crisis is to be directed to the Department of Health media query line and managed by the Department of Health's Communications Directorate.
- It may be appropriate for selected hospital or health staff to speak to the media but this should be done in consultation with the Communications Directorate and with the approval of the Director General's delegate.
- Condition reports can be given to the media as per usual protocols.

State Emergency Public Information

The State EM Plan provides additional media relations support for the health emergency management functions, if required. The Director General's delegate, with advice from the Media Manager, is responsible for determining if such assistance is required.

Annex O: Other Health response considerations

Registration and reunification

The WA health system has an obligation under “The Plan - Registration and Reunification” to identify, track and record all patients admitted to hospitals in a disaster or major incident. The exchange of information by the WA health system is as specified under Section 72 of the *Emergency Management Act 2005*.

Where there is a need to reunify displaced people and casualties, the Australian Red Cross may be requested to activate the [Register.Find.Reunite](#) service on behalf of the Department of DoC to assist with registration and reunification of displaced persons. Hospitals should have processes in place to cater for the reception and registration of relatives and casualties presenting to hospitals.

The delegate of the Director General may authorise the activation of a Patient Administration System (PAS) disaster flag to capture details of presenting patients who have been involved in a disaster. Extracts from the PAS Disaster Flag are then sent to the Australian Red Cross. Operational Directive (OD) 0428/13 Disaster Flag Activation for Patient Administration Systems outlines the disaster flag activation roles and responsibilities.

Financial arrangements

The Department of Health has an obligation to ensure that an efficient health response can be activated to meet health disaster and emergency management requirements.

The SHICC will activate a single cost centre for the event in order to track all expenses. In the event of major emergencies, where financial expenditure has been incurred to the extent that core health services are likely to be affected, Health Service Units should prepare a case for supplementary funding, which will be assessed by the Director General’s delegate, who will then liaise with the Director General of Health for special financial support.

Hospitals and Health Service Providers should not assume that all costs will be reimbursed.

Annex P: Glossary of terms/acronyms

AUSMAT	Australian Medical Assistance Team A state or territory-based medical assistance team, with self-sustaining field capability, that can be deployed in response to domestic or international incidents.
CBRN	Chemical, Biological, Radiological and Nuclear
CCP	Casualty Clearing Post An area adjacent to an incident site that is used to perform secondary triage, treatment and preparation for transport.
CSF	Clinical Services Framework The principal, government endorsed clinical service planning document for Western Australia's public health system.
DACC	Defence Assistance to the Civil Community Assistance to the community provided by Department of Defence personnel in the event of natural disaster or civil emergency.
Director General's delegate	This role is the delegated officer with the authority to command the coordinated use of all health resources within WA, for response to and recovery from, the impacts and effects of a major emergency or disaster situation.
Disaster	A serious disruption to community life which threatens or causes death or injury in that community and damage to property which is beyond the day-to-day capacity of the prescribed statutory authorities and which requires special mobilisation and organisation or resources other than those normally available to those authorities
DoC	Department of Communities A support agency under section 32 the <i>Emergency Management Regulations (2006)</i> with responsibility for providing welfare services during an emergency.
DVI	Disaster Victim Identification
Emergency	An event, actual or imminent, which endangers or threatens to endanger life, property or the environment, and which requires a significant and coordinated response.

FSH	Fiona Stanley Hospital
Hazard	Any event, situation or condition that is capable of causing or resulting in: <ul style="list-style-type: none"> • loss of life, prejudice to the safety, or harm to the health or persons or animals; or • destruction of or damage to property or any part of the environment
HAZMAT	Hazardous materials
HMA	Hazard Management Agency A public authority or other person who or which, because of that agency's functions under any written law or specialised knowledge, expertise and resources, is responsible for emergency management, or the prescribed emergency management aspect, in the area prescribed of the hazard for which it is prescribed.
HRT	Health Response Team A deployable team that can be sent to an incident site to augment the pre-hospital response or to provide specialist procedures and advice.
IC	Incident Controller The person(s) who is responsible for the overall management and control of an incident and the tasking of agencies in accordance with the needs of the situation.
LEOC	Local Emergency Operations Centre A local facility established to provide local coordination across a WA Country Health Service hospital or health service during an incident or emergency.
LO	Liaison Officer A representative of an agency or organisation who deploys at the request of the controlling agency to establish communication between the host agency and the agency they represent.
MIMMS	Major Incident Medical Management and Support A licensed methodology that teaches health care professionals how to respond to a major incident in the pre-hospital setting. It involves the principles of command and control, safety, communication, assessment, triage, treatment, and transport.
MERN	Metropolitan Emergency Radio Network
MCI	Mass Casualty Incident

NIR	National Incident Room – Department of Health (Australian Government)
PCH	Perth Children’s Hospital
PMH	Princess Margaret Hospital
PPE	Personal Protective Equipment
RFDS	Royal Flying Doctor Service – Western Operations
REOC	Regional Emergency Operation Centre A regional level facility established to provide coordination across a WA Country Health Service region during an incident or emergency.
RHDC	Regional Health Disaster Coordinator A designated senior officer who has the authority to command and coordinate the use of all resources with a WA Country Health Service region during an incident.
RPH	Royal Perth Hospital
RRC	Regional Resource Centre
SCGH	Sir Charles Gairdner Hospital
SEC	State Emergency Coordinator The State Emergency Coordinator is the Commissioner for Police and is responsible for coordinating the response to an emergency during a State of Emergency.
SHC	State Health Coordinator The SHC is the Hazard Management Agency for heatwave and accidental release of biological hazards substances as outlined in the <i>Emergency Management Act 2005</i> .
SOP	Standard Operating Procedure A set of directions detailing what actions could be taken, as well as how, when, by whom and why, for specific events or tasks.
SHICC	State Health Incident Coordination Centre The State-level centre responsible for the strategic coordination of the Health response to an incident.
SJA	St John Ambulance Western Australia Inc.
WA	Western Australia

WA health system Western Australia's public health care system which comprises of:

- The Department of Health (*the system manager*)
- health service providers
- contracted health entities

WACHS **WA Country Health Service**

WAMAT **WA Medical Assistance Team**



This document can be made available in alternative formats on request for a person with a disability.

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