Project Recompense

Prepared by the WA Police Union

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Executive Summary

As police perform the duties necessary of them "to enhance the quality of life and wellbeing of all people in Western Australia by contributing to making our State a safe and secure place", they are required to undertake some of the most challenging, dangerous, unpredictable and life-threatening work in society[1]. The duties they perform expose them to inherently traumatic situations; situations in which they are exposed to scenes of abstract horror and violence. Police officers also face intense organisational pressures and stress in the form of emotional dissonance with respect to both organisational culture and perceptions of justice.

Police officers in Western Australia (WA) face working conditions that are unique to other public sector employees, including other emergency services employees. For example:

- They interact with members of the public from all walks of life, in every conceivable situation, 24 hours a day/seven days a week, across the world's largest single police jurisdiction (covering 2.5 million square kilometres)[2];
- The powers conferred on a police officer, reflected in the officer's oath of office and subscribed upon their appointment, is an affirmation which attests to the importance of serving and protecting the community at all times (hence where police intervention is required, whether an officer is on duty or off duty, members of the police force will *always* come to the aid of anyone requiring assistance);
- Police officers are specifically excluded from the *Workers' Compensation and Injury Management Act 1981* unless they suffer an injury and die as a result of that injury; and
- Police officers are covered by the *Occupational Safety and Health Act 1984* but, again, are singled out as being unable to exercise Section 26 of this Act when performing dangerous work in a covert or dangerous operation.

Police work encompasses a myriad of different skills to be employed in countless unique situations, but it is ultimately varied, intense, difficult, confronting and dangerous, yet rewarding. The sentiment amongst police officers is that they dedicate their lives (and put their bodies on the line) in order to protect and serve the community. Police officers see their job as a lifelong career, not a mere stepping stone to work in other industries.

[1] Western Australia Police, *About Us*, Government of Western Australia, 2014. < http://www.police.wa.gov.au/Aboutus/tabid/893/Default.aspx >.
[2] Ibid.

Whilst a police officer is employed by Western Australia Police ("WA Police" or "the Agency"), should they be injured or fall ill, they receive a range of medical and sick leave entitlements in lieu of the entitlements afforded under the *Workers' Compensation and Injury Management Act 1981*. However, once an officer separates, retires or is medically retired from the Agency, they are only entitled to access a restricted medical benefits scheme, *if* they are eligible. The medical retirement process is antiquated, undignified, protracted and harrowing, and is felt to exacerbate any illnesses or injuries an officer is experiencing. Once a police officer has separated from the Agency, no formal WA Police-centric support, monitoring, rehabilitation or liaison services for retired Members exist to be offered to eligible Members. Police officers, especially those who are medically retired, are severed completely from the Agency to which they devoted themselves.

Physical injuries, especially those that are high profile, are the injuries to which WA Police, the WA Government and the greater public pay attention. However, psychological illnesses, resulting from a culmination of various stressors experienced throughout a police officers' career, are more pervasive and insidious than are acknowledged. Should an officer suffer a psychological illness as a result of their work environment, there is no formal acknowledgement that WA Police has contributed to an officer's deteriorating mental state with inadequate support systems, ineffective monitoring of attendance at traumatic incidents and an ambivalent, "toughen up princess" police culture.

Project Recompense was conceived out of the innumerable calls the WA Police Union ("WAPU") received from both serving and retired Members seeking assistance and support in the wake of life-changing physical or psychological trauma. WAPU has been so overwhelmed with requests for assistance with ex-gratia applications, that it was deemed necessary to undertake research into not only the Member experience of work-related physical or psychological trauma and Agency response to said trauma, but also the validity of a variety of forms of compensation.

WAPU conducted a Member survey of both serving and separated Members to ascertain the extent of physical and psychological illnesses and injuries and was overwhelmed with the response. Of the nearly 900 responses, just over three quarters of respondents had currently or previously suffered a work-related physical or psychological illness or injury. For those Members affected by a physical or psychological illness or injury, the following was generally noted:

- Disability benefits for those who were eligible to receive them were inadequate;
- The shortfall in earnings between medical retirement or separation and WA Police retirement age averaged $1,000,000;

- Re-engagement in meaningful, secure employment post-service was unattainable;
- A number of Members were ineligible to receive post-service medical benefits, which created an enormous cost impost to individuals;
- Whilst there were many Members who responded in detail to the questions about the trauma they suffered and the critical incidents they attended throughout their career, there were equal numbers of Members who indicated they found it far too difficult to discuss the trauma they had witnessed and suffered;
- The types of critical incidents attended by police officers most frequently involved suspicious deaths, suicides, assaults, car accidents, murders, incidents involving children and rape;
- Enduring these critical incidents impacted individual officers by manifesting as: withdrawal from life and leisure activities, from family and friends and from work; mood swings, anxiety and depression; suicidal behaviours; alcohol dependency; and health problems including digestive and sleep disorders; and
- Dealings with WA Police, including management and Health and Welfare Services, often intensified feelings of despair, loneliness and helplessness as Members believed WA Police (and affiliate associations) could be distant, unsupportive and biased.

This report has incorporated a number of Member experiences in order to provide a detailed example of the situations police officers regularly face and the treatment they have withstood from WA Police. There have been, in recent times, a parliamentary inquiry and an inquest into the death of a police Sergeant that have outlined concerns about the daily travails of police officers and the inadequate support they receive from the Agency. The inquiry and inquest depict an organisation that is faced with many challenges when dealing with members of the public, especially the most vulnerable and violent. As pressures increase on WA Police to meet intensifying service demands, police officer health and welfare doesn't just become more important but is somehow becoming more impartial and cost-driven. In canvassing our Membership, WAPU not only supports the recommendations that have arisen from these independent bodies but believes that little is being done to rectify the status quo.

Of concern is that Members who have separated from WA Police are unsupported as no government agency exists to monitor or support these officers. Independent organisations, such as WAPU, the Retired Police Officers' Association and Medically Retired WA Police Officers' Association, are currently the only forms of support and assistance available for retired Members.

Project Recompense aimed to encapsulate the experience of medically retired Members, most specifically, Members who had suffered a work-related illness or injury (be it physical or psychological in nature) and were so broken as a result of their police duties they: were unable to work again; could not maintain a normal, healthy, balanced life; were facing financial hardship; and just wanted to have their pain and suffering acknowledged. This report has not only captured this but illustrated the shortcomings of WA Police with respect to police officer health and welfare and demonstrated that there will be a new vanguard of broken police officers if something is not done to change Agency processes and culture immediately.

Project Recompense can be broadly divided into three areas of discussion:

1. A background section, which summarises an array of literature (on police health and welfare, forms of compensation and legislation that informs this debate), recent parliamentary inquiries and an overview of WA Police and affiliated agencies;
2. A Member experiences section, which details the results of a survey conducted by WAPU of past and present Members, most notably relaying the experiences of Members with respect to attendance at traumatic situations, the nature of physical or psychological illnesses or injuries suffered and subsequent experience with WA Police and its Health and Welfare Services; and
3. A recommendations section, which outlines Member suggestions for a suitable compensation scheme and WAPU's recommendations for WA Police and Government.

Recommendations

Recommendation 1

That WA Police acknowledge there are Members who have suffered immeasurable trauma as a result of attending a number of critical incidents without the appropriate support from the Agency, and that this trauma has been life-changing for those affected.

Recommendation 2

That WA Police further explore the benefits of resilience training, greater mental health awareness and psychological first aid and implement these initiatives immediately.

Recommendation 3

That WA Police ensure appropriate interventions are administered during an officer's career to mitigate the likelihood of developing psychological illnesses.

Recommendation 4

That WA Police increase the number of support staff in its Health and Welfare Services. Currently, there are approximately 33 members of staff across several units (including psychologists, claims management staff, chaplains, vocational rehabilitation staff and peer support employees) that are intended to service more than 6,000 police officers. If WA Police is to apply the appropriate interventions, increase training and awareness and connect more effectively with both current and retired Members, there is an urgent need to increase support staff across the various units.

Recommendation 5

That WA Police initiate a connection with separated Members, especially those who have been medically retired, so that mental health and welfare can be monitored once an officer has exited the Agency.

Recommendation 6

That WA Police, with the assistance of the Government, implement, as part of its vocational rehabilitation system, a program that invests in re-training human resources so that they may be utilised in other employment areas (be it within the public sector or the private sector).

Recommendation 7

That WA Police share the 2011 PricewaterhouseCoopers review of the Health and Welfare Services with WAPU and other relevant stakeholders.

Recommendation 8

That WA Police reassess its response to the Community Development and Justice Standing Committee's *The Toll of Trauma on Emergency Staff and Volunteers* report.

Recommendation 9

That the Former Officers' Medical Benefits Scheme be amended to encompass officers who suffered a work-related illness or injury before 1 July 2007 and to provide for vocational rehabilitation.

Recommendation 10

That an organisation similar in intent and structure to that of the Department of Veterans' Affairs, and independent of the Health and Welfare Services of WA Police, be established for police officers. This organisation must encompass units that: remunerate eligible members appropriate benefits; provide a range of health care and support services for eligible members; and offer specialised, free counselling.

Recommendation 11

That a service similar to Operation *Life*, and linked to the National Suicide Prevention Strategy, is developed for WA police officers.

Recommendation 12

That a compensation scheme for police officers, similar in intent and structure to the Workers' Compensation scheme, is thoroughly explored and an appropriate proposal is developed in conjunction with the relevant invested parties. The proposal must maintain appropriate sick leave provisions (both work and non-work related) similar to those currently in place for serving officers and take into consideration that police officers and their work duties are unique in comparison to all other workers.

Recommendation 13

That, in conjunction with Recommendation 12, as a compensation scheme similar to Workers' Compensation is explored for police officers, presumptive legislation (similar to that for professional firefighters) is considered for police officers with respect to a range of specific illnesses and injuries.

Recommendation 14

That the Government establish an ongoing scheme, similar in structure to Redress WA, that adequately and appropriately financially compensates those police officers who have been injured in the line of duty who are ineligible for other benefits and reinvigorated support services.

NB: A full explanation of each recommendation is provided from page 133.

Background

A dangerous job: the lasting effects of police work

Emergency service work, particularly that which is undertaken by police officers, "carries an inherent risk of exposure to situations that many would find traumatic"[3]. Police officers experience more stress-related physical and psychological complaints than workers in most other professions, and this is assumed to be a result of the violence that is predominant in their work culture[4]. Police work is different from other public sector work, not only because police work is inherently dangerous, but because police must "respond to a variety of situations which may be considered shocking, disturbing and upsetting to many people"[5]. There are numerous work conditions that are unique to police officers, and (unlike any other public sector worker) their work duties require them "to make split-second life and death decisions, enforce laws, ensure public safety and work in an environment that has the potential for danger and life-threatening situations"[6]. As such, this occupational group is considered "psychologically 'at risk' with higher lifetime prevalence rates of mental health difficulties such as post-traumatic stress disorder (PTSD) than the general population"[7].

Police officers are not only "exposed to multiple traumas throughout their career" but are exposed to "many different types of traumas as well"[8]. Police officers are exposed to a number of stressful tasks as part of their daily workload: duties concerned with violence or threatened violence; being shot at; being physically threatened or having one's family threatened; working with victims who have been badly beaten; killing someone in the line of duty; death of a fellow officer; and physical attack[9]. The majority of traumatic events that police officers are exposed to are "intentional, human-made

[3] R. Evans, N. Pistrang & J. Billings, "Police officer's experiences of supportive and unsupportive social interactions following traumatic incidents", *European Journal of Psychotraumatology*, vol. 4, 2013, p. 1.
[4] E. Kendall, P. Murphy, V. O'Neill & S. Bursnall, "Occupational Stress: Factors that Contribute to its Occurrence and Effective Management", Centre for Human Services, Griffith University, 2000, pp. 48-49.
[5] A.D. MacEachern, D. Jindal-Snape & S. Jackson, "Child abuse investigation: police officers and secondary traumatic stress", *International Journal of Occupational Safety and Ergonomics*, vol. 17, no. 4, 2011, p. 329.
[6] G. Patterson, "Mental stress and worker's compensation claims among police officers", *Journal of Workplace Rights*, vol. 14, no. 4, 2009, p. 443.
[7] R. Evans et al., p. 1.
[8] B. Chopko, "Post-traumatic distress and growth: an empirical study of police officers", *American Journal of Psychotherapy*, vol. 64, no. 1, 2010, p. 65.
[9] N. Addis & C. Stephens, "An evaluation of a police debriefing programme: outcomes for police officers five years after a police shooting", *International Journal of Police Science and Management*, vol. 10, no. 4, 2008, p. 361.

disasters such as sexual assault, involvement in shootings, hostage situations…, and the death or serious injury of children," not natural or accidental disasters[10].

Police officers suffer immeasurable stress as they not only face a high risk of assault and harm through exposure to communicable diseases (that may be "transferred through attacks with syringes, bottles, saliva or airborne cough droplets") but are constantly exposed to "danger, traumatic events, prisoner threats, conflicting task demands, short-staffed stations, court appearances, departmental enquiries and work in isolated rural areas"[11].

In addition to the possible exposure to situations where they are at risk of being injured or killed, police officers "are often exposed to people who have been injured or killed because of traffic accidents, murders, suicides and other incidents"[12]. Chopko asserts that "exposure to dead bodies has been found to be a significant psychological stressor among officers", especially when "the incident is traumatic and unexpected"[13]. Police officers who handle dead bodies are also said to be "traumatised by visual, tactile and olfactory sensations"[14].

As well as exposure to traumatic events, the other sources of stressors for police officers can be broadly divided into three categories. The organisation itself is seen as a source of stress. Administrative issues (for example, unnecessary, excessive and burdensome paperwork, inconsistent application of agency policies and outdated technology), communication issues (for example, a bureaucratic hierarchy and lack of recognition) and problems with co-workers or management are perceived as organisational stressors[15]. Interaction directly with the community is another source of stress, as officers are frequently exposed to individuals who are suffering[16]. Police officers also face stress when dealing closely with the criminal justice system and the media: officers are likely to experience internal conflict when court rulings don't match perceptions of justice and there is negative media coverage of police officers[17].

[10] G. Patterson, p. 443.
[11] R. Guthrie, "The Industrial Relations of Sick Leave and Workers Compensation for Police Officers in Australia", National Research Centre for Occupational Health and Safety Regulation, the Australian National University, 2009, pp. 9-10.
[12] B. Chopko, p. 56.
[13] Ibid.
[14] Ibid.
[15] M.R. Tuckey, P.C. Winwood & M.F. Dollard, "Psychosocial culture and pathways to psychological injury within policing", *Police Practice and Research*, Vol. 13, No. 3, 2012, p. 225; G. Patterson, p. 444.
[16] G. Patterson, p. 442.
[17] Ibid.

Many stress management approaches have been widely criticised because they "place the responsibility for managing traumatic, organisational and personal stress on individual police officers while ignoring the organisational environment"[18]. Patterson noted that "even if officers used the most effective strategies for coping with workplace problems, police departments bear the burden of reducing or eliminating the workplace conditions that contribute to stress"[19]. Focussing on lessening organisational stressors (such as excessive paperwork, a lack of administrative support, inadequate equipment and inefficient supervision and training) could reduce the long-term effects of those stressors on police[20].

Finally, a lot has been written about the 'police culture'. Tuckey et al. note that "displaying emotion is regarded as a weakness, and emotional control, courage and toughness are represented within the [police] culture as important to police identity", and as such, these "norms and values of [the] police culture prevents officers from talking about their emotions, depriving them of the potential benefits of social support" and an appropriate, understanding "psychosocial work environment"[21]. An individual's social environment is thought to promote or deter "willingness to talk about a traumatic event, in turn influencing the level of cognitive processing and adaptive adjustments"[22]. As such, "unsupportive, unreceptive or critical responses from others… are thought to increase the risk of [PTSD] by discouraging talking and increasing cognitive avoidance and suppression of the trauma-related material"[23].

Leino et al. assert that the "police culture discourages the expression of personal feelings…, encourages officers to react unemotionally towards unpleasant situations… [and] encourages a tough outlook on life", buying into this perception that an officer's own emotions represent some sort of weakness[24]. Conversely, Evans et al. noted that the "ability to remain calm and dispassionate in response to potentially emotive incidents [is] seen as the hallmark of a reliable police officer" because it is believed that officers *should* just be able to cope[25]. A police culture that values impartiality and emotional strength is likely to result in officers who are "afraid of being identified as individuals who

[18] Ibid, p. 444.
[19] Ibid.
[20] Ibid, p. 450.
[21] pp. 225-226.
[22] R. Evans et al., p. 3.
[23] Ibid.
[24] T. Leino, K. Eskelinen, H. Summala & M. Virtanen, "Work-related violence, debriefing and increased alcohol consumption among police officers", *International Journal of Police Science and Management*, vol. 13, no. 2, 2011, p. 154.
[25] pp. 3-7.

have been compromised by stress" and therefore "discriminated against in their careers, removed from [operational] duty and relegated to office work"[26].

Whilst an emotional distance may assist during "operational duties, it cannot prevent a longer term cost"[27].

What defines a traumatic incident?

MacEachern et al. refer to psychological trauma as "any situation faced by emergency personnel that causes them to experience strong emotional reactions which have a potential to interfere with their ability to function either at the scene or [at some time] later"[28]. A psychological trauma also means a "severe cognitive-affective disruption which can follow the experience of certain kinds of extreme events, including those where there is no physical injury"[29]. Both a single "dramatic and violent event as well as a series of repeated and prolonged administrative events can cause… a neurobiological maladaptive reaction due to being forced to adapt to challenging environments characterised by behavioural and emotional changes known as 'distress'"[30]. Traumatic incidents are generally "linked to a life threat, and life-threatening situations may make individuals more aware of [their] mortality and the fragility of life"[31].

Most police forces have "clearly delineated definitions of what they consider to be a traumatic incident for the purposes of stress management"[32]. However, "due to the diverse nature of policing, compiling a comprehensive list of police job stressors that can be universally referred to by researchers… is unrealistic and, as a result, there [appears to be] no collective definition of a traumatic incident"[33].

Critical incidents: a WA Police perspective

WA Police cite a critical incident as being:

> "… any incident which may result in, or have the potential to result in, some degree of psychological distress, including:

[26] S. Garbarino, G. Cuomo, C. Chiorri & N. Magnavita, "Association of work-related stress with mental health problems in a special police force unit", *BMJ Open*, vol. 3, 2013, pp. 2-3.
[27] M.R. Tuckey et al., p. 225.
[28] pp. 329-330.
[29] D. Duckworth, "Facilitating recovery from disaster-work experiences", *British Journal of Guidance and Counselling*, vol. 19, issue 1, 1991, p. 15.
[30] S. Garbarino et al., p. 2.
[31] B. Chopko, p. 65.
[32] A.D. MacEachern et al., p. 335.
[33] Ibid, p. 331.

- Death of a fellow officer;
- Serious verbal and/or physical threat or injury to personnel;
- Death or serious injury to a civilian resulting from a police operation;
- Events in which there are multiple fatalities or mutilation of bodies;
- Dangerous police operations that extend over a prolonged period;
- Death or serious injury to children;
- Deaths or attempted suicides in custody;
- Unsuccessful attempts at resuscitation (CPR);
- Events in which the victims of the incident are known to police attending; and/or
- Any other work situation which causes a strong emotional reaction"[34].

WA Police identifies a range of common reactions to critical incidents, including recurring dreams/nightmares/flashbacks and other sleep disturbances, irritability, hypervigilance, avoidance and feelings of sadness, helplessness and disconnectedness.

WA Police has also identified a range of reactions that indicate help should be sought by an officer four to six weeks following a critical incident:

- You were stressed or traumatised prior to the incident;
- You felt your life was in danger;
- You continue to feel angry;
- You avoid being confronted with any aspects of the incident;
- You have little available support;
- You cannot get on with life and you feel you cannot cope with 'normal' day-to-day activities;
- You are drinking and/or smoking more[35].

Following this 'checklist', WA Police advise that counselling is important in assisting an officer through a trauma.

The definition of a traumatic or critical incident for the purposes of Project Recompense

For the purposes of Project Recompense, a traumatic (or critical) incident is defined as being a natural or man-made event that is characterised by violence and/or death or injury and/or life-threatening

[34] This information is lifted from a pamphlet distributed by WA Police to its employees entitled *Coping with critical incidents*.
[35] This information is lifted from a pamphlet distributed by WA Police to its employees entitled *When to seek help following critical incidents*.

circumstances that are faced by a police officer which elicits a strong emotional response and which may have a negative, maladaptive and detrimental effect on their wellbeing.

Within this report, a 'critical incident' and a 'traumatic incident' are used alternately and have the same meaning.

Understanding post-traumatic stress disorder (PTSD)

Garbarino et al. note that the "psychological dysfunction resulting from job distress can be a gradual and progressive process that impairs wellbeing over time"[36]. This distress can result from a single traumatic incident or ongoing, cumulative events that occur during interactions with the public and within the organisation. The "acute stress of critical incidents or traumatic events can become the catalyst for the development of post-traumatic reactions, including post-traumatic stress disorder" (or PTSD)[37].

When individuals are exposed to a traumatic event, some go on to develop PTSD[38]. If a person reacts to a catastrophic event with intense fear, helplessness or horror, these ongoing difficulties are known as PTSD[39]. PTSD is a "chronic, debilitating disorder characterised by feelings of fear, an increase in arousal, avoidance of stimuli associated with the trauma and persistent and distressing re-experience of the event"[40]. PTSD often "leads the sufferer to be incapacitated, both psychologically and physiologically," leading to poor physical health and reduced work productivity[41].

There are three types of post-traumatic stress reactions. A person can relive the traumatic experience by having distressing thoughts or mental images of the event, dream about what happened or have flashbacks[42]. This is called an 'intrusive reaction'. An 'avoidance and withdrawal reaction' is characterised by reactions that people use to "keep away from, or protect against, distress"[43]. These reactions include avoiding "talking, thinking and having feelings about the traumatic incident, and

[36] p. 2.
[37] B. Chopko, p. 56.
[38] G.J. Devilly & T. Varker, "The prevention of trauma reactions in police officers: Decreasing reliance on drugs and alcohol", *National Drug Law Enforcement Research Fund*, Commonwealth of Australia, Australian Capital Territory, 2013, p. 1.
[39] Picking up the Peaces, *What is post-traumatic stress disorder*, < http://www.pickingupthepeaces.org.au/ >.
[40] G.J. Devilly & T. Varker, p. 1.
[41] Ibid.
[42] *Psychological First Aid: Field Operations Guide*, 2nd Edition, National Child Traumatic Stress Network and National Centre for PTSD, 2006, p. 78. < http://www.nctsn.org/sites/default/files/pfa/english/1-psyfirstaid_final_complete_manual.pdf >.
[43] Ibid.

avoiding any reminders of the event, including places and people connected to what happened"[44]. An avoidance or withdrawal reaction is characterised by feelings of estrangement and detachment, social withdrawal and a loss of interest in activities[45]. Thirdly, there is the 'physical arousal reaction'. These are reactions that bring about physical changes that occur when the body feels as if danger is still present[46]. These reactions include "constantly being 'on the lookout' for danger, startling easily…, [irritability] or having outbursts of anger, difficulty falling or staying asleep, and difficulty concentrating"[47].

Duckworth notes that people adversely affected by trauma, including those whose suffer PTSD, "can undergo what seems like a complete personality change: from being employed, physically fit and active, good-natured, fun-loving and self-sufficient… [to] unemployable, unfit and sedentary, short-tempered, depressed and dependent"[48].

Devilly and Varker estimate that "at any given time, 15-32 per cent of all emergency responders are dealing with a reaction to post-traumatic stress and that there is a 30-64 per cent chance that they will have a negative mental health reaction to it during their lifetime" [49].

The peak awareness body for PTSD in Australia, "Picking up the Peaces", notes the following regarding PTSD:

- It is a normal reaction to trauma, not a personality trait;
- Some are not affected by PTSD immediately, but rather have a diagnosis after an additional stressful event;
- Most sufferers of PTSD re-experience their trauma in nightmares or flashbacks;
- PTSD symptoms and secondary conditions can become chronic or recur off and on, substantially impairing an individual's ability to cope with daily life;
- One of the best aids to recovery is to acknowledge that a traumatic event has occurred.

A lack of social support has been identified as "one of the strongest risk factors for PTSD after trauma exposure"[50].

[44] Ibid.
[45] Ibid.
[46] Ibid.
[47] Ibid.
[48] p. 14.
[49] G.J. Devilly & T. Varker, p. 1.
[50] R. Evans et al., p. 1.

Other impacts of stress

Police-centric research has "comprehensively established that if not managed effectively, stress has a significant negative impact on the physical health and psychological functioning of police officers"[51]. Police officers experience a range of widely documented reactions (reactions that generally precede PTSD) to traumatic incidents, including depression, insomnia, guilt, tension, irritability, feelings of withdrawal, anxiety and nightmares[52]. Other noted effects of stress and stressful incidents include: an increased propensity for illness and subsequent sick leave; poor work performance; job dissatisfaction and dissonance; reduction in motivation; impaired ability to perform complex tasks; raised levels of aggression; and maladaptive coping mechanisms, such as an overindulgence in alcohol[53].

In their study, Leino et al. found that police officers who internalise their stress following a traumatic incident were more likely to increase their alcohol consumption[54]. Those officers who "lacked debriefing or training to handle violent situations, [as well as] those who felt a shortage of [staff], increased their alcohol consumption", even more so if the police culture encouraged toughness and efficiency[55].

One particular Australian study of police officers found that "officers suffered higher incidents of heart disease, hypertension, asthma, repeated skin illnesses and nervous breakdowns than did the Australian population as a whole"[56].

Burnout is another noted side effect of stress. Burnout is considered to be the "emotional exhaustion, depersonalisation and reduced personal accomplishment that can occur among individuals who do 'people work' of some kind"[57].

Information on coping

Coping is defined as "an individual's cognitive and behavioural actions to manage internal or external stressors or problems which exceed their personal resources"[58]. Following a traumatic incident,

[51] G.M. Balmer, J.A. Pooley & L. Cohen, "Psychological resilience of Western Australian police officers: relationship between resilience, coping style, psychological functioning and demographics", *Police Practice and Research*, vol. 15, no. 4, 2014, p. 270.
[52] B. Chopko, p. 56.
[53] A.D. McEachern et al., p. 333.
[54] p. 150.
[55] Ibid, p. 154.
[56] L.K. Savery, G.N. Soutar & J.R. Weaver, "Stress: some West Australian evidence", *The Police Journal*, vol. 66, 1993, p. 278.
[57] G.J. Devilly & T. Varker, p. 10.
[58] G.M. Balmer et al., p. 271.

individuals can either cope in a positive or a negative fashion. According to Balmer et al., coping strategies have been identified as a "contributing factor in the development and maintenance of resilience during periods of stress or trauma"[59].

Adaptive coping actions are considered to be actions that "help to reduce anxiety, lessen other distressing reactions…, or help people get through bad times"[60]. Generally, coping methods that are considered to be helpful include:

- Talking to another person for support;
- Getting adequate and necessary information;
- Participating in a support group;
- Maintaining a regular schedule;
- Getting adequate rest, nutrition and exercise; and
- Seeking counselling[61].

Maladaptive coping methods are seen as ineffective in addressing problems, and include such actions as:

- Using alcohol or drugs to cope;
- Withdrawing from activities, friends and family;
- Exhibiting violent behaviours;
- Watching too much TV or playing too many computer games;
- Excessive blaming of self or others; and
- Not taking care of yourself (regarding sleep, diet, exercise et cetera)[62].

Maladaptive coping strategies are considered to reduce resilience to traumatic incidents "by contributing to poorer mental health as officers [avoid] sharing their experiences with others…, leading to increased social isolation and maintenance of stress symptoms"[63].

[59] Ibid.
[60] *Psychological First Aid: Field Operations Guide*, p. 81.
[61] Ibid.
[62] Ibid, p. 82.
[63] G.M. Balmer et al., p. 272.

Forms of compensation

Ex-gratia (act of grace) payments

Ex-gratia means "out of grace" in Latin. An ex-gratia payment is a means to provide "compensation or financial assistance… despite there being no legal obligation to do so"[64]. An ex-gratia payment is usually made where there is some moral obligation on behalf of an agency to "provide redress for loss or damage suffered by the recipient"[65]. Ex-gratia payments, which are discretionary payments made under executive powers, is usually accompanied by a Deed of Discharge or Release as there is no recognition of liability attached to the payment[66]. An ex-gratia payment is generally only considered if compensation is not available under any other scheme[67], can be one-off or periodic[68] and are only ever paid out in exceptional circumstances.

Ex-gratia payments are granted to "remedy an injustice that otherwise remains incapable of repair or solution through the ordinary or usual processes of the law"[69].

Legislation

As there is no criteria for determining when an ex-gratia payment should be made and Deeds of Discharge or Release generally contain a confidentiality clause, the only guidance or protocol to the payment decision-making process is provided by WA legislation.

Ex-gratia payments (the term of which is used interchangeably with act of grace payments) are briefly outlined within the *Financial Management Act 2006* at section 80 (Appendix 1A) and within the *Financial Management Regulations 2007* at section 8 (Appendix 1B). The Treasurer's Instructions elaborate on the sources of ex-gratia funding and criteria for the assessment of ex-gratia claims (Appendix 1C).

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[64] Queensland Ombudsman, *Legal Perspective*, Issue 7 – May 2012, The State of Queensland, 2012, p. 2. < http://www.ombudsman.qld.gov.au/Portals/0/docs/Publications/Perspective_Newsletters/Legal_Perspective_Issue7_web.pdf >.
[65] Ibid.
[66] Ibid.
[67] Ibid.
[68] Department of Treasury and Finance, *Financial Reporting Directions and Guidance: Disclosure of Ex Gratia Expenses*, State Government of Victoria, 2014. < http://www.dtf.vic.gov.au/Publications/Government-Financial-Management-publications/Financial-reporting-policy/Financial-reporting-directions-and-guidance >.
[69] Department of Finance and Deregulation, *Senate Review of Government Compensation: Submission to the Standing Committee on Legal and Constitutional Affairs*, Australian Government, 2010. < http://www.finance.gov.au/sites/default/files/compensation_payments_finance_submission.pdf >.

Given the brevity of the legislation surrounding the process, ex-gratia payments do not always provide for certainty and equity.

How are ex-gratia payments calculated?[70]

The approach that is taken when calculating claims for ex-gratia payments is to apply the same principles that are applied by the courts to calculate amounts of compensation that would typically be awarded in successful personal injuries cases.

The discrete amounts claimed for each individual item (for example, damages for pain and suffering, and future medical expenses) are called "heads of damage". These heads of damage, when added together, make up the total sum claimed as an ex-gratia amount. The amounts claimed and the supporting evidence relied upon for each item are compiled in a Schedule of Damages.

Before deciding upon whether to make an ex-gratia payment, the Schedule of Damages and any other supporting materials are referred to the State Solicitor's Office for analysis.

Police officers and ex-gratia payments[71]

For police officers injured in the line of duty, the types of exceptional circumstances that would support the making of an ex-gratia payment include (but are not limited to):

- Police officers do not have the legal right to sue their employer;
- Police officers do not have the protection of Workers' Compensation or similar statutory compensation schemes;
- Other legal avenues that may be available to officers (such as legal proceedings against third parties) are costly, drawn out, with uncertain outcomes;
- When protecting the public, police officers are required to expose themselves to risks of injury that workers in other professions do not face; and
- There may be a strong public outcry in support of an injured officer.

In practice, although these first four exceptional circumstances are almost always present in every claim for an ex-gratia payment, the "acts of grace" that properly compensate injured police officers tend to only be made following a strong public outcry. In these cases, the desire to limit adverse publicity and the re-election cycle appear to be more persuasive arguments for the making of an ex-

[70] The following information has been provided to WAPU by legal counsel, Tim Kucera of McNally Jones Staff.
[71] The following information has been provided to WAPU by legal counsel, Tim Kucera of McNally Jones Staff.

gratia payment than the proper consideration of the other exceptional circumstances that should support awards of compensation to injured officers.

Forms of compensation: precedents

Redress WA

On 17 December 2007, the Government announced an ex-gratia payment scheme known as Redress WA to compensate those who as children were abused in State care in Western Australia[72]. The key priorities of the scheme were to: acknowledge and formally apologise for the suffering experienced as a result of abuse in State care; compensate for the impact of the abuse on a person's life; and provide a range of support services for those who suffered abuse, including counselling, advice, advocacy and self-help groups[73]. $114 million was allocated by the Government for the Redress WA scheme, of which just over $90 million was set aside for ex-gratia payments alone[74].

Guidelines were established to compensate those persons who were abused and/or neglected whilst in State care[75]. The Redress WA Guidelines outlined:

- Definitions (including that of *injury* and *medical evidence* linking abuse and illness/injury)[76];
- How to make an application for an ex-gratia payment;
- Assessments to ascertain whether or not the applicant has experienced that which is alleged;
- A review and complaints process; and
- A schedule which outlines "levels" for payment on a scale according to the "severity of the abuse and/or neglect and the degree of harm, injury and loss suffered by the applicant"[77].

[72] Redress WA: Acknowledging the past, *Message from the Minister*, Government of Western Australia, 2008. < http://pandora.nla.gov.au/pan/81490/20080211-1621/www.redress.wa.gov.au/index-2.html >.
[73] Ibid.
[74] Robyn McSweeney MLC, *Start of Redress WA Ex-gratia Payment Offers*, Liberal Party of Australia, Western Australian Division, 2010. < https://www.wa.liberal.org.au/article/start-redress-wa-ex-gratia-payment-offers >.
[75] *Redress WA Guidelines*, Government of Western Australia, 2011, p.1. < http://www.findandconnect.gov.au/ref/wa/objects/pdfs/Redress%20WA%20Guidelines%2018%20May%202011.pdf >.
[76] Ibid, pp. 9-10.
[77] Ibid, p. 39.

The Toll of Trauma on Western Australian Emergency Staff and Volunteers

In August 2011, the Community Development and Justice Standing Committee (the Committee) of the Legislative Assembly of the Parliament of Western Australia "agreed to conduct an *Inquiry into the Recognition and Adequacy of the Responses by State Government Agencies to Experience of Trauma by Workers and Volunteers Arising from Disasters*"[78].

In September 2012, the Committee released its findings from the inquiry into the Toll of Trauma on Western Australian Emergency Staff and Volunteers (referred to herein as 'the Toll of Trauma Inquiry'). In the Chair's foreword, it was acknowledged that the inquiry "initially focussed on natural disasters", but the Committee unexpectedly found that "emergency staff suffer great stress by attending traumatic incidents on a day to day basis as part of their normal tasks"[79]. The evidence gathered by the Committee "clearly showed that Western Australian agencies have processes for dealing with the trauma of emergency staff that are less advanced than in other jurisdictions", which left first responder agencies "derelict in their duties to some of their staff and volunteers exposed to traumatic incidents"[80]. It was found that in some cases, "official responses exacerbated the effects of trauma"[81].

The inquiry heard from, amongst many others: experts on the subject matter; first responder agencies from international and other Australian jurisdictions; WA Police; and WAPU. From the evidence gathered, the following observations are particularly relevant for WA Police:

- The Agency desperately required a system that tracked the number of traumatic events staff attended[82];
- Regional WA (RWA) desperately required the deployment of trauma support staff as this service tended to be metro-centric[83];
- Psychological testing for serving AND retired police officers was necessary (but this seems unachievable due to the cost and scale of such a program)[84];

[78] Community Development and Justice Standing Committee, *The Toll of Trauma on Western Australian Emergency Staff and Volunteers*, Legislative Assembly, Parliament of Western Australia, Perth, 2012, p. i.
[79] Ibid.
[80] Ibid.
[81] Ibid.
[82] Ibid, p. 12.
[83] Ibid, p. 16.
[84] Ibid, pp. 53-56.

- The role of the peer support officer (PSO) was invaluable[85];
- WA Police has a *lower* incidence of referrals to its employee assistance program (EAP) than the public sector as a whole (approximately four per cent as compared to approximately six per cent), despite the inherently dangerous and stressful work they undertake[86]. This was thought to arise from the fact that WA Police "use its own internal welfare staff to support officers after critical incidents"[87];
- Staff are concerned about the confidentiality of the information they provide when seeking help following a traumatic incident[88], if they are in fact willing to discuss it at all[89];
- Compensation received by officers appears skewed towards those who have suffered a physical (rather than a mental) injury[90];
- Information provided by WA Police to the Committee indicated approximately 64 per cent of medical retirements in the five years preceding July 2012 were due to stress-related illnesses[91];
- None of the State's agencies, including WA Police, kept track of their staff and their health outcomes once they had left the Agency, and separated police officers did not feel the exit interview was adequate[92];
- WA Police did not utilise retired staff as PSOs, despite the overwhelming support for it[93];
- EAP companies, like those used by WA Police, do not offer follow-up checks a year or two later for staff, support is only immediate[94]; and
- EAP staff, though "no doubt professional and competent", do not necessarily understand the policing context and environment, which leads to difficulties in engagement from affected officers[95].

The inquiry made 27 findings and 23 recommendations. Of the findings, WAPU believes that 21 are applicable to police, and 11 of these are particularly pertinent to Project Recompense (see Appendix 2A). Of the recommendations, 14 are applicable to police (see Appendix 2B).

[85] Ibid, p. 67.
[86] Ibid, pp. 73-75.
[87] Ibid, p. 114.
[88] Ibid, p. 97.
[89] Ibid, p. 99.
[90] Ibid, p. 98.
[91] Ibid, p. 100.
[92] Ibid, p. 103.
[93] Ibid, pp. 112-114.
[94] Ibid, p. 118.
[95] Ibid, p. 119.

To date, WAPU has not sighted a formal review or report prepared by WA Police, as requested by the Committee in Recommendation 1. A Government response to the Committee (albeit a brief response) was released in August. Other than this response, there have been no reports or formal, ongoing updates about the implementation of any of the recommendations, beyond a letter dated 22 May 2014 from the Executive Director of WA Police. The letter acknowledged the relevant recommendations and then stated that they either had been, or were in the process of being, implemented. The letter conceded that a review of WA Police's Health and Welfare Services had been undertaken by PricewaterhouseCoopers (PWC) and a report presented in September 2011. However, WAPU was not afforded a copy of the report (which was said to mirror the recommendations of the inquiry).

WAPU has only since received a seven-page summary of Health and Welfare Services' application of the inquiry's recommendations. Within it, Health and Welfare:

- Outline that the formal review (as requested by the Inquiry in Recommendation 1) is sufficed by the PWC report;
- Believes that the *Occupational Safety and Health Act 1984* is clear in outlining the responsibilities of the employer with respect to hazards in the workplace and as such, does not concede for the need to recognise that the Commissioner of Police should be made personally responsible for the psychological health of his staff (as per Recommendation 3);
- Is costing and evaluating the expense of a critical incident component to their systems (as per Recommendation 4);
- Has indicated it has increased its visits to RWA, sent letters to all employees' families outlining the EAP service and stated it has 21 PSOs in RWA (as per Recommendation 5);
- Has noted that capturing the costs surrounding employee preparation for critical incidents is too difficult (as per Recommendation 7);
- Believes that psychological first aid (PFA) is appropriate only for smaller, lower level critical incidents (as per Recommendation 10);
- Has worked closely with the Department of Fire and Emergency Services to information share (as per Recommendation 11);
- Agrees with the importance of the chaplaincy program but has no plans to increase the number of chaplains from the current two (as per Recommendation 12);
- Agrees with the importance of peer support programs but will not incentivise the program due to associated costs (as per Recommendation 14);

- Holds exercises on an annual basis to test its plans to manage emergencies and disasters (as per Recommendation 15);
- Believes that the department must become proactive and preventative in its service to employees and has implemented a new mental health training package at the Academy (as per Recommendation 19);
- Is not prepared to change the exit interview strategies because it is not receiving feedback indicating that police officers are leaving due to stress and trauma. On top of that, it asserts it is already the policy of WA Police to minimise separation rates and identify opportunities to improve the workplace by meeting with employees to ensure their separation decisions are fully informed (as per Recommendation 20);
- Believes there are merits to the proposed use of retired officers in the peer support program but had concerns about the costs (support, training, industrial entitlements) and risks (monitoring wellbeing, experience, knowledge) involved (as per Recommendation 22); and
- Had concerns about confidentiality with respect to auditing the EAP invoicing (as per Recommendation 23).

The WA Government Response

The only formal response to date is entitled "The Western Australian Government Response to Community Development and Justice Standing Committee Report No. 19: *The Toll of Trauma on Emergency Staff and Volunteers*" ("the response") and was released in August 2014. The response only iterated what was initially revealed to WAPU in the aforementioned Health and Welfare Services document.

The response, which was formatted in a table, appears in an abbreviated form in Appendix 2C. Generally:

- WA Police support those recommendations that require implementing something that the Agency already has in place (the recording of critical incidents, strategic reform, providing trauma services to regional locations including chaplaincy and EAP, and exit processes); and
- WA Police either 'supports in part' or does 'not support' certain recommendations without necessarily elaborating why and what aspects of the recommendation with which it either agrees or disagrees. No alternatives are proposed. For example:
    - The establishment of a formal platform of knowledge sharing amongst other Government first responder agencies is only partly supported on the basis that

"information sharing about issues of stress from disasters and critical incidents currently occurs on an informal basis". Is this recommendation 'supported in part' because WA Police disagrees about a formal platform of knowledge sharing? Or because WA Police is happy with the status quo? Or because WA Police doesn't think anything should occur beyond this informal, ad hoc communication?

- The implementation of psychological first aid is 'supported in part', with WA Police claiming that it provides "training to all recruits on how to manage a critical incident via academy training and mortuary based learning" and that psychological first aid is only appropriate for smaller scale incidents and not for disaster victim identification (DVI). There is no mention in the response of the benefits of psychological first aid and if it is worthwhile implementing at any level, or if it would be beneficial for other critical incidents beyond DVI, given the majority of police work does not entail DVI.

Psychological first aid

The Toll of Trauma Inquiry findings and recommendations relating to psychological first aid

The Toll of Trauma Inquiry made reference to the validity of psychological first aid (PFA) in reducing staff stress[96]. The inquiry noted that PFA, in the words of the World Health Organisation, is defined as "a process which involves humane, supportive and practical help to fellow human beings suffering serious crisis events", which "covers both social and psychological support"[97]. The inquiry indicated that the PFA approach "stresses that it is not professional counselling, nor something that only professionals do, nor is it psychological debriefing, but is made up of processes that:

- Provide practical care and support, which do not intrude;
- Assess needs and concerns;…
- Listen to people but not pressure them to talk;…
- Help people to connect to information, services and social supports; and
- Protect people from further harm"[98].

The Committee had canvassed a number of Australian policing jurisdictions and emergency service organisations that had adopted the PFA approach and found that the PFA approach not only prepared staff for confronting a traumatic incident but also encouraged those affected to access their own coping mechanisms and social supports, whether it was a mental health professional or their friends, family and colleagues[99]. Not only did the Committee find that "none of the main State first responder agencies base their processes for preparing their staff to deal with trauma on the PFA approach", but that WA Police indicated that it used a debriefing process for support at an officer's first fatal attendance, despite evidence this may not be effective and an earlier inquest into an on-duty police officer suicide had recommended to the contrary.

As such, the Committee found that:

> "All of the State's emergency responder agencies are currently not using the industry standard approach of psychological first aid in preparing their staff to deal with the trauma of critical

[96] *The Toll of Trauma on Western Australian Emergency Staff and Volunteers*, p. 33.
[97] Ibid.
[98] Ibid.
[99] Ibid, pp. 33-34.

incidents, but are still applying a debriefing approach that research has shown is either not useful or actually exacerbates the stress of some staff who participate in it"[100].

It was thus recommended that:

> "The Ministers for Emergency Services, Environment and Police provide additional funds in the 2013-14 Budget so that the State's emergency response agencies can implement a psychological first aid approach to preparing staff to deal with critical incidents and disasters, as is used in other Australian jurisdictions"[101].

What does the literature say about the PFA approach?

PFA is an approach that is used to help people who have not only endured a disaster (be it natural or man-made) but who have witnessed a traumatic event. PFA aims to build people's capacity to recover following a traumatic incident[102]. PFA is "designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping"[103]. The goals of PFA include efforts to: reduce distress; identify and assist with current needs; establish a human connection; facilitate people's social support; foster a belief in people's ability to cope; give hope; assist with early screening for people needing further or specialised help; get people through the first period of high intensity and uncertainty; and reduce the risk factors of mental illness as a result of the event (such as PTSD)[104].

The principles and actions of PFA are said to meet four basic standards, being: evidence informed; applicable and practical in field settings (as opposed to being located in a medical office); appropriate for developmental levels across the lifespan; and culturally informed and delivered in a flexible manner[105].

There are five basic elements of PFA:

1. To promote safety – for example, provide physical and emotional comfort;

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[100] Ibid, p. 42.
[101] Ibid.
[102] *Psychological First Aid: An Australian guide to supporting people affected by disaster*, Australian Psychological Society (in conjunction with Australian Red Cross), Carlton, Victoria, November 2013, p. 9. < http://www.psychology.org.au/assets/files/red-cross-psychological-first-aid-book.pdf >.
[103] *Psychological First Aid: Field Operations Guide*, p. 5.
[104] *Psychological First Aid: An Australian guide to supporting people affected by disaster*, p .9.
[105] Australian Institute of Professional Counsellors, "What is Psychological First Aid?", *AIPC Article Library*, 2014. < http://www.aipc.net.au/articles/what-is-psychological-first-aid/ >.

2. To promote calm – for example, provide an environment (as far as practical) removed from stressful situations, listen to people who wish to share their stories, be friendly and compassionate, and provide information on stress and coping;
3. To promote connectedness – for example, help establish contacts with support people, provide information and direct people to those services that are available, and offer practical help to people;
4. To promote self-efficacy – for example, engage people in meeting their own needs; and
5. To promote hope – for example, be willing to help, and reassure people that their feelings are normal[106].

PFA recognises that, despite varying factors that affect how a person responds to and copes with a trauma, some people may be more at risk of negative consequences:

- Those who have suffered previous traumas;
- Those who were exposed to events where the horror element was high; and
- Those who thought they were going to die[107].

PFA stresses that it is **not**:

- Debriefing;
- Obtaining details of traumatic experiences and losses;
- Labelling or diagnosing;
- Counselling;
- Something only professionals can do; and
- Something that everybody who has been affected by an emergency will need[108].

[106] Ibid, p. 11.
[107] Ibid, p. 7.
[108] Ibid.

The Watt Inquest

An inquest into the death of Sergeant Elliott Peter Watt (who, at the time of his death in December 2008, was a serving WA police officer) was undertaken in February 2012. The Watt Inquest outlined that Sergeant Watt had deteriorating mental health, characterised by:

- Irritable moods, generally quite snappy and grumpy;
- Pushing his wife away, threatening separation;
- Expressing unhappiness in areas of his work and life;
- Isolation;
- No motivation;
- Being short-tempered and moody; and
- Becoming completely absorbed in computer games[109].

It was noted that Sergeant Watt had experienced three specific traumatic incidents in his career, being: the attendance at a car accident that had involved young children; the attendance at a suicide by a farmer in which Sergeant Watt had to clean the utility involved before returning it to the family; and the prolonged, attempted resuscitation of a young footballer, who later died[110].

It appeared that as Sergeant Watt's job responsibilities increased, his stress levels increased and his mental health declined. Despite an informal mental health assessment by his senior management[111], none of Sergeant Watt's colleagues "had any real appreciation of his deteriorating mental health"[112].

The coroner made several very important comments regarding police officer health and safety as it was noted that "serving police officers can be vulnerable to serious mental health problems as a result of their work"[113]. The coroner noted that:

- Being transferred to certain locations can place pressures on police officers;
- Police officers "face regular exposure to stressful situations including violence inflicted on them and others, trauma and death scenes"[114];

[109] Coroner's Court of Western Australia, *Inquest into the death of Elliott Peter Watt*, Government of Western Australia, Perth, 2012.
[110] Ibid, p. 10.
[111] Ibid, p. 17.
[112] Ibid, p. 36.
[113] Ibid, p. 29.
[114] Ibid.

- "The health and welfare of serving police officers requires ongoing monitoring and support"[115];
- "It is the responsibility of the Health and Welfare Services of WA Police to educate and train personnel in the management of stress, and in particular, post-trauma stress"[116];
- "Officers involved in critical incidents may suffer problems months or even years after those incidents and so there is an ongoing need to monitor [police officer] health and wellbeing"[117]; and
- It is vital that "families of serving members are alert to the available services as it is often family members who are most aware of changes in a person suffering from mental health problems"[118].

The inquest outlined four recommendations:

1. WA Police must take action to better promote information in relation to available [mental health] services to families of serving Members[119];
2. Training for police officers entering management roles should include identification and management of officers suffering from stress or depression[120];
3. WA Police is to ensure that appropriate computer software is in place to enable the recording of all contacts to the Health and Welfare Services relating to individual officers where concerns have been expressed about the welfare of those officers[121]; and
4. WA Police must put in place a system which would ensure a wellness review be conducted (or at least offered) to every member, in order to identify significant changes in physical and mental health[122].

The coroner was adamant that there needed to be some mechanism within WA Police to *regularly* review the mental and physical health and wellbeing of every WA Police officer[123]. Significant changes such as "an increase or decrease of over 10kg in weight over a 12 month period, significant deterioration in fitness, unexplained mood changes or an officer becoming more isolated from his or

[115] Ibid.
[116] Ibid, p. 32.
[117] Ibid, p. 33.
[118] Ibid, p. 34.
[119] Ibid.
[120] Ibid, p. 35.
[121] Ibid, p. 36.
[122] Ibid, p. 38.
[123] Ibid, p. 37.

her colleagues" were flagged as being important to note within these welfare checks[124]. The coroner also acknowledged, to some extent, the stigma associated with admitting to suffering from stress or from mental health problems and the likelihood this declaration has on promotional opportunities.

The recommendations outlined in the Watt Inquest were also referred to within the Toll of Trauma Inquiry[125].

[124] Ibid, p. 38.
[125] *The Toll of Trauma on Western Australian Emergency Staff and Volunteers*, pages vi, 38 & 104.

Developing effective interventions and preventative measures

The role of resilience as a preventative measure

The Devilly and Varker study

It is only in recent times that researchers have examined the possibility of preventing adverse reactions to trauma by police, by assessing pre- and post-trauma "vulnerabilities" (or predispositions susceptibilities) and fostering resilience[126].

In a study funded by the National Drug Law Enforcement Research Fund, Devilly and Varker endeavoured to "develop and evaluate a resilience training program designed specifically to help new-recruit police officers mitigate stress reactions and the use of drugs and alcohol"[127]. Within their study, Devilly and Varker assert that "no evidence-based program exists that is designed to prepare police officers for the psychological reactions they may experience on encountering a traumatic situation"[128]. They note that the assistance that is generally provided to officers is post-trauma and is in "the form of psychological debriefing, counselling and peer support"[129]. The study aimed to evaluate the effectiveness of resilience training (by incorporating cognitive behavioural therapy exercises, psycho-educational training and skills training via group interaction) for the prevention of stress reactions[130].

In understanding the aetiology of PTSD, Devilly and Varker note a spectrum of person- and trauma-specific vulnerabilities. Personality, previous exposure to trauma, a personal history of psychiatric illness and gender are pre-trauma factors that affect the propensity for PTSD[131]. Post-trauma vulnerabilities include the extent of a person's social network or support, a person's level of optimism and anger, a person's ability to cope under stress, organisational stressors, burnout and maladaptive coping mechanisms (such as using drugs and alcohol to self-medicate)[132].

In their study, Devilly and Varker examine numerous definitions of resilience. They note resilience as being:

[126] G.J. Devilly & T. Varker.
[127] Ibid, p. xi.
[128] Ibid, p. 18.
[129] Ibid.
[130] Ibid, pp. 18-19.
[131] Ibid, p. 6.
[132] Ibid, pp. 7-14.

- "The capacity of a given system to implement early, effective adjustment processes to alleviate strain imposed by exposure to stress, thus efficiently restoring… balance or adaptive functioning"[133];
- "The absence of PTSD symptoms following exposure to a potentially traumatic event"[134]; and
- "Good levels of mental and physical health"[135].

Analysis of a group of police recruits across 12 months indicated the following:

- "Resilience training was not found to have any statistically significant beneficial effects" when reacting to trauma[136];
- The results indicated that "recruits who were provided with the resilience training may have learnt important skills and strategies that helped them to deal with workplace stress"[137]; and
- Officers with "higher substance involvement [being alcohol and drug use] scores [were] more likely to have higher trauma symptomology", which adds to the body of evidence that suggests that drugs and alcohol are used to self-medicate trauma symptoms[138].

<u>The Balmer, Pooley and Cohen study</u>

A study undertaken in 2014 by Balmer et al. of WA police officers examined the "relationships between resilience, coping style, psychological functioning and the demographic values of age, rank and length of service" in a sample of WA police officers[139]. Balmer et al. defined psychological resilience as being "the ability to successfully cope and adapt when faced with adversity or stressful life events"[140]. They conceived resilience as being a "complex, multidimensional construct in which there is no single specific characteristic or trait that makes an individual resilient"; rather, there are multiple pathways to resilience that differ for everyone based on their circumstances[141]. However, they noted that researching a police officer's resilience is markedly different from the resilience of the general population because "police officers experience repeated exposure to stressful and potentially traumatic events whilst on duty"[142].

[133] Ibid, p. 14.
[134] Ibid, p. 15.
[135] Ibid, p. 16.
[136] Ibid, p. 64.
[137] Ibid, p. 68.
[138] Ibid, p. 70.
[139] p. 270.
[140] p. 271.
[141] Ibid.
[142] Ibid.

Balmer et al. asserted that the "defining attributes of resilience can be classified into dispositional attributes, family support and cohesion and external support systems" and hypothesised that coping style has an impact on resilience level[143]. They purported that problem-solving (or approach-based) coping attempts to modify or eliminate stressors through direct action, whilst emotion-focused (or avoidance-based) coping attempts to alleviate the emotional reactions to stressors through cognitive efforts to change the meaning of the situation[144].

The study uncovered the following:

- Police culture and training may reinforce the use of problem-solving coping at the expense of emotion-focused coping. This denies the officer the skills to effectively manage their emotional reactions to the stressors of police work. Thus in order to enhance police resilience, it is necessary to not only improve officers' use of effective emotional coping strategies but also promote change within the police culture to support the effective expression of emotions[145];
- Resilience was found to be negatively affected by increased rank, age and length of service. The decline in officers' resilience with increased length of service was believed to result from a cumulative exposure to stressful and traumatic incidents over the course of their career, which may overwhelm and burden an officer's coping skills[146]; and
- As officers age, it is further believed their resilience is reduced because they are exposed to increased organisational stressors stemming from the responsibilities and demands associated with senior rank. The resilience of senior ranked officers was also seen to be undermined by a lack of suitable social support networks within the workplace, networks of which are found to moderate the negative effects of occupational stressors[147].

<u>What does this mean for police officer resilience?</u>

What do these studies mean for the ability of police officers to cope with trauma and develop resilience? In summary:

- Resilience is multi-dimensional, comprises many physiological and psychological facets and differs between people;

[143] pp. 271-272.
[144] Ibid.
[145] Ibid, p. 278.
[146] Ibid.
[147] Ibid, pp. 278-279.

- Police officer resilience will differ to that of the general population due to a greater propensity for exposure to trauma and stressful events;
- Assistance with respect to a critical incident is generally provided post-trauma and little is devoted pre-trauma to developing coping mechanisms and resilience;
- Coping mechanisms, both internal (such as a person's disposition) and external (factors such as support networks), are important for managing the effects of stress and trauma;
    - Here, the role of the police culture is vital;
- Maladaptive coping mechanisms that involve alcohol or drug use do not alleviate trauma symptoms;
- Police officers are more likely to take direct action to reduce stress rather than change their emotions and perceptions;
- Age, rank and length of service impact coping and resilience but largely because these attributes mean a greater length of time has been spent exposed to stressors; and
- Whilst coping mechanisms are undeniably essential to a person's experience of trauma, resilience training may or may not be beneficial and requires further exploration.

Developing effective interventions

Despite the relevance of (amongst many factors):

- A person's disposition;
- Support network; and
- Coping mechanisms and level of resilience;

in gauging person specific reactions to critical incidents, the volatile nature of police work means that it is inevitable that police officers are going to be exposed to traumatic events.

As such, it is imperative that effective interventions are administered during an officer's career to mitigate the likelihood of developing psychological illnesses, such as PTSD. First responder (or emergency service) agencies should have the following interventions in place both before, during and after an emergency to facilitate the most supportive outcomes:

- Appropriate, realistic training
    - Including training for emergencies and stress inoculation;
- Provision of support services
    - Support needs to be considered for the long term, with emphasis on the necessity to monitor situations over a longer period of time; and
- Review of the responses to emergencies

- A review should be impartial and all exercises should allow for staff feedback and criticisms[148].

[148] This information was proffered to WAPU by the New Zealand Police Association by way of a paper that accompanies the New Zealand Police Trauma Policy. The paper, presented to the Airport Operator's Council International Airport Security Workshop is entitled "Human responses to traumatic incidents: factors in dealing with terrorism and other disasters" by Dr Ian Miller, Coordinator: Psychological Services, New Zealand Police, Wellington, November 1988.

Police officer working conditions with respect to Workers' Compensation and Occupational Safety and Health

Workers' Compensation in Western Australia

West Australian employees are covered by the *Workers' Compensation and Injury Management Act 1981* (referred to as "Workers' Compensation" or the "Workers' Compensation Act"). The Act is established to deal with: compensation payable to or in respect of workers who suffer an injury; the management of workers' injuries in a manner directed at enabling injured workers to return to work; and specialised retraining programs for injured workers[149].

Briefly, Workers' Compensation in WA provides for:

- reasonable medical and allied health treatment expenses;
- compensation for loss of wages;
- reasonable workplace rehabilitation expenses; and
- travel and other expenses;

should an employee suffer a work-related illness or injury[150].

A disease is described as being any physical or mental ailment, disorder, defect, or morbid condition whether of sudden or gradual development[151]. An injury is described as meaning:

- A personal injury by accident arising out of or in the course of the employment, or whilst the worker is acting under the employer's instructions; or
- A disease because of which an injury occurs under section 32 or 33; or
- A disease contracted by a worker in the course of his employment at or away from his place of employment and to which the employment was a contributing factor and contributed to a significant degree; or
- The recurrence, aggravation, or acceleration of any pre-existing disease where the employment was a contributing factor to that recurrence, aggravation, or acceleration and contributed to a significant degree; or

[149] *Workers' Compensation and Injury Management Act 1981*, State Law Publisher, Government of Western Australia, p. 2. < http://www.slp.wa.gov.au/pco/prod/FileStore.nsf/Documents/MRDocument:25362P/$FILE/Workers%20Compensation%20And%20Injury%20Management%20Act%201981%20-%20[10-h0-00].pdf?OpenElement >.
[150] WorkCoverWA, *Receiving compensation*, Government of Western Australia, 2010. < http://www.workcover.wa.gov.au/Workers/Receiving+compensation/Default.htm >.
[151] *Workers' Compensation and Injury Management Act 1981*, p. 8.

- A loss of function that occurs in the circumstances mentioned in section 49, but does not include a disease caused by stress if the stress wholly or predominantly arises from a matter mentioned in subsection (4) unless the matter is mentioned in paragraph (a) or (b) of that subsection and is unreasonable and harsh on the part of the employer[152].

Compensation is not payable for diseases caused by stress if the stress wholly or predominantly arises from a worker's dismissal, retrenchment, demotion, discipline, transfer or redeployment unless it is considered to be harsh on the part of the employer[153]. Should a psychological condition arise as a secondary, or less direct, consequence of an injury, they are not included for the purposes of assessing impairment, specialised re-training or payment of additional medical expenses[154].

Compensation under the Act means:

- If you are injured at work, you may claim for a range of reasonable medical expenses, including:
    - first aid and ambulance;
    - medicines;
    - medical or surgical attendance;
    - treatment by specialists;
    - dental;
    - physiotherapy;
    - chiropractic;
    - charges for hospital treatment; and
    - other approved treatment, including osteopathy, clinical psychology, occupational therapy, speech pathology, and exercise physiology[155].

  You may have to pay a gap as the total payment for medical expenses is finite, yet if a worker meets exceptional medical circumstances criteria, an extension may be granted[156];
- You will be compensated for loss of earnings by receiving weekly payment entitlements on the normal pay day and in the normal pay manner from your employer[157];

[152] Ibid, pp. 9-10.
[153] As per section 5(4) of the Workers' Compensation Act. Safe Work Australia, *Comparison of workers' compensation arrangements in Australia and New Zealand*, Commonwealth of Australia, 2012, p. 86.
[154] As per section 146 of the Workers' Compensation Act. Ibid.
[155] WorkCoverWA, *Medical expenses*, Government of Western Australia, 2010. < http://www.workcover.wa.gov.au/Workers/Receiving+compensation/Medical+expenses.htm >.
[156] Ibid.
[157] WorkCoverWA, *Loss of wages*, Government of Western Australia, 2010. < http://www.workcover.wa.gov.au/Workers/Receiving+compensation/Loss+of+wages.htm >.

- You will receive workplace rehabilitation expenses and services to assist with your rehabilitation and return to work. Approved workplace rehabilitation providers offer expertise in a broad range of return to work activities including:
    - identifying appropriate duties;
    - developing graduated return to work programs; and
    - monitoring your progress at work in consultation with yourself, your employer, their insurer and your doctor[158].
- If your work-related illness or injury necessitates travel from your home to a medical appointment or rehabilitation provider, you can claim the cost of reasonable travel expenses. Travel expenses incurred by a worker in obtaining an assessment by an Approved Medical Specialist can also be claimed. For workers in regional areas, reasonable costs may also include reasonable meals and accommodation expenses[159].

The compensation entitlements are outlined in Schedule 1 of the Act[160].

Workers' Compensation also conceives for "compensable personal injuries by accident"[161]. If a worker experiences a "loss of" use of a part or faculty of the body, that employee can be compensated a "percentage [including 100 per cent] of the appropriate amount payable as is equal to the percentage of the diminution of the full efficient use"[162]. The Schedule in which the nature of injury or impairment and correlating sum payable is outlined at Appendix 3A.

Schedule 3 of the Workers' Compensation Act outlines the compensable "specified industrial diseases" that are recognised by the Act as being caused by the nature of employment[163]. Most notably, the Schedule lists "communicable diseases" as a specified industrial disease, arrived at by:

> "(e)mployment in an occupation or in a situation exposing the worker to infection by the intermediate hosts of any communicable disease or by agencies transmitting any communicable disease"[164].

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[158] WorkCoverWA, *Rehabilitation expenses*, Government of Western Australia, 2010. < http://www.workcover.wa.gov.au/Workers/Receiving+compensation/Rehabilitation+Expenses.htm >.
[159] WorkCoverWA, *Travel and other expenses*, Government of Western Australia, 2010. < http://www.workcover.wa.gov.au/Workers/Receiving+compensation/Travel+and+other+expenses.htm >.
[160] Schedule 1 of the *Workers' Compensation and Injury Management Act 1981* notes compensation entitlements for death, varying incapacities, medical and other expenses, impairment and travelling expenses. Ibid, pp. 355-379.
[161] Ibid, p. 35.
[162] Ibid, pp. 39-40.
[163] Ibid, pp. 386-389.
[164] Ibid, p. 386.

In 2011, the Workers' Compensation Act was amended to remove all age based limits on Workers' Compensation entitlements[165]. As a result, injured workers aged 65 years or older are able to access weekly income payments on the same terms as all other injured workers[166].

Workers' Compensation and WA police officers

One distinct way in which police officers differ in their working conditions from employees in Western Australia is their treatment within Workers' Compensation legislation.

Unlike other State and Federal police forces, a WA police officer is only covered by Workers' Compensation if he or she "suffers an injury and dies as a result of the injury"[167]. Whilst a police officer is serving, they have, ostensibly in lieu of Workers' Compensation, provisions that compensate for work and non-work related medical expenses and leave (as outlined in their Industrial Agreement at clauses 33, 35 and 36 [see Appendix 3B][168]) that can be extended at the Commissioner's discretion[169]. The difference in access to Workers' Compensation between police officers and all other government employees is outlined in more depth at Appendix 3C.

Police officer entitlements in comparison to public servants

Two arguments are worth noting when comparing a police officer's and public sector worker's Workers' Compensation entitlements. Firstly, *Police Force Regulations 1979* stipulate at Regulation 1308 that a police officer is excluded from any entitlement to sick leave and/or payment of medical expenses where illness or injury is attributable to the officer's own fault or misconduct[170]. For other government employees, Workers' Compensation payments may be disallowed in the event of a worker's wilful misconduct[171], but compensation is payable regardless of the fault of the worker[172].

Secondly, several Regulations require that an officer must submit evidence of medical fitness before returning to work, undergo medical examinations if required by the Commissioner of Police and attest

[165] Safe Work Australia, pp. 9-10.
[166] Ibid, p. 28.
[167] Section 5 of the *Workers' Compensation and Injury Management Act 1981* notes that the term "worker" does not mean a police officer or Aboriginal police liaison officer appointed under the *Police Act 1892* save for when the police officer or Aboriginal police liaison officer dies as a result of their injury. Ibid, p. 16.
[168] *Western Australia Police Industrial Agreement 2011*, Western Australian Industrial Relations Commission, 2011, pp. 72-76. < http://www.wairc.wa.gov.au/Pages/AwardsAgreements/Agreements.aspx?agreements=w >.
[169] R. Guthrie.
[170] Ibid, p. 23.
[171] As per section 22 of the *Workers' Compensation and Injury Management Act 1981*, p. 32.
[172] R. Guthrie, p. 23.

to one's fitness for duty to a medical board should the Commissioner have doubts about that officer's state of health (see Regulations 1311, 1312 and 1402 respectively)[173]. These Regulations "arguably do not provide any incentive for the Commissioner or [WA Police] to engage in injury management procedures"[174]. Workers' Compensation, at Section 84AA, provides for rehabilitation and injury management by outlining the onus of the employer to keep the injured employee's position available[175]. Concurrently, sections 155 – 157B clearly summarise injury management practice and procedures, which foster rehabilitation by noting:

- A code of practice for injury management;
- Employer's duties towards managing a workplace injury;
- The establishment of a return to work program;
- The possibility of vocational rehabilitation; and
- WorkCover's provision of information about injury management[176].

Ironically, the *Police Assistance Compensation Act 1964* (WA) provides for payment of compensation to persons who are injured whilst assisting police in the execution of their duty and these entitlements are equivalent to that which is provided to a worker under Workers' Compensation[177]. This means that police officers who are injured in the execution of their duty are not covered under the *Workers Compensation and Injury Management Act 1981*, yet civilians who assist them are entitled to equivalent Workers' Compensation coverage[178].

Police Officers and the *Occupational Safety and Health Act*

The omission of police officers from Workers' Compensation cannot be discussed without acknowledging the exclusionary nature of WA's Occupational Safety and Health legislation. Police officers are covered by the *Occupational Safety and Health Act 1984*[179], however, unlike other emergency service workers in WA (such as ambulance officers and firefighters) who perform similar dangerous duties and who can exercise their right to refuse dangerous work, police officers are not

[173] Ibid, p. 24.
[174] Ibid.
[175] *Workers' Compensation and Injury Management Act 1981*, p. 105.
[176] Ibid, pp. 202-208.
[177] See section 5 of the *Police Assistance Compensation Act 1964,* namely parts (1) and (2)(b). R. Guthrie, p. 30.
[178] Ibid.
[179] Section 3 of the *Occupational Safety and Health Act 1984* notes that a police officer is treated as an employee (of the Crown) for the purposes of the Act. *Occupational Safety and Health Act 1984*, State Law Publisher, Government of Western Australia, p. 6. < http://www.slp.wa.gov.au/pco/prod/FileStore.nsf/Documents/MRDocument:25167P/$FILE/Occupational%20Safety%20And%20Health%20Act%201984%20-%20[07-f0-00].pdf?OpenElement >.

able to utilise Section 26 of the *Occupational Safety and Health Act 1984* (the "OSH Act") in covert or dangerous operations[180]. Section 4A of the OSH Act expressly states that:

> "(2) A police officer cannot refuse to work as mentioned in Section 26(1)[181] if the refusal to work would adversely affect, or could reasonably be expected to affect adversely, a covert operation or dangerous operation"[182].

Life-threatening tasks are inherent in the duties of emergency workers and service men and women accept that dangerous duties are part and parcel of their work. However, there are different expectations placed on police officers than any other group of emergency worker. For example, if a firefighter reasonably and fairly appraises a dangerous operation as presenting an imminent threat to their safety, that firefighter is protected by Section 26 of the OSH Act and can refuse to enter into the dangerous situation. A police officer is prevented from exercising this entitlement due to the provisions stipulated in Section 4A of the OSH Act. As a consequence, police officers not only risk exposure to situations that are inherently dangerous and life-threatening, but face disturbing and traumatic situations from which most people would withdraw.

In fact, if a police officer does refuse to work as he or she has appraised the dangerous operation as presenting an imminent danger to their health and safety, then that officer jeopardises their employment by refusing to obey a lawful order or direction (whether or not it is unreasonable is not always a consideration).

[180] A dangerous operation is broadly and non-specifically identified within the OSH Act as performing the functions of a police officer in a situation that is reasonably necessary and is not possible without exposing the officer to imminent danger or serious injury or harm. Ibid, p. 11.
[181] An employee can refuse to work "where he or she has reasonable grounds to believe that to continue to work would expose him or her or any other person to a risk of imminent and serious injury or imminent and serious harm to his or her health". Ibid, p. 51.
[182] Ibid, p. 12.

Presumptive legislation for professional firefighters

During a fire, it has been proven that carcinogens are released upon combustion of materials and accumulated exposure to these carcinogens cause cancer[183]. Both studies and meta-analyses show that "firefighters are at increased risk of certain types of cancer through accumulated exposure to carcinogens"[184].

On 7 December 2011, the *Safety, Rehabilitation and Compensation Amendment (Fair Protection for Firefighters) Act 2011* was passed through Federal Parliament and amended the *Safety, Rehabilitation and Compensation Act 1988*[185]. The amendment provides that:

> "If a firefighter contracts a prescribed disease after having been employed as a firefighter for the requisite qualifying period, the disease is presumed to be a result of their employment as a firefighter. The firefighter in question is then entitled to receive compensation for the disease[186]".

The *Safety, Rehabilitation and Compensation Amendment (Fair Protection for Firefighters) Act 2011* simplifies:

> "Workers' Compensation claims by firefighters who have contracted a range of prescribed cancers, and who have been employed for a certain period, by establishing a rebuttable presumption that the cancers are work-related. Under this presumption, if a firefighter is diagnosed with one of the twelve cancers listed…, and has served as a firefighter for the relevant qualifying period, it will be presumed that the cancer is an occupational disease and is therefore compensable"[187].

To be compensated under the Federal Act, the firefighter must have been involved in firefighting duties for a substantial portion of his or her duties[188]. The relevant sections of the *Safety, Rehabilitation and Compensation Amendment (Fair Protection for Firefighters) Act 2011* can be seen

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[183] *Presumptive Legislation for volunteer and former firefighters – consultative paper*, SES Volunteers Association of WA, 2013, p. 2. < http://www.ses-wa.asn.au/sites/default/files/Presumptive%20Legislation%20-%20Consultative%20Paper.pdf >.
[184] Ibid.
[185] Ibid.
[186] Ibid.
[187] *Safety, Rehabilitation and Compensation Amendment (Fair Protection for Firefighters) Bill 2011*, Revised explanatory memorandum, Parliament of Australia, Commonwealth of Australia, p. 1. < http://parlinfo.aph.gov.au/parlInfo/download/legislation/ems/r4605_ems_e18b84ac-4fdc-4ec3-af85-7d71f0a6851a/upload_pdf/362281rem.pdf;fileType=application%2Fpdf#search=%22legislation/ems/r4605_ems_e18b84ac-4fdc-4ec3-af85-7d71f0a6851a%22 >.
[188] Ibid, p. 4.

at Appendix 4A. This legislation reverses the onus of proof in favour of firefighters by providing that certain, specified cancers are work-related, unless the employer can prove to the contrary[189].

In May 2013, a consultative paper was released by the Government of Western Australia and the Department of Fire & Emergency Services (DFES) about transposing the Federal legislation regarding firefighters who contract cancer to State legislation.

The paper outlines:

- The gist of the Federal legislation;
- The diseases covered and the stipulation that the cancers will only be covered if they are primary site cancers;
- On what basis a firefighter was employed or volunteers to be eligible under the Act;
- The definition of a firefighter, both employed and volunteer;
- The qualifying periods of service, which are based on the latency periods for the cancers;
- What constitutes being "exposed to the hazards of a fire scene";
- The intention of the Bill to only cover individuals who suffer a disease after the amendments to the State Act;
- The compensation entitlements if an individual's claim is accepted, being:
    - Reasonable medical and health treatment expenses;
    - Compensation for loss of wages;
    - Reasonable workplace rehabilitation expenses;
    - Travel and other expenses;
    - Death benefits; and
- The management of claims, including the requirement to attend medical examinations.

On 12 November 2013, the presumptive legislation was passed as the *Workers' Compensation and Injury Management Amendment Act 2013 (No. 21 of 2013)*, in recognition of those firefighters who "perform a dangerous and lifesaving role for the community"[190]. The amendments appear in the *Workers' Compensation and Injury Management Act 1981* at Division 4A (of Part III: Compensation) and Schedule 4A (see Appendix 4B).

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[189] *Workers' Compensation and Injury Management Amendment Bill 2013*, Second reading speech, Legislative Council, Parliament of Western Australia, 2013. < http://www.parliament.wa.gov.au/Parliament/Bills.nsf/51F2C6F0CD3AE20A48257BC000373F98/$File/Bill25-1SR.pdf >.

[190] Ibid, p. 4.

Exploring the viability of presumptive legislation for police officers

Police officers face a range of hazardous and life-threatening situations on a daily basis. These dangerous, covert or life-threatening duties can expose police officers to a range of illnesses or injuries that they may experience at a greater rate than that of the general public. Dismantling clandestine drug labs, attendance of Arson Squad officers at fire sites when toxicity is most acute, exposure to bodily fluids through frequent interactions with drug-affected individuals, witnessing the aftermath of murders, suicides, sudden infant deaths, fatal traffic accidents, sudden deaths which are precursors for PTSD: these are some of the highly dangerous and potentially lethal situations that police officers face on a daily basis.

WAPU understands that, just like the presumptive legislation for professional firefighters, further research is required to demonstrate the incidence of certain ailments in police officers. However, current literature and patterns that are prevalent in separated Members prove that police officers are at a higher rate of suffering particular illnesses, especially psychological disorders such as PTSD, as a result of their work.

WA Police – an overview

WA Police Health and Welfare Services structure

Currently, the Health and Welfare Services at WA Police employs approximately 33 staff. Overseen by an Assistant Director, the Branch is made up of a psychology unit (that employs police psychologists), a corporate health unit (that incorporates the Agency's "fit-for-life" program), a vocational rehabilitation unit (that employs vocational rehabilitation consultants), a welfare unit (with welfare officers and police chaplains who report to a welfare manager) and a claims management unit.

Within the WA Police intranet, the following is (briefly) noted for each of the units:

- Psychology Unit: responsible for the psychological wellbeing of all WA Police employees, offering specialised counselling and psychological support, early interventions, critical incident response, fitness for duty evaluations, welfare checks, advisory support to Officers in Charge (OICs), managers and supervisors;
- Vocational Rehabilitation: primary role is to assist with work and non-work related injuries when they impact on the employee's work capacity, offering referrals to independent medical specialists, identification of barriers to returning to work, coordination of return to work programs;
- Welfare Unit: provides assistance, advice and support to employees within WA Police and their immediate families on welfare related matters, including response to critical incidents, support with respect to the EAP, medical retirements, monitoring long term sick leave, facilitating regular contact with ill employees, administration of the peer support program, liaise with other health groups and professionals to ensure officers receive appropriate assistance;
- Peer Support Program: provides an accessible group of trained employees who are willing to provide support and assistance to other employees during times of personal and/or work-related stress; and
- WA Police Chaplaincy Support: a pastoral service available 24/7 to assist and advise on any spiritual related matter[191].

[191] This information was gathered from the WA Police intranet, from the Health and Welfare Services home page.

WA Police EAP and PSO

WA Police fund an external, confidential counselling service for employees and their immediate families, free of charge and available 24/7[192]. The Employee Assistance Program (EAP) promises no feedback on individuals to WA Police, unless the counsellor/psychologist believes there is a serious risk for the client (or someone else)[193]. WA Police employees and their family members are each eligible for six sessions per financial year[194]. The EAP also offers internet-based resources and self-help tools[195]. PPC Worldwide, the international EAP provider used by WA Police, claims that 80 per cent of all cases are resolved within six sessions.

WA Police also run a Peer Support Program, coordinated by a Sergeant, for its employees all over the State. According to WA Police, peer support works on the premise that employees may feel more comfortable seeking out support or advice from a local, familiar and friendly face rather than seeking out a person not known to them[196]. A Peer Support Officer (PSO) is available to provide support only. PSOs only receive basic training about determining a person's needs, recognising problems and referring colleagues to other professional services as required. PSOs are provided with training from a clinical psychologist within Health and Welfare to enable them to identify and assist members who are indicating signs of stress, frustration, depression or general concerns for themselves or their families[197].

At the time of writing, there are 89 PSOs at WA Police, 23 of which are police staff and 20 of which are located in regional WA[198].

The WA Police medical retirement process

The WA Police medical retirement process is an extensive and convoluted process. Medical retirement can be simplified insofar as noting what legislation guides police medical retirement, but the process itself is complex and protracted. Medical retirement is generally perceived as unsatisfactory to both

[192] This information is lifted from a pamphlet distributed by WA Police to its employees entitled *WA Police Employee Assistance Program (EAP)*.
[193] Ibid.
[194] Ibid.
[195] Ibid.
[196] This information has come from the WA Police Intranet.
[197] This information has come from a WA Police internal newsletter entitled *From the Line*, Issue 451, 26 March 2014, p. 4.
[198] This information has come from the WA Police Intranet within the Health and Welfare section.

parties for a number of reasons, including the stigma attached to the loss of confidence proceedings[199].

A decision to proceed with medical retirement is initiated if the WA Police occupational health physician or consultant psychiatrist deems a police officer or Aboriginal police liaison officer to be unable to perform their duties. This usually follows an extended period of sick leave. The *Police Act 1892* (the "Police Act") at section 8 outlines the powers to remove both commissioned and non-commissioned officers on the grounds of a "disability"[200] (see Appendix 5A). Within Part IIB (entitled "Removal of Members"), Division 2 of the Police Act, specifically, Section 33L, the Commissioner of Police (the "Commissioner") must confer a notice of loss of confidence upon the member who is to be removed[201] (see Appendix 5B). Within this section, there is no reference to the removal of a member due to medical retirement: instead, the Commissioner is entitled to remove a member if he or she does not have confidence in the member's suitability to continue as a police officer, "having regard to… integrity, honesty, competence, performance or conduct"[202].

Part IIB also outlines terms, maintenance payment upon removal, the Commissioner's right to revoke the removal action, the right for a member to resign before removal and the right for a Member to appeal the removal action.

The *Police Force Regulations 1979* (the "Regulations") refer to a medically unfit members' examination by a medical board in instances where the Commissioner is of the opinion that a police officer or Aboriginal police liaison officer is not fit for further duty[203].

The medical retirement process, which is illustrated in depth at Appendix 5C and 5D, ensues in the following general fashion:

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[199] As per a confidential report to WA Police by worker injury risk management consultancy agency, Aurenda. Aurenda Report, *Western Australia Police Service: Workplace injury, sick leave and medical entitlements*, May 2005, p. 6.

[200] State Law Publisher, *Police Act 1892*, version 14 as at 2 May 2011, Government of Western Australia, Department of Premier and Cabinet, Perth, 2011, p. 4. < http://www.slp.wa.gov.au/pco/prod/FileStore.nsf/Documents/MRDocument:21204P/$FILE/POLICE%20ACT%201892%20-%20[14-d0-03].pdf?OpenElement >.

[201] Ibid, p. 22.

[202] Ibid.

[203] State Law Publisher, *Police Force Regulations 1979*, Reprint 5: The regulations as at 17 September 2010, Government of Western Australia, Department of Premier and Cabinet, Perth, 2010, p. 64. < http://www.slp.wa.gov.au/pco/prod/FileStore.nsf/Documents/MRDocument:22718P/$FILE/PoliceForceRegs1979_05-00-00.pdf?OpenElement >.

Decision is made to proceed with the medical retirement of an employee

↓

Employee (and their manager and District Office) notified and provided with information

↓

Information requested from employee's treating medical practitioners (upon signing of 'Authority to Release" forms)

↓

Recommendation made by the WA Police occupational health physician or consultant psychiatrist (to either medically retire or continue on a return to work program)

↓

Request made to the WA Health Department to convene a medical board

↓

Decision made by Health Department to convene a medical board

↓

Medical board meet

↓

Application is made to the Government Employees Superannuation Board (GESB)

↓

Determination of medical board (sent to Health and Welfare Services for actioning)

↓

GESB advised of outcome[204]

↓

Recommendation made to the Commissioner to medically retire the employee (with a section 33L notice served)

↓

Employees invited to respond (21 day period)

↓

Minister's approval requested (and maintenance payment endorsed)

↓

Employee informed of Minister's approval[205]

↓

Retirement process completed (and a Certificate of Service and letter from the Commissioner delivered).

[204] The GESB process of determining incapacity and entitlement to disability benefits is independent of WA Police and Health and Welfare.

[205] It is at this stage that a Commissioned Officer is to attend the employee's home to inform them of the decision to medically retire. Accompanying the Commissioned Officer is a letter from Human Resources outlining the medical retirement proceedings, which that officer must present and explain to the affected employee.

Police (Medical and Other Expenses for Former Officers) Act 2008

In August 2006, a Bill was introduced into the Legislative Assembly of Parliament by Member Murray John Cowper, a former police officer. The Bill, entitled *Police (Compensation for Injured Officers) Amendment Bill 2006* was to address the anomaly of no "statutory provision for the support, compensation and rehabilitation of members and former members of WA Police… who retire, resign or otherwise leave the Police… with residual illness or injuries which arise through the performance of a police duty or function" by "amending the Police Act to provide compensation and ongoing medical benefits" for eligible police officers[206]. The two vital aspects of the proposed amendment were:

- The "insertion of new Section 135B, which provides for the Commissioner of Police to pay reasonable medical and hospital expenses incurred by a member or former member as a result of injury suffered on duty"; and
- The "insertion of new Section 135C, which provides for the Commissioner of Police to pay a lump sum compensation calculated in accordance with a prescribed formula, to a former member who left [WA Police] as a consequence of injury suffered on duty"[207].

The section of the draft Bill that proposes compensation for the suffering arising from a work-related illness or injury is noted at Appendix 5E.

Ultimately, the Bill was not supported in its entirety. Government conceded to a Bill that proposed the payment of the reasonable medical and hospital expenses incurred by a member as a result of a work-related injury, which eventuated in the *Police (Medical and Other Expenses for Former Officers) Act 2008* (the "Police Medical Act"). The Police Medical Act:

- Provides for the payment of medical and other expenses incurred by former police officers and former Aboriginal police liaison officer in respect of employment related injuries;
- Provides for the resolution of disputes in connection with claims for payment of amounts, or liability to pay amounts; and
- Provides for the management of claims for payment of amounts outlined by the Act[208].

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[206] Explanatory memorandum, *Police (Compensation for Injured Officers) Amendment Bill 2006*, Parliament of Western Australia, Perth, 2014. < http://www.parliament.wa.gov.au/Parliament/Bills.nsf/07E557F63F0ECE03482571D30009A95F/$File/EM-Bill159.pdf >.

[207] Ibid.

[208] State Law Publisher, *Police (Medical and Other Expenses for Former Officers) Act 2008*, as at 1 July 2009, Government of Western Australia, Department of Premier and Cabinet, Perth, 2014, p. 1. < http://www.slp.wa.gov.au/pco/prod/FileStore.nsf/Documents/MRDocument:26064P/$FILE/Police%20(Medical%20and%20Other%20Expenses%20for%20Former%20Officers)%20Act%202008%20-%20[00-c0-00].pdf?OpenElement >.

The "Western Australia Police (Medical and Other Expenses for Former Officers) Scheme" (colloquially referred to as "Post Service Medical" or the "Former Officers' Medical Benefits Scheme") enables former police officers to access payment for medical and other expenses incurred on or after 1 July 2007[209]. The expenses must relate to a work-related injury or disease sustained during their employment by WA Police[210]. The Former Officers' Medical Benefits Scheme is managed by the Insurance Commission of Western Australia (ICWA). All reimbursements are in line with Workers' Compensation entitlements and a member is not entitled to claim benefits if they have previously received compensation for the same illness or injury[211]. The Former Officers' Medical Benefits Scheme only compensates officers for expenses incurred *after* 1 July 2007, regardless of when their work-related illness or injury occurred[212]. Medical specialists, ambulance, pharmaceutical and psychological expenses are examples of the expenses that can be claimed through the Scheme[213].

The Aurenda Report

In May 2005, a report written by worker injury risk management consultancy agency, Aurenda, entitled "Western Australia Police Service: workplace injury, sick leave and medical entitlements" was released to WA Police. The confidential report focussed on sick leave in the workplace and officers' sick leave entitlements. From a review of information gleaned during 2004, the following was reported:

- There were inconsistencies in the management of sick leave across a number of parameters;
- Sick leave was utilised to avoid apparent HR/IR issues;
- There were insufficient post-service entitlements for severe work-related injuries;
- The medical retirement process was unsatisfactory; and
- Confusion surrounded the roles and responsibilities of all parties involved in the management of sick leave, between both Health and Welfare Services and managers/supervisors[214].

[209] This information is lifted from a pamphlet distributed by WA Police to its (current and former) employees entitled *Western Australia Police (Medical and Other Expenses for Former Officers) Scheme*.
[210] Ibid.
[211] Ibid.
[212] Ibid.
[213] Ibid.
[214] Aurenda Report, *Western Australia Police Service: Workplace injury, sick leave and medical entitlements*.

Workforce Optimisation Project

In 2012, WA Police undertook an internal review with the aim to develop an Agency position "on how to best cater for non-operational officers"[215]. The review, entitled the "Deployment Optimisation Project", was initiated out of "concerns regarding the non-operational workforce"[216]. The objectives of the review included (but were not limited to):

- Quantifying the impact of non-operational officers on the service delivery of the Agency;
- Identifying the full extent of the non-operational workforce;
- Considering career and pathway options for officers designated as non-operational;
- Considering the impact of officers transferring between non-frontline roles and avoiding frontline service;
- Deciding whether there needed to be a differentiation between work-related and non-work-related non-operational status;
- Deciding whether there needed to be a differentiation between physical, psychological and terminal illness in relation to non-operational status; and
- Considering the impact of the proposed legislative amendments in relation to medical retirement[217].

Several recommendations arose from the project, including:

- Building a model that supported proactive and effective case management and the use of early intervention strategies, being:
    - HR practitioners at each portfolio/district/division to manage officers;
    - Mandatory HR training for managers and supervisors;
    - Adequate FTE and required specialists at Health and Welfare Services; and
    - A computerised case management system for Health and Welfare Services to improve data capture, functionality and communication;
- Further progressing the medical retirement provisions, changing the medical board requirements and developing supporting procedures for medical retirement. As part of this recommendation, it was suggested that further investigation be done into the likelihood of support for, and impacts of, a small ex-gratia payment for officers with work-related psychiatric conditions or high degree of physical impairment upon medical retirement; and
- Developing a new workforce model that:
    - Changes the naming convention from 'non-operational' to 'restricted duties' officer;

[215] Western Australia Police, *Deployment Optimisation Project: Phase 1*, 2012, p. 7.
[216] Ibid, p. 12.
[217] Ibid.

- Provides a more equitable allocation of restricted duties officers across portfolios; and
- Reviews the functions and potential roles available within each district/division for restricted duties officers[218].

The review noted that there was a "very low percentage of active case management of non-operational officers" (nine per cent permanent and 20 per cent temporary), that psychological issues were "much more difficult to manage than physical injury or illness" and non-operational officers felt they could contribute more given the opportunity, yet felt insecure in their positions[219].

At the time of writing this paper, WA Police had not initiated the recommendations outlined by the Deployment Optimisation Project, but rather had commenced yet another review (by an independent auditor) of non-operational officers in the workplace. WAPU has not been privy to a background paper or the terms of reference governing the review, conducted by the Nous Group. To date, WAPU has had one meeting, with one representative each from Nous Group and WA Police. Within the meeting, a paper was presented which briefly outlined the structure of the review, being:

- Phase 1: Officer availability and deployment
  - Non-operational status
  - Sick leave
  - Medical retirement
  - Fitness to serve
  - Workforce composition
- Phase 2: Workforce management
  - Remuneration and conditions
  - Workforce management
  - Industrial relations.

WAPU understands that the Nous Group will present the final paper to relevant stakeholders in December 2014/January 2015. WAPU also understands that the recommendations of the Nous Group will focus largely on redefining operational status and introducing a new methodology for managing non-operational cases (including the escalation of cases with no likelihood of meeting the newly defined operational status).

[218] Ibid, pp. 4-5.
[219] Ibid, p. 7.

WA Police medical retirements: a snapshot

WA Police has kept WAPU abreast of its attrition rates over a number years by supplying data about police separations and recruits for each calendar year. Table 1 represents a snapshot of police who have been retired medically unfit since 2001.

	Number of Officers Retired Medically Unfit (by Calendar Year)
2001	39
2002	32
2003	36
2004	21
2005	30
2006	26
2007	32
2008	18
2009	20
2010	14
2011	11
2012	10
2013	14
Total	**303**
(Total in the last 10 years)	(232)

Table 1: Number of police officers retired on the grounds of being medically unfit, by calendar year

WA Police has shared with WAPU a snapshot of the medical retirements over the past nine financial years, outlined below at Table 2.

	Physical		Psychological		Both		Total
YEAR	WR	NWR	WR	NWR	WR	NWR	
2004/2005	2	3	9	5	1	-	20
2005/2006	-	6	15	9	-	4	34
2006/2007	-	3	7	9	1	2	22
2007/2008	1	7	11	5	1	5	30
2008/2009	1	3	9	2	3	-	18
2009/2010	-	-	7	-	2	1	10
2010/2011	2	-	8	2	1	2	15
2011/2012	2	2	7	-	2	2	15
2012/2013	-	-	6	-	2	-	8
Total	8	24	79	32	13	16	**172**

Table 2: Work related (WR) and non-work related (NWR) medical retirements on the grounds of physical and/or psychological health[220]

It must be noted that in July 2014, WAPU flagged with WA Police discrepancies between the attrition report and the figures provided by Health and Welfare Services, with respect to the number of medically retired officers in the following years:

- 2007/2008 (Table 2 states 30, from the attrition report they total 32)
- 2008/2009 (Table 2 states 18, from the attrition report they total 19)
- 2009/2010 (Table 2 states 10, from the attrition report they total 12).

Once this was raised with the Assistant Director of Health and Welfare Services, WAPU received this response:

> "[Health and Welfare Services] did an audit the other day and there were a couple of changes to the totals. For 2005/2006 we changed the total to 36. For 2008/2009 we had 20 and for 2001/2013 we had 9. We haven't done the other breakdowns unfortunately. We work off our running sheet which has the names of the people that went through the process. I can't

[220] Based on rudimentary data obtained from the Health and Welfare Services of WA Police.

comment on the attrition report unfortunately. These are the figures that we use for reporting[221]."

It is concerning that there are inconsistencies with the data obtained from the Agency. WAPU believes this should highlight the importance of implementing an integrated, high-quality tracking system for officers who have been, or may possibly be, medically retired at WA Police. Given the assertion from the Assistant Director at Health and Welfare Services that the figures provided in Table 2 are used for reporting, these figures are used in the discussion below.

From the data, we can see that WA Police has recorded more retirements on psychological grounds than physical (111 as compared to 32), with a roughly equal number separating on both psychological and physical grounds. Interestingly, there were more retirements on the grounds of non-work related physical injuries than work-related. WAPU is not privy to how these injuries have been recorded or treated, but knowing that there are instances where an injury not necessarily sustained at the workplace can be aggravated by a workplace injury or some officers have opted to treat an injury as non-work related for a multitude of reasons, WAPU cannot be entirely certain of the validity of these figures.

Likewise, whilst there can be many factors that cause psychological illnesses (genetic predisposition, family breakdowns), given the complexities of police work, especially in comparison to other employment (for example: the potential for involvement at any time in life threatening situations, critical incidents, national disasters; can never be completely 'off-duty'; rigours of daily work pressures and uncertainties about daily work; expectations from society to constantly uphold certain values and behaviours), it is WAPU's view that it would be difficult to isolate *all* psychological illnesses as being *either* work related *or* non-work related.

[221] As per an email from the Assistant Director of Health and Welfare dated 8 August 2014.

A comparative analysis across Australian policing jurisdictions

Both medical retirement and forms of recompense for West Australian police officers injured in the line of duty cannot be considered without an analysis of what is in place for similarly injured officers in other Australian policing jurisdictions.

Medical retirement

New South Wales

In NSW, the *Police Act 1990* at section 72A gives the Commissioner power to medically retire officers. At section 72A, an incapable, non-executive police officer may be retired by the Commissioner if:

- A non-executive police officer is found on medical grounds to be unfit to discharge or incapable of discharging the duties of the officer's position, and
- The officer's unfitness or incapacity:
    - appears likely to be of a permanent nature; and
    - has not arisen from actual misconduct on the part of the officer, or from causes within the officer's control[222].

This provision is replicated at clause 50 for executive officers, who are the senior executive officers.

There are two different processes that apply for NSW police officers to be medically retired depending on when an officer joined the NSW Police. Officers who joined the NSW Police prior to 1 April 1988 (colloquially termed "pre-1988") have the right to commence their own medical discharge process subject to meeting the requirements under *The Police Regulation (Superannuation) Act 1906*[223].

It's a very different situation for officers who joined after 1 April 1988 (colloquially termed "post-1988") as there is no entitlement to self medically discharge. However, the NSW Police Association work with NSW Police on improving injury management and supporting permanently injured officers by seeking to identify suitable employment opportunities within NSW Police to ensure that injury does not prevent continuing employment and career progression in the Agency. NSW Police have a Deployment Policy which focuses on retaining police rather than medically discharging them. In circumstances where an injured employee may not be able to return to full pre-injury duties, NSW

[222] New South Wales Consolidated Acts, *Police Act 1990*, Australasian Legal Information Institute, 2014. < http://www.austlii.edu.au/au/legis/nsw/consol_act/pa199075/s72a.html >.

[223] This information has been obtained from an information booklet disseminated to members by the NSW Police Association. Police Association of NSW, *Pre 88 Medical Discharge Procedures and Entitlements: information booklet for members*, 2014.

Police will make all reasonable attempts to identify suitable employment to enable them to continue work within the Agency, commencing with the modification of an injured officer's pre-injury duties position.

Suitable vacant positions are examined in the following priority order:

- Within the same Command/same job (with reasonable adjustment as required);
- Within the same Command/different job;
- A different Command/similar job; or
- A different Command/different job.

The medical discharge of an injured employee post-88 will only be considered in exceptional circumstances, where, due to incapacity, the officer can no longer perform the inherent requirements of their pre-injury position, reasonable modifications are unable to be made to the position and no other positions can be found or modified to accommodate the officer[224]. An internal dispute resolution pathway is available for officers when there are disputes about reasonable suitable employment.

NSW Police has a Deployment Unit that assists in identifying suitable employment opportunities for officers. Where suitable employment has not been identified within three months of an officer's return-to-work goal and medical advice indicates their condition will not improve in the foreseeable future, a case review is held with the Deployment Unit to identify further strategies that will assist in finding suitable employment.

Once all options have been exhausted and the medical advice supports the officer as being unfit to continue to work in NSW Police, the officer's file is referred to a specific unit within NSW Police that collates all medical information on file for the officer and for referral to the Medical Discharge Review Panel to consider (on which a NSW Police Association representative sits). The Panel make a recommendation about whether the officer should be discharged. The recommendation is then forwarded to the Commissioner's delegate to formally retire the officer under section 72A. There is a further appeal right if an officer wishes to dispute the medical discharge recommendation on limited grounds such as specific medical information was not considered or the decision is inconsistent with other medical advice.

[224] Police Association of NSW, *Post-88 Workers' Compensation Procedures and Entitlements: information booklet for members*, 2014.

Victoria

Section 16B of the *Police Regulation Act 1958* and Clause 110 of the *Victoria Police Force Enterprise Agreement 2011* infer the power on the Chief Commissioner to medically retire an employee. After a member submits to a medical inquiry regarding their fitness and capacity to discharge the duties of his or her office, if the Chief Commissioner is satisfied that the member is incapacitated for the performance of his or her duty by infirmity of mind or body, the Chief Commissioner may initial the retirement process[225].

A work related incapacitation means a work related illness or injury where the employee's workers compensation claim has been accepted[226].

An employee may be directed by the Chief Commissioner to attend for medical examination(s) by the police medical officer to assess their fitness for work where:

- The employee has been on personal leave for personal illness for at least 28 days and provides a medical certificate indicating an ongoing incapacity for the duties of their position; or
- The employee provides a medical certificate (including workers compensation) indicating a permanent and/or ongoing incapacity to perform the duties of their position; or
- The employee fails to attain mandatory qualifications for the position they own because of a verified medical condition; or
- The employee indicates a severe or chronic medical related condition as a result of the Victoria Police mandatory physical fitness assessment process; or
- On reasonable grounds there are genuine concerns about the employee's capacity to undertake the duties of their position[227].

Where it is identified that the employee cannot return to their substantive position the Agency will attempt to identify a suitable position[228]. On the provision of 14 days' notice the employee may be discharged on medical grounds, subject to Victorian Workers' Compensation legislation, where an employee is found to be unfit for all duties in Victoria Police and is likely to continue indefinitely to have no work capacity and the Agency is unable to provide duties that comply with the stated medical

[225] Victorian Law Resources, *Police Regulation Act 1958*, Australasian Legal Information Institute, 2014. < http://www.austlii.edu.au/au/legis/vic/consol_act/pra1958187/s16b.html >.
[226] The Police Association Victoria, *The Victoria Police Force Enterprise Agreement 2011*, 2012, p. 65. < http://www.tpav.org.au/_documents/EB2011/55f047db-c650-4b64-9f32-0c80bcd0a92e/Victoria_Police_Enterprise_Agreement_2011.pdf >.
[227] Ibid, pp. 65-66.
[228] Ibid, p. 67.

limitations or restrictions and the medical limitations or restrictions and the inability to provide duties are likely to continue indefinitely[229].

The Police Association of Victoria has noted that its members' main concerns about the medical retirement process are bullying by referral to the police medical officer and inadequate accommodation by the Force.

Queensland

Section 8.3 of the *Police Service Administration Act 1990* provides for the medical retirement of police officers by reason of physical or mental infirmity[230]. If, having regard to any medical opinions expressed by medical practitioners (including any such opinions furnished by the officer) on the health or condition of the officer concerned, if the Commissioner is satisfied that the officer should not continue to be required to perform the duties of office, then the Commissioner may call upon the officer to retire from the service within a specified time[231]. The Commissioner may appoint an incapacitated police officer as a member of staff (by which they relinquish their powers and duties of constable) at the same rate of pay, if the Commissioner believes they can adequately perform the duties of a staff member[232].

From the view of the Queensland Police Union, most members have a level of distrust in the process and how it is applied in many instances. There are some instances where officers see it as beneficial (in instances where an injury or illness has been sustained where an officer can truly no longer function), particularly when it comes to accessing superannuation entitlements for total and permanent incapacity. The Queensland Police Union has also noted that where it becomes apparent that an officer may no longer be able to perform the duties of a police officer, Queensland Police appear to be encouraging them to transition into other work, including through host employment. The concern is if an officer applies for and wins on merit a public service job they will not maintain their current rate of pay in the same way they would if they are medically retried into a public service position.

[229] Ibid.
[230] Queensland Legislation, *Police Service Administration Act 1990*, Queensland Government, 2014. < https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/P/PoliceServAdA90.pdf >.
[231] Ibid, p. 87.
[232] Ibid.

Tasmania

In Tasmania, sections 28 and 29 of the *Police Service Act 2003* specify medical retirement on the grounds of being unable to efficiently and effectively perform his or her duties because of a mental illness within the meaning of the *Mental Health Act 2013*, any injury, illness or disease or any general physical unfitness[233].

The Commissioner, under this Act, can not only direct an officer to undertake a medical examination but can take a range of actions for an unfit officer including retrain, transfer, demote or remove the officer[234].

The Police Association of Tasmania notes that there has not been a section 29 dismissal since the *Police Service Act* was introduced in 2003. A dismissal under this section is fully reviewable by the Police Review Board.

South Australia

The Commissioner has the power to medically retire an officer under section 45 of the *Police Act 1998*. If the Commissioner is satisfied after due inquiry that the appointment of a member of SA Police should be terminated because of the member's incapacity to perform duties as a member by reason of physical or mental disability or illness, the Commissioner may terminate the appointment of the member[235]. However, the Commissioner must comply with either applicable act (*Police Superannuation Act 1990* or *Southern State Superannuation Act 1994*) when terminating employment on this basis.

According to the Police Association of South Australia, the only time this has been used since its introduction in 1998 has been when requested by the member, which has been few and far between.

Compensation

New South Wales

NSW has two different Workers' Compensation schemes for officers, dependant on the date on which the officer was sworn in as a member of NSW Police. Officers who joined pre-1988 are in a unique

[233] Tasmanian Law Resources, *Police Service Act 2003*, Australasian Legal Information Institute, 2014. < http://www.austlii.edu.au/au/legis/tas/consol_act/psa2003149/s29.html >.
[234] Ibid.
[235] South Australian Legislation, *Police Act 1998*, Attorney-General's Department, Government of South Australia, p. 18. < http://www.legislation.sa.gov.au/LZ/C/A/POLICE%20ACT%201998/CURRENT/1998.55.UN.PDF >.

scheme that combines both superannuation and Workers' Compensation benefits under the one regime. Upon medical retirement, the officer is entitled to receive compensation in a pension form or as a lump sum benefit. The benefit is dependent on whether an officer was: not hurt on duty; hurt on duty whilst a serving police officer; and hurt on duty but are now a former police officer[236].

Unlike the pre-1988 officers who are excluded from certain aspects of Workers' Compensation given their unique medical separation entitlements, officers who joined post-1988 are considered 'workers' under the *Workers' Compensation Act 1987*[237]. Therefore, all of the relevant Workers' Compensation rights and entitlements are applicable to post-88 police officers. Police officers were made exempt from changes to Workers' Compensation that occurred in 2012.

The *Crown Employees (Police Officers Death and Disability) Award 2005* (from which arose the "Death and Disability Scheme") applied with respect to compensation, but this Award was rescinded in December 2011. This Award previously provided for the lump sum payment for officers suffering a partial and permanent disability or total and permanent disability. Payments were made for both on and off duty injuries, with higher benefit levels for on duty injuries.

The Death and Disability Scheme covered all officers employed on or after 1 April 1988 who were injured the workplace on or after 23 June 2005. If an officer was medically discharged after 23 June 2005 with an **on duty** injury and was not eligible for coverage under the Death and Disability Scheme, they may have been eligible for compensation under the previous entitlement of section 216 "Special Risk Benefit" of the *Police Act 1990*, which was repealed on and from 30 January 2006.

The Death and Disability Scheme was replaced with a varied *Police Blue Ribbon Insurance Scheme* (PBRI). This scheme provides for:

- Income Protection Benefits providing for 75 per cent of salary maintenance for a period of five or seven years (depending on the date of injury) for on duty matters (two years for off duty matters) which is offset by any other income earned, including wages and workers compensation; and
- Total and Permanent Disablement Benefit which provides for a lump sum payment for officers who are unlikely to ever engage in any gainful profession, trade or occupation for which they are reasonably qualified by reason of education, training or experience. The lump sum

[236] Police Association of NSW, *Pre 88 Medical Discharge Procedures and Entitlements: information booklet for members*, 2014, p. 5.
[237] *Post-88 Workers' Compensation Procedures and Entitlements: information booklet for members*, p. 6.

payment was considerably reduced upon the recession of the Death and Disability Scheme and the varied benefit level does not distinguish the amount of payment for an on duty v off duty injury.

The benefit level payable for the total and permanent disablement claim will depend on the date of injury.

Given the benefits for post-88 officers are limited upon a medical discharge there has been a greater focus on rehabilitation and redeployment within NSW Police.

Victoria

Victorian officers receive, like all other workers, Workers' Compensation under the *Accident Compensation Act 1985*. Under this legislation, if a worker is injured arising out of or in the course of any employment, the worker shall be entitled to compensation[238]. The 1985 Act contemplates that four types of payments will be made to compensate for an injury:

- Weekly payments for incapacity. Weekly payments are payable if, as a result of an injury, a worker has "no current work capacity" or has "current work capacity"[239];
- Benefits in respect of death. Lump sums and weekly pensions are paid to dependent partners (which include a spouse) and children[240];
- Medical and like expenses. A worker injured in compensable circumstances, whether or not the injury results in time off work, is entitled to payment or reimbursement of reasonable medical and other related expenses. The types of such expenses covered by the 1985 Act cover such items as medical, hospital, ambulance, chemist, nursing and travelling expenses, artificial medical aids, as well as treatment by registered chiropractors and osteopaths. Counselling benefits up to $5,870 (as set out above) are payable to the family members of a "severely" injured worker where there is immediate hospital inpatient treatment or the worker dies from the injuries. Other claims can include personal household and occupational rehabilitation expenses such as home help, gardening, and car and home modifications[241]; and

[238] Section 82(1) of the *Accident Compensation Act 1985*, Victorian Law Resources, Australasian Legal Information Institute, 2014. < http://www.austlii.edu.au/au/legis/vic/consol_act/aca1985204/ >.
[239] The Law Handbook, *Workers' Compensation*, Fitzroy Legal Service, 2014. < http://www.lawhandbook.org.au/handbook/ch18s03s02.php >.
[240] Ibid.
[241] Ibid.

- Certain lump sum compensation, including damages. Injuries such as spinal injuries, limb injuries and loss of senses including hearing and sight are covered within the Act's Table of Maims[242].

It has been noted that the Victorian Police Association believes that this compensation scheme is fair, equitable and effective for its Members.

Queensland

Queensland police officers receive compensation for a work-related illness or injury under the *Workers' Compensation and Rehabilitation Act 2003*. The Act establishes a Workers' Compensation scheme for Queensland by:

- Providing benefits for workers who sustain injury in their employment, for dependants if a worker's injury results in the worker's death, for persons other than workers, and for other benefits; and
- Encouraging improved health and safety performance by employers[243].

The scheme provides some of the following for injuries sustained by workers in their employment: compensation; injury management, emphasising rehabilitation of workers particularly for return to work; procedures for assessment of injuries by appropriately qualified persons or by independent medical assessment tribunals; and rights of review of, and appeal against, decisions made under this Act[244]. It is intended that the scheme should:

- Maintain a balance between:
    - providing fair and appropriate benefits for injured workers or dependants and persons other than workers; and
    - ensuring reasonable cost levels for employers;
- Ensure that injured workers or dependants are treated fairly by insurers;
- Provide for employers and injured workers to participate in effective return to work programs; and
- Provide for workers or prospective workers not to be prejudiced in employment because they have sustained injury to which this Act or a former Act applies[245].

[242] Ibid.
[243] Queensland Legislation, *Workers' Compensation and Rehabilitation Act 2003*, Queensland Government, 2014, p. 34. < https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/W/WorkersCompA03.pdf >.
[244] Ibid, p. 35.
[245] Ibid.

Tasmania

In Tasmania, police officers receive compensation under the *Workers' Compensation and Rehabilitation Act 1988*. The objects of this Act are to establish a rehabilitation and compensation scheme for workplace injuries that: provides for the prompt and effective management of workplace injuries in a manner that promotes and assists the return to work of injured workers as soon as possible; provides fair and appropriate compensation to workers and their dependants for workplace injuries; assists in securing the health, safety and welfare of workers and in reducing the incidence of workplace injuries; and is fair, affordable, efficient and effective[246].

If the work-related illness or injury occurred before 15 November 1988, there is no entitlement to Workers' Compensation as the Act only conceives for injuries or illnesses sustained post 15 November 1988. If an officer remains totally incapacitated for work and continues to produce a Worker's Compensation medical certificate, then weekly benefits will be paid for up to nine years from the date of the initial incapacity. For work related injuries/illnesses incurred on or after 1 July 2010, the maximum period weekly benefits is dependent upon the officer's level of whole person impairment and the time period can range from nine years up to when the person reaches 65 years of age.

As long as a Worker's Compensation medical certificate is produced, all reasonable medical costs, rehabilitation (including physiotherapy, gym, natural therapies), ambulance, household services and other necessary expenses (such as travelling expenses) incurred by the person in connection with the Worker's Compensation claim will be paid for a period of up to 10 years from the date the claim was given to the employer.

There is no time limit on lodging an application under the 1988 Act for permanent impairment compensation. This compensation is in addition to any other compensation payable under the 1988 Act and is for a worker who suffers permanent impairment from the work-related illness or injury. It is a lump sum payment and depends on the level of 'whole person impairment' suffered by the person.

The 1988 Act also conceives for a presumption as to cause of certain diseases in relation to firefighters (at section 27)[247].

[246] Tasmanian Law Resources, *Workers' Compensation and Rehabilitation Act 1988*, Australasian Legal Information Institute, 2014. < http://www.austlii.edu.au/au/legis/tas/consol_act/wraca1988400/ >.
[247] Ibid.

South Australia

South Australian police officers are covered by the *Workers' Rehabilitation and Compensation Act 1986*. This Act aims to establish a workers' rehabilitation and compensation scheme that: provides for the effective rehabilitation of injured workers and their early return to work; provides fair compensation for employment-related injuries; reduces the overall social and economic cost to the community of employment-related injuries; and ensures that employers' costs are contained within reasonable limits so that the impact of employment-related injuries on South Australian businesses is minimised[248].

The *Workers' Rehabilitation and Compensation (General) Regulations 1999* stipulate compensation for a loss of earning capacity, lump sum compensation and compensation payable upon death (being a funeral benefit)[249]. To determine the quantity of the equal instalments to a loss of earnings payment, the formula at Appendix 6A is used[250].

New Zealand Police Trauma Policy

New Zealand Police have developed a Trauma Policy (which came into formal operation in 1992) which is to provide access to appropriate psychological assessment and support for all employees, a timely and confidential response to employees following attendance at a critical incident and a support system which addresses the psychological risks associated with policing generally[251]. Under this policy, employees may self-refer, otherwise, employees must be referred to welfare officers following their involvement in a specified critical incident (see Appendix 6B for the list).

An employee who is involved in:

- The death of a colleague or member of the public in the course of duty;
- The discharge of a lethal weapon or vehicle accident resulting in serious injury or death; and/or
- The discharge of a Taser causing serious injury or death;

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[248] South Australian Legislation, *Workers' Rehabilitation and Compensation Act 1986*, Attorney-General's Department, Government of South Australia, Adelaide, p. 1. < http://www.legislation.sa.gov.au/LZ/C/A/WORKERS%20REHABILITATION%20AND%20COMPENSATION%20ACT%201986/CURRENT/1986.124.UN.PDF >.

[249] South Australian Legislation, *Workers' Rehabilitation and Compensation (General) Regulations 1999*, Attorney-General's Department, Government of South Australia, Adelaide, pp. 8-9. < http://www.legislation.sa.gov.au/LZ/C/R/WORKERS%20REHABILITATION%20AND%20COMPENSATION%20(GENERAL)%20REGULATIONS%201999/2010.10.31/1999.239.UN.PDF >.

[250] Ibid.

[251] This information has been accessed from the New Zealand Police Intranet.

must be referred, through the district welfare officer, to a psychologist for a one-on-one assessment and/or debrief before being cleared fit to return to duties[252]. These situations, characterised by their serious nature, require mandatory consultation "in recognition of their inherent potential for later adverse reactions[253]".

There is a manual that accompanies the Trauma Policy, and this manual is for use by supervisors, welfare officers and those delivering psychological services to police officers[254]. The guiding principle outlined in the manual is the "provision of a *quick* response to, and *confidential* support contact between, members of police and mental health professionals who provide such services[255]". The Trauma Policy is designed to address not only members who are immediately affected by a traumatic incident, but also staff who may not be directly involved at the scene (for example, control room staff) but may warrant psychological assistance[256]. The manual also outlines the procedural steps of the support process.

[252] Ibid.
[253] This information was proffered to WAPU by the New Zealand Police Association by way of a manual that accompanies the Trauma Policy. The document is entitled "The New Zealand Police Trauma Policy, 30 January 2001, Manual" by Jonathan Black, Manager Psychological Services, Wellington. Page 5.
[254] Ibid.
[255] Ibid, p. 2.
[256] Ibid, p. 6.

Department of Veterans' Affairs

Over the years, WAPU has heard from its serving and retired Members that an organisation similar in intent and structure to the Department of Veterans' Affairs (DVA) would be greatly beneficial in providing a range of support and services to officers who have dedicated their lives to serving the community. As such, WAPU feels that it is important to explore, albeit in brief, the important services that are provided by the DVA to veterans in order to demonstrate that no similar organisation exists for police officers.

What does the DVA do?

The mission statement of the DVA is "to support those who serve or have served in defence of our nation and commemorate their service and sacrifice"[257]. The DVA work to:

- "Maintain and enhance the financial wellbeing and self-sufficiency of eligible persons and their dependants through access to income support, compensation, and other support services, including advice and information about entitlements";
- "Maintain and enhance the physical wellbeing and quality of life of eligible persons and their dependants through health and other care services that promote early intervention, prevention and treatment, including advice and information about health service entitlements"; and
- "[Acknowledge and commemorate]… those who served Australia and its allies in wars, conflicts and peace operations through promoting recognition of service and sacrifice, preservation of Australia's wartime heritage, and official commemorations"[258].

The DVA offer many and varied benefits and services for its veterans and members, including (and most importantly):

- Pensions – Disability Compensation: compensation (dependent on level of incapacity suffered) for veterans who have been injured/diseased by war service;
- Incapacity Benefits: payments for economic loss following illness/injury that inhibits or reduces the ability to work;
- Permanent Impairment Payments: compensation for an injury or disease that has left a veteran with a permanent (mental or physical) impairment;

[257] Department of Veterans' Affairs, *Our purpose*, Australian Government, 2011. < http://www.dva.gov.au/aboutDVA/overview/Pages/our%20purpose.aspx >.
[258] Ibid.

- Healthcare: a range of health care and support services to meet the clinical needs of eligible veterans;
- Rehabilitation: designed to assist veterans to return to the same physical and psychological state (and some social, vocational and educational status) they had before being injured or becoming ill; and
- Counselling: a specialised, free and confidential counselling service for veterans, their partners and dependent children[259].

Two key components to the DVA include rehabilitation and compensation, benefits of which are legislated under the *Military Rehabilitation and Compensation Act 2004*. In its Military Rehabilitation and Compensation Information Booklet, rehabilitation is defined as being designed to assist an eligible member if they are injured or become ill as a result of service[260]. Rehabilitation can be medical (for example, physiotherapy), vocational (the process of which assists in the return to the workforce) and/or psychological (for example, adjustment counselling and community support services)[261]. Compensation is commonly associated with a loss. If, due to the eligible member's injury or illness, a future loss (such as a medical expense, a loss of income or a functional impairment), compensation for that loss may be awarded[262].

Operation *Life*

In his independent study into suicide in the ex-service community, Dunt asserted that:

> "Modern armed forces engaging in modern warfare and peacekeeping unavoidably place very high demands and stresses on their members. This can have adverse effects on the mental health of some members. Many of these only become apparent sometimes only many years after discharge, DVA is well aware of this and has put in place a Mental Health Strategy and a range of health, welfare, rehabilitation services aimed at their prevention and amelioration"[263].

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[259] Department of Veterans' Affairs, *DVA03: Overview of DVA benefits and services*, Australian Government, 2013, pp. 1-5. < http://factsheets.dva.gov.au/factsheets/documents/DVA03%20Overview%20of%20DVA%20Benefits%20and%20Services.pdf >.

[260] Department of Veterans' Affairs, *Military Rehabilitation and Compensation Information Booklet*, Australian Government, 2011, p. 1. < http://www.dva.gov.au/aboutDVA/publications/servingmembers/Documents/MRCinfobook.pdf >.

[261] Ibid.

[262] Ibid.

[263] D. Dunt, "Independent study into suicide in the ex-service community", Dunt Health Evaluation Services, Victoria, 2009, p. 2. < http://www.dva.gov.au/health_and_wellbeing/research/Documents/Dunt%20Suicide%20Study%20Jan%202009.pdf >.

In his study, Dunt examined:

> "…The broad issues of suicide in the ex-service community, and a number of specific cases of suicide in the last three years, to help identify:
>
> - Ex-service members who are at increased risk of self-harm;
> - Common contributing factors among ex-service members who have committed or attempted suicide;
> - The extent of suicide in the ex-service community;
> - Lifestyle or other factors that may be contributing to suicide in the ex-service community; and
> - Recommended administrative reforms or initiatives to help combat suicide in the ex-service community[264]."

Dunt's study informed a recent review of Operation *Life* (*L*ife *I*s *F*or *E*veryone) by McKay et al. which links closely to the National Suicide Prevention Strategy for the Australian veteran community[265]. Operation *Life* was developed in 2007 and is the overarching framework under which different suicide prevention initiatives fall, including mental health promotion[266]. Operation *Life* has five key priority areas:

1. The promotion of resilience, mental health and wellbeing through education, training and self-awareness;
2. The enhancement of protective factors by reducing risk factors of veteran suicide and self-harm. For example, mental health, literacy training and ready access to health providers;
3. Support through different organisations for those most at risk of suicide and their families;
4. Partnership development with the veteran and ex-service officer communities through such areas as the men's health peer education facilitators; and
5. Increased evidence-based research on suicide prevention and best practice through community-based projects[267].

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[264] Ibid, p. 20.

[265] K. McKay, J. Hawgood, K. Kavalidou, K. Kolves, J. O'Gorman & D. De Leo, "A Review of the Operation *Life* Suicide Awareness Workshops: Report to the Department of Veterans' Affairs", Australian Institute for Suicide Research and Prevention, Brisbane, 2012, p. 9. < http://www.dva.gov.au/health_and_wellbeing/research/Documents/OpLife_workshops_final_report.pdf >.

[266] Ibid.

[267] D. Dunt, p.27; K.McKay et al., p. 9.

Four suicide prevention and mental health workshops have been available free of charge for the veteran community. In evaluating these workshops, McKay et al. found that participants felt favourably not only about the delivery of the workshops but also their increased capabilities as a result of participation[268]. Further, McKay et al. found participants felt there were real and substantial improvements in their perceptions of their capabilities in dealing with a person who may be considering suicide (and these skills did not deteriorate over a three month period) following involvement in certain workshops[269].

What is available for police officers similar to the DVA?

Without disrespectfully oversimplifying either profession, police officers, in the vein of our military personnel, dedicate their lives to bringing law, order, peace and justice to the community. Yet no organisation devoted to the holistic care of police officers currently exists for serving and retired members (however, please see the following section, "Available support for separated officers").

Police officers do not receive any disability compensation if they are injured or diseased by their service. Police officers do not receive any incapacity benefits should they suffer a financial hardship because they have had their ability to work reduced as a result of an injury or illness. Police officers do not receive any permanent impairment payments for any physical or mental impairment resulting from their work. Police officers receive health care and assistance whilst they are serving, but are not eligible should they separate or are medically retired. Police officers who are medically retired do not receive any rehabilitation to assist them to return to the same vocational, social and/or educational status they had prior to being ill or injured. Police officers who are medically retired do not receive any specialised counselling, unless they are eligible for rebates for using recognised professionals under the Former Officers' Medical Benefits Scheme.

There are no police-specific programs (like Operation *Life*) aimed at raising awareness about mental health, despite the proliferation of literature that suggests how severely impacted police officers are by the traumas they face in the line of duty. To WAPU's knowledge, despite the consensus that police officers face a greater likelihood of suffering psychological trauma due to the violent and unpredictable nature of their work, there have been no similar studies to that of Dunt's which explore suicide (or other grave mental health issues) in the post-service police community.

[268] p. 36.
[269] p. 43.

Essentially, if a police officer is injured, diseased, incapacitated or impaired as a result of their duties and are deemed to be no longer suitable for police work, they do not separate from the Agency knowing that there will be ongoing counselling, support, rehabilitation and compensation. A police officer does not even have the assurance that there are Government initiatives that aim to reach out and assist with treatment options and resources[270]. Instead, a police officer leaves a lifetime of dedicated service with little more than 28 days of pay.

[270] These support services are offered by the DVA as part of their "At Ease: Recognise, Act, Maintain" initiative. The "At Ease" initiative notes the following: "It's not unusual to experience sadness, distress or anger after deployment. At Ease can help veterans, ADF personnel, and family members identify the symptoms of not coping. When you need to reach out, seek treatment or identify effective ways to move forward, At Ease can provide tips, treatment options and resources."
Department of Veterans' Affairs, *At Ease*, Commonwealth of Australia, 2012. < http://at-ease.dva.gov.au/ >.

Available support for separated police officers

Whilst war veterans are afforded support from the DVA (and its many affiliates) during and after service, no similar agency exists for separated or retired police officers in WA. There are six organisations, all non-government organisations (NGOs), which have been established to assist and support separated/retired members. However, presently only the Retired Police Officers' Association and the Medically Retired Western Australian Police Officers' Association exist to solely service retired members.

Retired Police Officers' Association[271]

The Retired Police Officers' Association (RPOA) was formed in 1972 and presently has 496 members. The constitution was amended two years ago for membership to include any former police officer as a full member and any widow of a police officer can join as an associate member. The RPOA currently has branches in Geraldton, Mandurah and the South West, with consideration to commence one in Albany. The Perth Branch covers all of the metropolitan area and all other areas without a branch.

The RPOA has an active committee who meet bi-monthly and this includes open invitations to the police chaplains. They have a sponsorship arrangement with P&N Bank, which provide them $2000 a year and attend functions to allow members to talk to them as required. The RPOA send bi-monthly newsletters to members, outlining recent happenings, function details and other police information members may need.

The RPOA works closely with WAPU and, where necessary, will discuss a member's medical issues and request assistance. A number of former WAPU Directors are current members of the RPOA. WAPU also help with payment of mail outs for those members not currently on email, which is seen as a great benefit. The RPOA has welfare officers that contact members when necessary and liaise with other community groups, like the men's shed initiative, and other states with similar associations. It also liaises with and supports the work of the Medically Retired Western Australian Police Officers' Association, as the RPOA recognise many members have been medically retired.

The RPOA supply an award at the WA Police recruit graduation ceremony and attend all retired officers

[271] The following information has been kindly provided by the Secretary of the Retired Police Officers' Association, as this organisation currently does not have an online presence.

funerals and read the Police Ode for the families. They have four main functions a year, of which three are casual barbeques and a Christmas lunch.

The RPOA has said these events elicit a good turn out from members and other guests who have assisted the association. The RPOA is a valuable group that keeps members feeling part of the police family, which is seen as really important to the long term members.

Medically Retired Western Australian Police Officers' Association

The Medically Retired Western Australian Police Officers' Association (MRWAPOA) was created in 2013 after the need for a support group for medically retired WA police officers was identified. In 2012, three medically retired police officers gave verbal evidence to the Toll of Trauma Inquiry and their evidence revealed that there were many other medically retired police officers who were suffering physical and psychological injuries many years after being discharged from the organisation, with little or no after service support[272]. After appearing in the newspaper, the three officers were regularly contacted by other injured and ill former and serving WA police officers seeking assistance and it soon became obvious that something needed to be done to raise awareness of the situation[273]. The MRWAPOA was developed with the aim to "to create a support network for medically retired Western Australian police officers… while proactively raising the awareness of their poor treatment and seeking redress"[274].

The MRWAPOA currently has 50 financial members and 150 non-financial members. It meets bi-monthly during the cooler months and monthly during the warmer season.

WA Police Legacy and the Police Families Assistance Council

WA Police Legacy was established in 1992 as a joint initiative of WAPU and WA Police. The Legacy Board has 10 elected members plus representation from the Commissioner of Police, WA Police Widows Guild and WAPU. There are currently 361 widows, three widowers and 43 children under 20 years of age being supported by WA Police Legacy[275].

WA Police Legacy was formed to assist with the welfare of police officers' families to ensure they are not in want of assistance and support when they lose a loved one. Some of the ways Legacy assists

[272] *Medically Retired Western Australian Police Officers Association Inc (MRWAPOA Inc.)*, Medically Retired Western Australian Police Officers Association Inc., 2013. < http://www.mrwapoa.org.au/index.html >.
[273] Ibid.
[274] Ibid.
[275] WA Police Legacy, *About Us*, WA Police Legacy Inc, 2014. < http://www.policelegacywa.org.au/index.html >.

include: financial assistance in times of hardship; social activities throughout the year including Christmas cruises and lunches; education assistance; personal visits throughout the year; and Police Remembrance Day[276].

The Police Families Assistance Council (PFAC) was formed in 1976 as a benevolent body to assist and guide police officers and their families who find themselves facing medical, emotional or financial hardship. All PFAC funds come from police officers voluntary contributions made through direct deductions from their wages. PFAC supplements the support and assistance offered by WAPU and WA Police Legacy.

Requests for support can be made by a member personally, however they are often submitted by a supervisor, peer or concerned individual on behalf of the member in need. The operation of PFAC is bound by a formal Constitution and each request for assistance is considered by the Board of Directors having due consideration of the necessitous circumstances.

The assistance is strictly confidential and the nature varies in accordance with the particular need of the individual or family. The assistance is most often unconditional however, if it is considered that the member is in need due to unforeseen short term financial hardship and has the future capacity to repay the monies without exacerbating the circumstances, there may be a requirement to repay some over time. The PFAC only functions with the generous support from serving members of WA Police.

Both Legacy and PFAC look after serving and retired Members and their families.

The Ryan Marron Foundation

The Ryan Marron Foundation was formed in 2011 with the aim of raising funds for Murray Valley Encephalitis-affected police officer Ryan Marron to receive treatment at the world renowned Rehabilitation Institute of Chicago[277]. After securing the necessary treatment, the organisation evolved to provide assistance to police officers in necessitous circumstances, ensuring that other officers in tough circumstances wouldn't have to struggle like Ryan did to obtain the required support.

The Ryan Marron Foundation has three trustees including its founder, Toni Misitano. The Ryan Marron Foundation is a not-for-profit organisation and thus relies solely on donations from police members

[276] WA Police Legacy, *WA Police Legacy Services*, WA Police Legacy Inc, 2014. < http://www.policelegacywa.org.au/services.htm >.
[277] The Ryan Marron Foundation, 2014. < http://www.ryanmarronfoundation.org/ >.

and the general public. Ms Misitano has said that she aims to expand the scope of the foundation and increase the monetary contributions. She has said there are many cases, similar to Ryan's, that 'fall through the cracks' and she wants to ensure that police officers get the support they need without having to worry about fundraising when they are facing tough times.

Ms Misitano has also stated that the Ryan Marron Foundation would benefit from the support of WA Police in the following ways:

- For members to be able to show their support by wearing Foundation merchandise at work (pins, lanyards, ties, et cetera);
- Permission to brief new recruits about the Foundation at the Academy, similar to that of Police Legacy;
- A link to the Foundation webpage on the WA Police Intranet with information about the Foundation and access to the fortnightly deduction form; and
- WA Police to offer the Steel Blue Response Range police specific boots for purchase by members at the same rate as the cheaper Magnum boots with an option for the member to pay the difference out of pocket to procure them. This would be at no added cost to the Agency and would contribute greatly to the Foundation (as currently Steel Blue is contributing $4 from each sale).

The WA Police Union

WAPU was established in 1911 and serves both serving and retired Members. As per the Western Australia Police Union of Workers Constitution, Rules and By-Laws, Rule 5.2: "Any Member who ceases to be eligible for Membership by reason of their retirement because of age or total permanent incapacity may apply for Membership as a Retired Member". Retired Members benefit from many of the services offered by WAPU to its serving Members: welfare support; discounted fees with legal services; access to holiday home properties; advocate support for industrial issues which may have occurred during their employment with WA Police; and assistance with financial and funeral arrangements if they suffer the passing of a spouse or child.

Member experiences

WAPU's Project Recompense survey – an overview

In April 2014, WAPU ran a month-long survey utilising the online survey tool, SurveyMonkey. Canvassing retired and current Members, the survey proposed 40 questions that spanned general demographics (name, age, rank, length of service, et cetera), the medical retirement process, the illness or injury suffered, experience with WA Police and associated organisations involved in the medical retirement process, support services and forms of compensation. The survey elicited a total of 876 responses, with more than 250 responses received in the final week of the survey. WAPU emailed an initial newsletter to both current and retired Members requesting input (dated 8 April 2014, and can be seen at Appendix 7A) and sent a reminder newsletter on 30 April 2014.

Respondent demographics

Age

The average age of respondents was 49 years. The youngest respondent was 21 years and the oldest was 84 years. The most frequently occurring age noted was 45 years whilst the median age was 49 years. However, the standard deviation from the mean age was substantial (11.8; almost 12 years), which means that the spread of ages from the mean is large.

This would indicate that whilst the mode and median were similar to the average age of respondents, the wide spread of ages means that a variety of respondents were captured within the survey.

Employment with WA Police

Approximately 73 per cent (being 639 respondents) were currently employed by WA Police, whilst approximately 27 per cent (being 236 respondents) were no longer employed by WA Police.

The average length of service with WA Police (for both retired and current Members) was approximately 21.5 years, with the minimum tenure one year and the maximum tenure 43 years. The most frequently occurring length of service noted was 25 years, with the median length of service 23 years. The standard deviation from the mean length of service was great, at approximately 10.5 years.

Again, this would suggest that whilst that the mode and median were similar to the average length of tenure of respondents, the varying lengths of tenure means that a variety of respondents were captured within the survey.

For those no longer employed by WA Police, the average year of retirement was between 2002 and 2003. The survey captured data from officers who had retired across 30 years, with the earliest date of separation being 1984 and the most recent date of separation being 2014. The most frequently occurring year of retirement was noted as 2009 whilst the median year of retirement was 2003. The standard deviation from the mean year of retirement was approximately 7.1 years.

These figures could be interpreted in several ways. Given the mean and median year of retirement was noted as around 2003, and WA Police attrition reports note a spike in medical retirements (being 32 and 36 retirements in the 2002 and 2003 calendar years respectively), this could mean that the data set accurately captures the spate of medical retirements across the early 2000s. Even though WAPU does not have details for attrition rates prior to 2001, by applying the standard deviation of approximately seven years from the 2002/2003 we can see that there are higher incidences of medical retirements between 2002/2003 and 2009/2010 (with numbers of retired officers hovering at around 30) than post 2010 (where the number sits at an average of approximately 12).

Duties performed for majority of career

Respondents were asked what duties they performed for the majority of their operational career (for example, General Duties, Traffic or Detective in a specialist unit). As the question was open-ended, respondents were able to answer if their career necessitated the performance of more than one duty. The following was broadly noted:

- 601 respondents performed General Duties;
- 206 respondents worked in Traffic;
- 145 respondents worked as a Detective;
- 39 respondents worked in a specialist unit (such as the Tactical Response Group or Arson Squad); and
- 38 respondents worked in Forensics.

Rank

Respondents were asked what their current rank was and, if they were no longer employed by WA Police, what was their rank at retirement/separation. The following was broadly noted:

- 419 respondents were Constables
    - Of which 332 respondents were Senior Constables;
- 333 respondents were Sergeants
    - Of which 58 were First Class Sergeants and 53 were Senior Sergeants;
- 22 respondents were Inspectors; and
- 11 respondents were Superintendents.

General information about respondent illness/injury

Respondents were asked the following question:

> "Do you currently suffer, or have you previously suffered, from a physical or psychological illness/injury that arose from your police duties?"

Whilst 24.82 per cent of respondents said no, 75.18 per cent said yes.

Members were asked what length of time they had suffered from their work-related physical or psychological illness or injury. The average duration of a Member's illness or injury spanned 12 years and 10 months. The minimum length of time a survey respondent had suffered an illness or injury was six months, whilst the maximum length of time a Member had suffered from their illness or injury was 50 years. The most frequently cited illness or injury duration was five years.

Again, the spread of data was sizeable, as the standard deviation from the average was nine years and nine months. This not only indicates that a variety of respondents were captured within the survey but that the duration of Member illnesses and injuries appear protracted.

Medical retirement

138 respondents to the survey had been medically retired as a result of their illness or injury. 117 respondents were either medically retired, or would be medically retired, before the age of 55. There were 201 Members who had not been medically retired but were currently suffering an illness or injury that was likely to result in them being medically retired.

Members were asked if they had not been medically retired and had continued in their job as a police officer, what would they'd have roughly earned (between being medically retired and retirement age[278]). Members noted, on average, they would have earned $1,223,412 had they continued in their

[278] Retirement age for WA Police officers is 55 years, as per the Western Australia Police Industrial Agreement 2013 at clause 37.

employment as a police officer. The minimum earnings quoted was $100,000 and the maximum quoted was $3,500,000. The most frequently cited potential earnings was $1,000,000.

Some Members indicated they had absolutely no idea how much they would have earned had they not been medically retired, especially those who had been medically retired very early in their career.

Disability benefits

For those 138 Members who had been medically retired, 79 were currently in receipt of, or had received, the partial or permanent Government Employees Superannuation Board (or GESB) disability benefits. For those who answered that they were receiving (or had received) the disability benefits, the question was asked:

> "How much benefit do you, or did you, receive? If possible, please quantify what percentage your disability was assessed at."

Members indicated they received anywhere between 60 to 100 per cent of the disability benefit. Some Members received lump sum payouts, whilst others receive the GESB pension. For those receiving the lump sum payout at 100 per cent permanent disability, the range of payments fell between approximately $50,000 and $428,000.

Of those who were receiving the disability benefits, only 8.97 per cent (or seven respondents) believed the benefits were satisfactory. Respondents who did not feel the GESB benefits were satisfactory were provided the opportunity to discuss why they felt disappointed with their 'reparation'. Overall, the sentiment was that the benefits paid out did not match the cost of living increases, did not compensate adequately for the lifelong impaired ability to function normally and did not cover the associated medical costs.

Members noted the following:

- "$55,000 did not go very far, [especially] when I had to pay my own medical bills after being discharged";
- "The payout does not reflect the years and type of service provided by me to the community";
- "After paying off mortgage, not much was left to survive on";
- "I was retired at 35 years of age. Unable to work. GESB worked out to be [about] $150,000 including my superannuation contributions. That equates to $5,000 per year until retirement at 65 years of age, or $96 per week";

- The “GESB pension does not allow any form of employment to earn extra money to compensate the shortfalls. Any money earned has to be paid back dollar for dollar”;
- “$200,000 is just over two years of wages. I will have no source of income and believe I will never be employed again, [this is a] huge financial loss… It does not [adequately] compensate for the trauma suffered to myself and the flow on effect it caused my family because of my service to the community as a police officer”;
- “Because I was incapable of work I was then forced to access the funds I had set aside for my retirement”;
- “I am still totally disabled, my injuries are getting progressively worse. My prospects of employment are nil. [I don’t have] enough money to survive on”;
- “Even by investing it wisely, I couldn’t maintain the standard of living”; and
- “My lifelong career contribution to superannuation was supposed to be an income source that could be drawn on by me and my family to provide a comfortable income at a normal expected retirement age of 65 years. It is not and should not be used as a de-facto compensation scheme when a person is medically retired because of a work-related illness or injury”.

A number of respondents also noted that tax on any payment significantly reduced the benefits. For example, one Member observed they received “in total $76,000 before being taxed at 20 per cent, take off $15,000, leaves $61,000 which equates to $3,000 per year of service with WA Police”. Another Member, incapable of working as a result of their injury, noted that they had to access their superannuation fund in order to ensure they could meet the cost of living, but as they were not over 60, they were not eligible for tax concessions.

Re-engagement in employment

Respondents who were medically retired were asked if they had been able to re-engage in some other employment. Approximately 47 per cent of respondents to the question answered yes, whilst approximately 53 per cent of respondents to the question answered no. Respondents were then asked why they were not able to re-engage in alternate work. Overall, Members indicated that psychological incapacities more so than a physical incapability prevented re-engagement in the workplace. Nine respondents cited not being “mentally able” to participate in paid work, whilst eight respondents specifically noted that their PTSD prevented them from working. One Member noted they suffered from “chronic pain and associated chronic depression”, one cited “major mental health issues” and another indicated that working was not viable because not only were they were unable to communicate with people they didn’t know but they suffered intense paranoia when going into public

places. Other Members cited being bedridden with chronic pain and one Member had been diagnosed with a degenerative heart condition and was unable to be subjected to any stress or anxiety.

For those who answered that they were able to re-engage in other work, they were asked in what kind of work were they employed, under what basis and why they opted to undertake this work. Nine were able to undertake part-time work; nine were employed casually; only three were able to work full-time; two became self-employed; and two could only undertake volunteer work. The type of work that was undertaken by many of the respondents differed vastly from that of policing: required skills were basic; tasks tended to be menial; the pay was substantially less. Some Members noted they became security officers ("I needed to be involved in something that would prevent me from becoming a complete recluse… Through a friend, I found employment as a security officer at a remote Kimberley mine site… This was the only work available at the time"), caretakers, groundskeepers or bus drivers.

Members noted that whilst re-engaging in some kind of work was vital to not only their finances but for maintaining a sense of inclusion and worth, often their illnesses were prohibitive in the type of work they could obtain. One respondent noted that they were a "Ranger at Whiteman Park for a short time but was unable to continue due to illness contracted whilst employed at WA Police". Another respondent noted that it took them six years to regain employment, despite "literally [hundreds] of job applications… I eventually found work in the clerical [industry]" but at a lower salary than they were receiving at WA Police.

Work-related illness/injury claims

Members were asked approximately how much they believed WA Police has paid for their individual work-related illness or injury medical claims. A majority of respondents indicated nil/nothing/zero. Despite the fact that the Former Officers' Medical Benefits Scheme restricts access to retired Members before 1 July 2007, WA Police has historically covered the work-related illness costs of serving Members. The 'nothing' response is, consequently, perplexing but there *are* a number of reasons as to why 'nothing' was noted.

The first explanation is that the respondents have not understood the question and have answered with respect to the provision of compensation for medical claims *post-service* (and either have not accessed or are not eligible for the Former Officers' Medical Benefits Scheme). Another explanation to this response could be that respondents are not eligible for the Former Officers' Medical Benefits

Scheme and are genuinely not having any work-related medical expenses reimbursed. Finally, the 'nothing' response could be explained by a trend of which WAPU is becoming increasingly aware. Many Members do not wish to disclose certain medical conditions to WA Police (often arising from a fear of being classified as non-operational or jeopardising their career prospects) and are therefore not filing claims with the Agency for specific medical treatment. Alternately to this, there are Members who noted that difficulties faced during the claims process have prevented them from claiming all work-related injuries/illnesses with the Agency (for example, "[WA Police] have made it very difficult for me to substantiate the claims. I have had to jump through hoops").

Members were then asked if there were any expenditures pertaining to their work-related injury/illness that WA Police had declined to pay. From the feedback, a trend emerged about Members paying for their own medical expenses without claiming them through WA Police because of the aforementioned issues (difficulties faced during the claims process and/or concerns about the perceptions of colleagues towards certain medical conditions). The following was noted by Members:

- "I haven't claimed for some medication which is my own fault. I did use to attend counselling once a week which is what I am supposed to be doing but other people started to comment that I was milking it so I gave it away. That isn't the [fault of WA Police] but there are very narrow minded people that just do not understand";
- "In the end it was easier to pay my own way. No bureaucratic hurdles";
- "[Health and Welfare Services] refused to pay for full PTSD Recovery Program run over 16 weeks. Paid for a 3 week program only";
- "I ceased further psychological treatments due to payments being refused by WAPOL. This was contrary to the police psychiatrist recommendation"; and
- "I am reluctant to seek any further assistance from [WA Police] because I felt belittled by previous experiences and felt that I was not being believed about the levels of pain I was experiencing. I am concerned that [WA Police] is only interested in reducing costs and removing me off the active SIMR incident list. I felt my integrity was being questioned and I was at risk of being labelled a malingerer. I have a high level of personal pride in my reputation and will persevere with these injuries without seeking assistance rather than risk this".

Some respondents expressed concern that WA Police medical practitioners give the impression they are more concerned with costs to the Agency than the treatment of the injured officers.

Pursuing a legal remedy

Respondents were asked if they had previously pursued any kind of legal remedy for their illness or injury (for example, Criminal Injuries Compensation, ex-gratia payments or motor vehicle claims). Almost 140 respondents answered that they had previously pursued a legal remedy and were given the chance to elaborate. Of those respondents, just over 80 per cent were successful.

A number of respondents went on to specify what they had secured. Fifty one Members had received some kind of Criminal Injuries Compensation, though many noted that the compensation rewarded was insufficient and did not adequately acknowledge the extent of damage (both physical and psychological). Twenty three had secured some compensation through a motor vehicle accident injury. Only two Members had successfully applied for an ex-gratia payment (but were bound by confidentiality to elaborate further) whilst three Members had their ex-gratia payments refused.

The physical and psychological traumas suffered by WA Police officers in the line of duty

Stories from the frontline

When respondents were asked to describe the circumstances that led to their illness or injury, they were also asked to include details about the number of traumatic incidents they attended during their career, whether they worked in a frontline or support role, and the type of incident they had experienced (for example, fatalities, assaults or natural disasters). Respondents were further asked to describe their illness or injury.

The response was overwhelming – 450 Members provided details about their illnesses/injuries and the circumstances that led them to their incapacitation. Members reported involvement in a number of harrowing incidents across their policing career, with virtually every respondent noting that they had been involved in some capacity with death (attending fatalities, notifying family members of deaths, cleaning up crime scenes). Many involved:

- Witnessing deaths or dead people (172 responses), fatalities (52 responses), sudden deaths (94 responses);
- Witnessing the aftermath of suicides (104 responses);
- Assaults, on the officer themselves or on another person (121 responses);
- Car crashes and serious traffic accidents (134 responses);
- Murders/homicides (105 responses);
- Serious accidents (78 responses).
- Incidents involving children (78 responses);
- Post-mortems, which seem especially prevalent in the country (17 responses); and/or
- Rape (10 responses) or sexual assault (17 responses).

Some Members attempted to quantify the critical incidents they had attended over their career; whilst some only noted the most traumatic they had endured, others believed they had attended anywhere between 50 and 400. Many noted that the number of traumatic events they had endured was countless: one Member said that the "number of traumatic incidents is something a police officer does not record" whilst another observed that "even a Constable of a few years' experience is unlikely to be able to count how many traumatic incidents they have attended".

Possibly because of the vast number of traumatic incidents attended by police over their career, hundreds of respondents seemed unable to elaborate on the circumstances surrounding specific

critical incidents ("it is near impossible to list every traumatic incident I have attended"; "can't give exact number of traumatic incidents that I have had to attend to"; "too numerous to mention, I do not keep a log of these things"; "the list is too extensive"). Many simply noted "numerous fatalities from traffic accidents/sudden deaths/murders/suicides/domestic violence". Others wrote that elaborating on any details would be "too painful", "too distressing" or "too disturbing". Virtually all noted that they could remember faces, smells, locations associated with the incident, for example:

- "A 14 year old boy fell into a wheat bin from which his father was elevating wheat into his truck and drowned in the wheat. I tried mouth to mouth resuscitation, but he was dead. I can still taste the wheat as I type";
- "The death of this little boy is as clear in my memory as if it happened yesterday";
- "I attended numerous fatalities and sudden deaths as part of my duties. This led to flashbacks and reliving violent arrests, so that my wife did not feel safe sleeping beside me due to violent kicking and punching by me in the night in my sleep";
- "This question is almost impossible to answer, I do not know whether to laugh or cry, I am constantly bombarded with horrific flashbacks which physically paralyses me, cause me to vomit and cry uncontrollably. Some flashbacks are just that, a flash of a mental image and then gone leaving me confused asking myself what was that? As a [general duties] officer I was faced with multiple human atrocities";
- "To this day, I get flashes of that accident [involving an 18 month old child]";
- "I think about these incidents weekly and often get nightmares"; and
- "Both the fatal traffic accidents and the murder scenes were very traumatic in their visual impact, which has lasted with me until this day and I constantly have flashbacks to those incidents".

Whilst every Member account is compelling and meaningful, this report does not have the capacity to elaborate on every narrative. As such, the following accounts are merely a sample of responses received. They are not more or less outstanding than other incidents that were relayed to us but are representative and indicative of many of the responses we received from Members. WAPU has not used Members' names and other identifying factors and as such, they have been modified where necessary.

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WARNING

READER DISCRETION ADVISED

Readers may find the following information disturbing. If you experience any persistent feelings of anxiety, depression or associated symptoms, please immediately contact your healthcare professional.

Member A

Member A is a serving male Senior Constable who has been employed by WA Police for 14 years. Member A has worked in general duties and forensic investigation for the majority of his career. The following details are in his own words.

Circumstances leading to illness/injury

"Working in Forensics, it is our role to investigate all types of incidents from minor to major. It is the nature of attending incidents that involve violence and death that affect me the most. Homicides, sexual offences, SUDI (child deaths), drug overdoses, sudden deaths, suicides, animal related deaths, sexual related deaths, work related accidental deaths, fatal traffic accidents (and all the other tasks in between because the ones above only make up a small part of my day). Our role of recording scenes, dead bodies, injuries, evidence collection and determining if incidents are suspicious or not means we literally get our hands dirty as we handle exhibits, biological material, bodies, body parts, et cetera.

Here is a snapshot of what I have done since 2010. This is off the top of my head, some I can remember but I know I've missed a lot because I have blocked them out. There are many more from the previous years but I cannot recall them all. I would estimate I have dealt with over 50 or more death related incidents in the last few years.

1. Seven incidents of SUDI (Sudden Unexplained Death of Infant). Self-explanatory, not pleasant. Two SUDIs were back to back incidents on two shifts in 2013.
2. Five homicides – All stabbing incidents – all violent bloodshed incidents.
3. One recovery of a man bitten in half by a great white shark, the top half of the body washed up on the beach and we had to record, handle and bag him.
4. One auto erotic hanging death where a man was hanging for numerous weeks, strung up on a wooden frame over his bed with numerous sex toys, including machines penetrating him. He was so decomposed and swollen that my partner and I had to actually *pop* him to let the gasses out. This was the most horrific thing I have ever seen, smelt or had to do in my life. It took hours just to figure out how to deal with something so disgusting. I have actually pin pointed this incident as the moment it changed me, it has and will have a long lasting effect on me.
5. A train death whereby a young male was run over by a train and torn into pieces. I did not do the scene but I had to go to the hospital, my partner and I had to find an arm amongst all the pieces in the body bag. Once we found the arm we had to fingerprint it for identification purposes. And yes it was as bad as it sounds.

I cannot even recall just how many fatal traffic crashes and serious road accident incidents– I can't recall how many dead people I have seen and how many body parts I've handled when dealing with fatal crashes. Some examples:

- A man was run over by two road trains, I had to photograph the trucks and collect the body parts from under them. His shin bone was stuck through the sump of the engine, so once I had done that I had to do the body and scene;
- Another man had his head run over by a truck and his brain was located a few metres from his body;
- Countless young dead males on motorcycles have been dealt with.

I have dealt with numerous work related death injuries – one example, a man fell off a fork lift while washing his truck at height, the large pallet fell off the fork lift onto his head and popped it. I had to record the scene then while at the hospital deal with the family. I was there with them looking at the dead body in the emergency room with his head open and what looked like the entire contents of his circulatory system on the floor of the room.

I have dealt with numerous drug related deaths – one example, first shift for me waiting at 7am on New Year's Day was a 22 year old female drug overdose victim. There have been innumerable sudden deaths – hangings, gunshot suicides, gassings. Some clean and some very, very nasty. These are but a few of many examples that make up my job.

I was at an awards ceremony where three officers were presented an award by the Police Commissioner for an outstanding job in dealing with seven or eight critical incidents in a nine month period in their town. Now this is a great effort by them and I'm not taking away from them what they did because I know firsthand what these jobs are like. What amazes me is that in a one year period I would deal with that 10 times over. I don't need or want an award, I would settle for a 'thank you' and 'a job well done' once in a while.

Up until recently, attending fatal and serious crash scenes at our office was optional and we would do it to help out traffic if we were available. Recently though our Inspector has made the ruling that we as Forensic Officers will attend all fatal and serious crashes in our district (at all hours of the day). The logic is that we go there to photograph the scene, the reality is once you're there you know you will be lifting bodies, picking up parts and so on. I understand that the job has to be done, what I don't understand is how they do not see the downside of exposing us to more incidents of death (the

unfortunate reality is they don't give a shit). On top of all the other horrific things I see on a weekly basis, mutilated bodies in road traffic accidents is one I don't want or need to add to the list.

I sometimes get an email after a critical incident, I have also seen a counsellor on a few occasions but the reality is that if the next day and the day after that I am again exposed to horrific scenes what am I supposed to do? It seems that you are treated like a robot, no one really cares about your state of mental health. I have to manage it myself and I have done so quite well, I know what I need to do to de-stress. The reality is that this job will turn you into an ice block if you let it you will become cold, void of emotion but I don't want to be like that."

Details about physical or psychological illness/injury

At this point in time, Member A believes he does not have an identified psychological illness but he is curious to know how this will affect him later on in life and what WA Police will do then. Member A acknowledges that in the last two years, the cumulative effects of the job have worn him down. He says that he doesn't have a medically diagnosed illness but feels that sometimes it's hard to deal with what he does. Member A says he is merely serving his community yet he is being exposed to things regular people don't and wouldn't be able to deal with.

Member B

Member B is a serving female Senior Constable who has been employed by WA Police for more than 25 years. Member B has worked in general duties for the majority of her career. The following details are in her own words.

Circumstances leading to illness/injury

"The number of traumatic incidents have been too numerous to list. They occurred on nearly a daily basis whilst performing general duties. It appeared that whenever there was an involved or traumatic incident, especially one that was [charged with emotion], I was directed to attend due to my experience and ability to handle pressure and apparent calmness with members of the public. It was a standard joke at all my stations that whoever worked with me would be directed to attend all the sudden deaths, domestics and violent assaults, in particular sexual assaults. [On almost all of these occasions] I was with junior officers, as they were partnered with me by the supervisors for experience. Incidents that stand out in particular are:

1. Having a 13 year old girl die in my arms after being hit by a vehicle and having to deal with her 10 year old brother who witnessed the accident and her mother when she arrived on site;
2. Witness a female pour accelerant over herself, turn and smile at us as we were running towards her yelling and then set herself on fire. We were forced to run down the hill after her stomping on spot fires in order not to prevent a bushfire;
3. Being first at scene to find male person lying on his lounge room floor screaming as he attempted to shove his intestines back into his stomach after an offender had slit him open [with a knife] as a result of a domestic;
4. Walking along a railway track picking up pieces of body after a male person had committed suicide by walking in front of a speeding train. We were instructed to keep count of all body parts to ensure we did not miss any. [I then had to] take a statement from a witness who was visibly upset to the point of throwing up. I was required to comfort him until he was in a fit state to provide the statement;
5. Take a statement from a six year old girl in Princess Margaret Hospital who had been so violently sexually assaulted by her uncle that she had undergone emergency surgery;
6. Attended Fremantle Hospital re the sudden death of [a high profile individual] and then spoke with his wife, son and brother to gain further information to complete the paper work. They were still at the hospital. Due to the circumstances preceding his death, they were extremely anti-police. I felt extreme pressure with it being so political and newsworthy;
7. Attended traffic accidents which resulted in serious injuries;

8. First responder to two attempted murders in Willetton whereby a male had attacked his mother and father in law with a large knife. Both elderly persons were lying on their driveway and in the middle of the road where they had been trying to escape. He had caused enormous open wounds to both of them. I again was with a junior officer. There were a crowd of people who had gathered in the street. I organised assistance for the two injured persons and then apprehended the offender and secured the weapon. After the initial inquiries were conducted by the detectives, I was then directed to remain inside the house overnight to guard the scene. There was blood throughout the house and visible signs of a struggle and bloody handprints;
9. Attended a suicide at a home where the children had returned from school to find their father handing in the garage. We were required to cut him down, complete all paper work as well as caring for the children until their mother arrived, then advise her and organise assistance for her from relatives;
10. Involved in an incident where a father murdered his three children by hitting their heads with a hammer, then slitting their throats over the bath, dressing them in their pyjamas and putting them back to bed. His wife returned home and he directed her to the children to see what he had done. He then murdered her in the same fashion, put a nappy on her, dressed her in pyjamas and put her to bed. He then slept in the same bed overnight. The next morning he wrote all messages over the wall in their blood then stabbed himself in the groin. Called police advising them that there had been a home invasion and the offender had killed all parties;
11. Whilst on patrol, located a teenage male lying in a park on his back who had died due to swallowing his own vomit. I then had to complete the death notification to his distraught parents;
12. I have performed innumerable death notifications;
13. Attended St Johns in Murdoch just before Christmas for a sudden death where a mother and baby had both died during the birthing process. I had to inspect both the mother's and baby's body and then speak with her husband who was still at the hospital with their three year old daughter who was continually asking for her mum. This incident really affected my junior partner. On returning to the station I spoke with my supervisor in regards to him receiving assistance and booking off on sick leave;
14. Attended a cot death incident and experienced difficulty in removing the baby from the mother's arms;
15. I was assaulted by an extremely large Middle Eastern male who had threatened to kill his de facto. This resulted in injuries to my jaw, knee and shoulder which eventuated in two lots of shoulder surgery. This has resulted in a permanent disability where I am unable to put my

right arm behind my back, causing me to be non-operational as I am unable to access my firearm effectively.

These are just the incidents I can recall readily to mind. There are so many more. To this day I can still see the faces and smell the odours."

Details about physical or psychological illness/injury

Member B was first diagnosed with depression in 2000 and has been on medication since that date. At that time, Member B felt she had no future and the prospect of going to work would only result in having to deal with people and their problems, problems she felt she was expected to solve without any support services or assistance. The medication allowed Member B to outwardly appear that she was coping but inside she still felt at complete odds. Eventually, her marriage disintegrated which only resulted in additional personal problems. Approximately three years ago, Member B began to have increasingly vivid and violent nightmares all with the common themes of the jobs she had attended over her career. She would awake screaming, as she could see their faces and smell the odour of blood and bodies. On a couple of occasions, Member B awoke so terrified she would run, only to collide with the bedroom wall and knock herself unconscious. In the end, she was refusing to go to sleep for fear of the nightmares and even when she fell asleep, it was so disrupted. This resulted in a mental collapse, where Member B was physically unable to leave the house, answer a phone or make even the smallest decision.

Member B refused to socialise and was totally dysfunctional. She was prescribed sleeping medication by her GP and stronger anti-depressants, which was of little assistance. She was eventually referred to Health and Welfare Services by her GP, as she was at the point where she had attempted suicide. She was provided counselling, which eventuated in a consultation with the police psychiatrist. Member B was diagnosed with PTSD and prescribed medication. She was on sick leave for approximately 12 months and then returned to work on a return to work program. This was in place for approximately 12 months.

Member B is currently on psychiatric medication. A couple of times she has attempted to reduce it, however symptoms reappear. Member B is devastated that she will probably be required to take this medication (the same which she says is prescribed to Vietnam Veterans) for the rest of her life.

Impact on her life

Member B definitely believes that everything she has witnessed and experienced has impacted her family. Prior to separating from her husband, her eldest son attempted to commit suicide. Member B notes that even seven years later, her son still speaks of issues the family was faced with whilst Member B was an operational officer dealing with trauma. Member B is now divorced from her husband. Her relationship with her two eldest children is damaged. She lost friends and family relationships were affected, including that of her parents. However, Member B says that when all of her private life was imploding, she would attend work and perform her duties professionally to such a point that no one was even aware of the difficulties she was facing. She notes that she actually received a number of commendations during this time for the level of service and dedication she provided to the community.

Member B believes there is definitely a stigma attached to being non-operational and having mental issues. She feels she has to work twice as hard as any co-worker to be accepted and even then, she feels 'substandard'. This is a pressure Member B feels on a daily basis and she physically fears taking any further sick leave. She worries about obtaining another position when her tenure is up, in particular, the lack of non-operational positions which tend to be filled with operational personnel. Member B feels after all the years of service she has given to WA Police (in fact, she feels as if she has given her soul), none of it is appreciated or even acknowledged. Member B believes you are judged on how you are at this point in time, not what you have given over all of those years: years of shift work; not always being there for your children, family and friends. Looking back, Member B truly wonders if it was worth it or if in the end, you are considered a disposable item with a use by date. Member B feels there is always that sense of isolation when you are suffering from mental health problems and the fear of losing her job hangs permanently over her head now that she is non-operational.

Member C

Member C is a serving male Senior Constable who has been employed by WA Police for more than 18 years. Member C has worked in general duties for the majority of his career. The following details are in his own words.

Circumstances leading to illness/injury

"I have been run down by a stolen car in Northbridge, where I sustained a broken left femur and several broken ribs. Nightclub security guards needed to form a ring around me to stop nightclub patrons kicking me while I was seriously injured on the road. It took two years of rehabilitation and recovery, working light duties and having further operations. I suffered severe PTSD for a long time after that.

I have also attended countless fatalities. The first one I recall is a 17 year old female, it was the middle of the night in darkness and I was shining a torch on a crashed vehicle which was half way up a tree with the female hanging out pinned from her waist hanging upside down with the top of her head cut off. I went home later that morning and realised I had parts of her brain all over the sole of my boots – I spent an hour cleaning it all out.

I remember an 18 month old being given CPR on the side of highway while the father lay trapped in the vehicle and the mother was also being given CPR. The child died on the roadside, I drove the ambulance to hospital (approximately 70 kilometres away) whilst the mother was being given CPR all the way by a lone SJA volunteer - I believe the mother survived. I had an 18 month old boy at the time.

I remember a man who crashed his vehicle into a bridge barrier, which speared through the vehicle pushing the front driver's wheel and driver into the back seat. I talked to him for a while before he became lucid. After some time he was extracted where I was then required to use cling wrap to wrap around his ankle to keep his foot connected to his leg. He died the following morning.

I also attended a crash where a young boy was on the side of the road, his dad lay dead nearby and the boy was asking if his dad was ok. There was another crash where a nine year old girl was in the front passengers side of the vehicle which had side swiped a tree. Her head impacted with the tree completely smashing her head open throwing her brains on to the road. I picked parts of her brains up and placed them in a plastic bag. I then later lifted her body out of the car and placed her into a

body bag. The whole time her 19 year old brother was in the back seat screaming from severe head injuries while being treated by paramedics.

I attended an excavator rollover, performed CPR on a male person who was later pronounced deceased at scene. I had to attend a prison where there was a collapsed prisoner, I performed CPR/EAR for 45 minutes and managed to bring him back to life but he died the next morning. I remember a crash with two elderly people, both of whom were alive at the scene. I performed first aid, the male survived just long enough to see his wife receive first aid and was being looked after, and then he died. His wife died two hours later in hospital.

I would estimate I've attended 80 to 100 serious and fatal crashes, not to mention other serious incidents, which carried significant stress."

Details about physical or psychological illness/injury

Although Member C says he didn't know it, over the years he developed severe chronic depression and anxiety disorders. It wasn't until 2007 that he was medicated for depression. In 2011, Member C suffered a massive breakdown requiring three months off work and a month in a psychiatric hospital for intense treatment. He also says he has a five per cent permanent disability in his knees from injuries sustained after being struck by a stolen vehicle.

Impact on his life

Member C says that his depression worsened over the years, which ultimately led to the end of his 17 year relationship with his wife. His two boys no longer live with him. His anxiety means he misses out on many special events as he is too anxious to attend them. Member C says that his behaviour at times appears odd to some people, which has led to the loss of some friends and being ostracized by colleagues. He hasn't seen many of his family members for many years due to anxiety issues.

Member D

Member D is a serving female Senior Constable who has been employed by WA Police for more than 24 years. Member D has worked in general duties and coronial investigations for the majority of her career. The following details are in her own words.

Circumstances leading to illness/injury

"Listed below are some of the most traumatic incidents that I have attended:

1. Putrid sudden death in caravan in summer, body juices leaked through mattress on to steel box underneath, this had to be wiped to gain access as firearms were suspected, smell horrendous, breathing apparatus from DFES were used by me to further search caravan after body removed with scalp falling onto floor. Further attended at morgue to take photos and lodge body. I had nightmares for weeks over this one;
2. Stolen motor vehicle drove at high speed towards our stationary police vehicle, I was the passenger, it veered off at the last second, I genuinely thought I was going to die;
3. Charged a 16 year old boy for a fraudulent trick, within an hour of police involvement he committed suicide by hanging. My partner and I were ordered to attend at home address and speak with parents as it was suggested we were somewhat responsible;
4. Whilst working at East Perth lock up, I was king hit from behind whilst processing an arrest, knocked to the ground heavily;
5. Removing violent arrest from rear of security van, kicked violently in chest, fell heavily backwards smashing my head on a raised concrete edge, which caused injuries to neck, upper back, suffered blurred vision for several days. My neck and shoulder still give me problems;
6. Aboriginal domestic, violent stabbing of female, she was trapped in toilet/laundry, stabbed numerous times , huge amounts of blood, smell was horrendous;
7. Stabbing of male in domestic, blood everywhere;
8. Attempted suicide of teenage girl by slashing wrists, still armed with knife, very tense situation;
9. Watermans riot, first on scene, rocks, bottles, bricks thrown. Back-up required, riot shields, helmets were needed to disperse out of control crowd, had rocks, bricks, bottles thrown at police;
10. Suicide of a Sergeant at Warwick Station (where I worked), he was under investigation, he could not cope with the scrutiny;
11. Innumerable death notifications;

12. Toddler drowning, very traumatic, hysterical woman collapsed, had to comfort her until ambulance officers took her to hospital. This event had a profound effect on me;
13. Murder of young mum in Newman by her partner who had bashed her to death, had to search body at morgue for injuries. Quite often I think of this one;
14. Young Aboriginal girl killed in accident near Jigalong, lodged body at morgue;
15. Newman plane crash, my partner and I had recently transferred out of Newman Station, we knew some of the police Officers killed, one of the officers had moved into our old house. Two other police officers first on scene, a Sergeant and a Constable, resigned due to the trauma suffered and lack of support from the Department. As they waited in the searing heat for support, they watched their dead colleagues start decomposing in front of them, I believe they suffered PTSD - they were broken men;
16. Living in Newman as police officers, we lived opposite an Aboriginal family. We had a terrified female and baby at our house in the early hours seeking help as her partner had threatened her. As police officers, we let her and her baby into our home for safety, but also feared for the safety of my daughter. The male person was ranting out the front of our house to let her out when the on duty police officer arrested him. This male person some weeks later murdered someone at the caravan park;
17. Unusual sudden deaths of two Russian men en route to Australia on a ship. The ship stopped at Geraldton, my partner and I attended took statements and removed the bodies, which had been placed in a freezer. The bodies had to be lowered off the ship by a hoist due to their frozen state;
18. Attended the death of a fellow officer. I was one of the first officers on the scene, he had broken his neck in a trail bike accident in the sand dunes. His wife turned up shortly afterwards – it was absolutely heart wrenching. We waited in the hot sun for some time for a body bag and a suitable 4WD. We watched his body blow up due to heat. I suffered terribly following his death. Kept on going over it; if only we had got there quicker. At his funeral, his wife said he helped everyone but help came too late for him when he needed it. I still live in Geraldton and to this day every time I look up the coast and see the sand dunes I am reminded of him. Approximately three weeks later, I applied for leave without pay for twelve months due to the stress associated with his death – I just finally broke down;
19. I acted as a relief Australian National Child Offender Registry (ANCOR) officer, where I dealt with paedophiles. I was made aware of gross sexual acts committed on children and babies;
20. Involved in investigation of coronial matters, dealing with grieving people, taking statements. I have been involved in: cot deaths; toddlers killed accidentally in driveways; suicides by

shooting, hanging, prescription drug overdoses. The worst one was a young boy, 16 years of age, he hung himself at his family home. I took statements from the mum and dad the following day at their home, mum and dad were a mess and the older brother. Once I finished hours later I was emotionally numb;

21. Have to strip bodies at the morgue, opening eyes and mouth to take photos, lifting head to photograph rope burn, due to hanging;
22. The incidents that front line police face day after day is unrelenting. I have attended hundreds of domestics, seen abused and neglected children, witnessed fights, and seen people severely affected by drugs and alcohol who are violent. I have had to deal with violent prisoners, I've had to strip search drug affected, diseased individuals who verbally abuse and make threats against your family. The very real threat that back-up will not arrive in time in very hostile situations is extremely frightening, the real fear that you could be seriously hurt if not killed on duty is extremely stressful.

I have found just recalling these incidents as exhausting, I know there are others but I can't recall them presently."

Details about physical or psychological illness/injury

Member D suffers from depression, anxiety and PTSD. She says she has suicidal thoughts. Her paranoia is extreme: she thinks everyone is against her; she is agitated all the time; she gets startled easily, hearing noises behind her which are nothing. She often thinks of dying and what sort of funeral she would have. Member D suffered endless stomach problems for months – she was put on antibiotics several times for so called stomach infections, presented at emergency in extreme pain, had tests and was told eventually she had a benign abnormal growth. To this day, Member D believes the growth was stress-related, given she felt there was no other medical explanation.

At points in her career, Member D felt like her life was spiraling out of control. After she went to the doctor and told him she was not coping at all, she got a week's sick leave for burn out syndrome, yet after a week she was back at work. Member D exploded at home at what she feels was at her lowest point ever. She lost it and violently self-inflicted injuries by punching herself repeatedly to the face and head, which she said was done in front of her partner and children, who were distraught to see their mum in such a state. The following morning, Member D again lost the plot after heated words with her partner about the night before, so she picked up a hard plastic toy from the table and smashed it over her head. Blood poured out everywhere yet she refused to go to the hospital as she didn't want anyone to know in her small country town because the shame would be too much.

Sometime later, when Member D was relieving as a Coronial officer, she was overcome by a sense of loss of control, she knew she could not take it anymore, so she booked off sick. In 16 months of sick leave, she has been taking anti-depressants, her emotional/mental state is still fragile and she still suffers from extreme anxiety anytime she feels any normal life pressures.

Impact on her life

Member D says that as a human being, you can only take so much unrelenting confrontational, violent behavior from others and be exposed to death and trauma, child abuse and neglect. She feels like the job finally broke her and is feel saddened at the effects it has had on her life and the lives of her children. Member D believes she is at a better place now and she realises how dangerously close she was to the edge and how well she hid it from others.

Member E

Member E is a male who left WA Police as a Senior Constable after almost 17 years employment. Member E worked traffic duties for the majority of his career. The following details are in his own words.

Circumstances leading to illness/injury

"With hindsight, as a teenage police cadet from 1976 to 1979, I was allowed to see too much violence and too many traumatic events whilst stationed at Midland Traffic Office, Midland Police Station and Northam Police Station. I was keen and very eager to please, and I don't think I should have been allowed to do half the things I was allowed to do. In particular, work in the station lockups, accompany officers on patrol as an observer, seeing significant violence and attending serious traffic accidents, some fatal, and attend numerous post-mortems. I have teenage children now and would be disgusted if WA Police allowed young teenage police cadets to see and do the things I did back then. I had originally thought my police cadetship was to strengthen my police career, but in reality I think it set me up to fail.

Earlier in my police constable days, like everyone else, I worked alone a lot of the time. On one occasion I was assaulted by 12 people, on another fought for my life on the side of an east-west highway, on another fought armed offenders leaving a bank hold up whilst I was alone and unarmed. For the rest of my career it was just going from fight to fight, accident scene to accident scene, driving fast to this emergency then to that emergency, chase this car, chase that car. There are too many traumatic events to detail, yet none would be out of the ordinary for most police.

I also have big blocks of time that don't exist in my mind. For example, I worked in the Traffic Accident Branch for some time and don't recall any accidents I attended there. I remember the red phone from St Johns Ambulance, but none of the accidents. I am told I have blocked a lot of trauma out. I have similar block-outs at other stations I worked at, in particular the several years I worked night shift traffic in Perth. I had a nervous breakdown and spent my 25th birthday and three months in a government psychiatric hospital. I was just drugged and never had any psychological counseling. Prior to my hospital stay, I had visited the police doctor's office 28 times over a two odd year period for a variety of injuries and stress related symptoms but remained operational during all that time. Most other officers tell me they are medically retired or deemed non-operational after becoming so unwell. In my case, around six months after leaving hospital I was medicated and sent back out to the police frontline to do it all over again, driving pursuit cars and carrying a gun."

Details about physical or psychological illness/injury

In 1993, Member E was medically retired with what he refers to as “an anxiety state”. In 1991, six and a half years after commencing psychiatric medication, Member E found out he was taking a prescribed medication that is highly addictive, impairs driving and reaction times and that he should have only been taking it for (at most) four weeks. This has likely compounded a lot of the trauma he has witnessed.

In 2014, Member E was told he suffered from PTSD as a consequence of his police service. More than 20 years after being medically retired, Member E says he is now working on his mental health with the Hollywood PTSD Clinic. Member E feels that it is the first time in his life that anyone has taken the time to ask him to detail the things that have happen to him as a police officer. At all other times, especially when he attended the WA Police doctor’s office, Member E was made to feel like the only problem in the room was him. The Hollywood Clinic has reviewed him and his medical notes over many months and told him he didn't stand a chance from very early on in his career and that not many people would have survived what he has been through.

Impact on his life

Member E acknowledges that he is lucky his wife has been very loyal and his marriage has stayed intact. He can't say the same for his mother, who he is now estranged from and has been for many years. He believes she found it very hard to understand what happened to him. Member E says his life is not like it was before: he used to hold parties at his house and have a wide circle of friends but today, and for the last 20 years, he does not socialise with anyone in his street or extended family. He does not accept any offers to social events as he knows he will struggle. It has only been in the last two to three years Member E feels he can venture briefly to the shops. He finds his nervous system gets very easily overloaded with noise, lights and movements. He also finds multiple conversations hard to follow with more than two people, which makes his attention span quite limited.

In 2008, Member E’s ex-gratia application lodged by the WA Police Union to then Attorney General Christian Porter was rejected.

Member F

Member F is a female who left WA Police 10 years ago as a First Class Constable after nearly 18 years employment. Member F worked general duties for the majority of her career. Though the following is in her words, a fellow former police officer had to complete Member F's survey responses due to Member F being very unwell.

Circumstances leading to illness/injury

Though not as detailed as some of the other Member recollections, Member F describes answering this question as being "impossible to answer. I do not know whether to laugh or cry, as I am constantly bombarded with horrific flashbacks which physically paralyses me, cause me to vomit and cry uncontrollably. Some flash backs are just that, a flash of a mental image and then gone leaving me confused asking myself what was that? As a [general duties] officer I was faced with multiple human atrocities. Being female also required me to take part in some extraordinary policing. Just when I thought I had seen it all - B A M - another shocking job, worse abuse or worse injury, worse pain, worse, worse, worse".

Details about physical or psychological illness/injury

Member F believes she has been suffering with psychological illnesses for 18 years. Member F says that she does not want to disclose her exact physical and psychological symptoms as she is too ashamed to do so. Member F gives two examples only of her illness: she sucks her thumb when she sleeps; and she wets her pants (no matter where) if someone yells at her.

Impact on her life

Member F is completely estranged from her family. Her husband left her seven years ago, and though she describes him as a wonderful man, husband and father, he became exhausted by her illnesses. Member F describes herself as follows:

> "I am 43 years of age. [I am] very unwell and unemployable. [I am] homeless. [I am] estranged from my beloved family. [I have attempted suicide twice] – one suicide note detailed my cause of death as being due to joining the WA Police. [I have had] two years of accumulated psychiatric hospital stays. [I am] on multiple medications. I can't remember what I did yesterday. [My mind is full of] horrific flashbacks. [I am] completely isolated and disconnected from normal society and the life I should have had… I have problems managing the very little money I do get as I can be forgetful, compulsive and obsessive".

Further examples of traumatic incidents experienced by Members

Member M was a police officer for more than 33 years. He says that in his career, he attended numerous traumatic incidents on the frontline, including: suicides; fatal traffic accidents; high speed chases; having a rifle leveled at his head by an offender whilst in the Tactical Response Group; and involvement in quelling riots. In his capacity as the Senior Investigator for the Coroner, Member M was involved in investigating over 100 deaths in all manner of circumstances and dealing with grief stricken relatives. Member M attended numerous traffic crashes and in one incident, he thought he had accidentally killed a baby in a bassinet. All these incidents had a cumulative effect on Member M, to the point where he had a breakdown in a regional posting. During that time, Member M describes having serious thoughts about murdering a senior officer who had no appreciation of the immense workload he was carrying as the Senior District Prosecutor for his district. Member M, who was medically retired, says he is estranged from his family and friends and was diagnosed with PTSD, which he was told upon diagnosis he had probably been living with for 13 years.

Member N has been a frontline officer for more than 11 years. Member N has attended numerous fatalities over the years. Member N said that one involved a nine year old girl who had been semi-decapitated when her mother's vehicle hit a tree. Her brother was trapped in the same vehicle with serious injuries. The trauma he suffered to his head caused brain damage. Member N could hear it in his cries for help and believes it was the cry of a mentally impaired person. Member N describes another crash that involved a man impaled on a bridge barrier. Member N says the man was still conscious when the Member first arrived and the Member held the man's hand through a broken window, while gripping the vehicle with their other hand and trying not to slide down an embankment into the river. Member N describes other traumatic incidents: a truck derailment which killed two people in a passing vehicle; a woman who decided to kill herself by throwing herself in front of a truck travelling at 100kms per hour; a woman who drove her car directly into a truck travelling at 100kms per hour; a fatality where a motorbike rider turned into the path of a truck, travelling at 100kms per hour – his helmet was found 50 metres away from his body. Member N drinks too much, has trouble sleeping without the aid of alcohol, gets angry over silly things and sometimes can't stop crying.

Member P is a serving officer, with more than 24 years' experience in general duties. He says he has experienced too many traumatic incidents to list them all. Member P remembers a violent murder scene where the offender had slit the throat of his step mother and left her to die slowly in a pool of blood, and the victim left claw marks in the pool of blood on the floor as she attempted to drag herself to help. Member P also recalls a murder scene in a remote community where the heavily pregnant

victim was thrown into a fire. He remembers another murder scene where an angry daughter used a vehicle to run down her family members, killing her father. Member P recalls nine fatal crashes in one year on Wanneroo Road, one of which a teenage girl was impaled by a tree branch and her sister was ejected out of the car, hitting her head on the road so hard her brain was forced out onto the road.

Member Q is a serving officer who has worked in crime for the majority of his 29 year tenure. Member Q believes his deteriorating mental health began when he experienced both a death in custody and the Geraldton riots of 1988-1990. Member Q was investigated, denied basic suspects cautions, placed under extreme stress and appeared before a Royal Commission. During the riots, Member Q was hospitalised after being knocked unconscious from a kick to the head (that injury resulted in Member Q having to wear a dental plate for 12 months to re-align a damaged jaw). With his fellow officers, Member Q was forced to stand firm against attacks on a daily basis over many months from large groups of drug affected and drunken people emanating from the "terror corner" of Geraldton. Member Q says he and his colleagues used to confront homemade missiles, bricks, rocks and bottles that were thrown off of Mount Tarcoola. He also used to disperse and prevent funeral riots and violence in Cue, Mt Magnet, Mullewa, Yalgoo and Carnarvon on a regular basis. On one occasion, Member Q and his Sergeant were assaulted and attacked by a group of people who forcibly removed an arrested suspect from a van. In that instance, the Sergeant had his top lip all but severed by a spade wielded by a juvenile. Standing his ground, Member Q says he protected the Sergeant from further attack by driving the main offender off at gun point, during which time he had to make a decision to shoot to kill or not.

As a Detective, Member Q says he has dealt with and headed investigations into multiple murders, attempted murders, suspicious deaths, vicious assaults, sudden infants' deaths, suspicious sudden deaths, suicides, child and adult sexual abuse and incest cases. He has apprehended armed robbers and armed offenders. He has also attended and managed the initial response to fatal traffic crashes. Member Q says he has been punched, kicked, threatened and had to defend himself more times than he cares to remember. Member Q has been abused, ridiculed and had his family and children threatened for the work he performs. Whilst a Detective, Member Q was bitten by a heroin addict who had AIDS and he was tested over a 12 month period in case he'd contracted the virus. During that period, intimacy with his wife and children was limited, as he worried constantly about infecting his family.

Member Q notes that he has suffered psychological illnesses for the past 20 years – he says that he suffers from depression and is medicated because of self-harm attempts. Member Q still presents to his doctor and psychologist because of the risk of harming himself and believes his illness will see him medically retired.

Police Health and Welfare Services' response to traumatic incidents

A running theme to the various Member accounts is either the lack of follow-up or poor support from Health and Welfare Services following a critical incident. The following examples highlight the experience of Members with respect to a lack of support and contact from Health and Welfare Services after a traumatic incident:

- "I have attended numerous traumatic incidents (sudden deaths, fatal crashes) which I suspect would be in the hundreds by now… I have had a long history of symptoms of PSTD (flashbacks, nightmares, restless sleep, anxiety, depression, alcohol abuse, anger et cetera), however, it wasn't until after attending an incident in January 2013 that it became apparent that I needed to seek professional help. To be frank, it was the best thing I could have done for my health, but the worst thing I could have done for my career... Health and Welfare is an absolute joke, only worrying about how quick they can get you back to work (bugger your health) and any assistance (if any [is offered]) creates more stress than it's worth";
- "As a result of this injury I ended up having three major back surgeries, resulting in being made permanently non-operational. This transition was a very difficult period as I received minimal support from Health & Welfare…, lip service from WAPOL and faced the stigma of been non-operational. The feeling of worthlessness [is] something that I have to deal with every day as job roles for non-op's are generally roles that have minimal responsibility, roles that no one else wants to do";
- "[During my career, I] attended numerous fatal [traffic accidents], suicides, sudden deaths…At no time did Health and Welfare contact me until a friend of mine rang them and informed them that I was not travelling that well, Health and Welfare were not helpful in any way… I sought help from Health and Welfare but was told not to take sick leave, private doctor diagnosed PTSD, Health and Welfare did not accept this";
- "[I experienced throughout my career] continual exposure to trauma and [was not] allowed to effectively deal with the trauma… I did a bloody great job but the boss will always find something you did wrong and criticise you for it rather than acknowledging good efforts. When diagnosed (with PTSD), Health and Welfare staff member dismissed diagnosis to avoid providing medical care which then exacerbated illness… I was diagnosed in 2003 with PTSD, advised Health and Welfare but was sent back to work. I was seriously injured at work in 2005 and early 2006 was again diagnosed with PTSD and admitted to private mental health hospital. I was advised by experts that if the symptoms were treated when reported to Health and Welfare in 2003, my condition would not have gotten as bad as it did";

- "Historic minor back issues were severely aggravated by a [workplace accident]… The department has taken the view that as I am 'operational' any ongoing physiotherapy treatment is merely maintenance and therefore they will not pay for physical exercise programs. Instead I should utilise the police gyms unsupervised. I was advised by Health and Welfare that they will not continue to pay forever. I felt belittled and ashamed so have not sought any assistance since";
- "Being sent an email after each critical incident as the only debrief offered to me is simply not sufficient"; and
- "I think unrealistic work expectations and a lack of support in difficult circumstances were bigger contributing factors to my anxiety than the actual incidents I attended".

Some Members cited receiving little more than a generic email following attendance at a traumatic incident. Other Members noted receiving a phone call, but for the majority of Members who cited contact with Health and Welfare Services, that contact was always initiated by the officer.

Many Members felt there was a lack of support from the Agency, especially when critical incidents warranted internal investigation. Rather than a neutral and impartial investigation, Members expressed being subjected to processes that were alienating, stressful, isolating and shameful. This would, more often than not, exacerbate the stress already incited by attendance at a traumatic incident. For example:

- "I have been involved in countless numbers of traumatic incidents throughout my career both in South Australia and Western Australia. They include, but are not limited to, serious and fatal crashes and industrial accidents involving adults, children and colleagues. Police pursuits involving serious and fatal crashes. Firearms incidents, murders and suicides. These all take their toll but can be managed in most cases. The bulk of the stress caused is from the WA Police management and hierarchy and the poor handling of these incidents and the investigations that follow. When you expect support from the Agency in these difficult times, it becomes bit of an ambush of sorts when you are made to feel like you are being targeted instead of supported"; and
- "[I am] always worried I will do something wrong or be accused of something".

<u>Bullying</u>

Members observed that being bullied and working in an environment that was not conducive to the provision of support, in combination with dealing with a series of critical incidents, was very traumatic.

Some Members cited their bullying experiences as contributing to their precarious mental health; as being 'the straw that broke the camel's back'. For example:

- "I suffer from depression and anxiety and I believe was caused (or brought to prominence) by a particular person who was managing my area. She was not my line manager (Inspector) but a person who the Inspector reported to. This person micro managed every single component of my business unit's work... She often bypassed the chain of command in my business unit and introduced policy changes that had no perceived benefit and in fact on many occasions were a backward step… I am a very outcome/result driven manager and to see my business unit's performance negatively impacted as well as staff morale decrease concerned me greatly. This micro managing behaviour drove me to suffer a breakdown for which I received assistance from Health and Welfare and was off work for two weeks. I returned to work and attempted to manage my own feelings/mood by using the stress management methods discussed at my sessions with Health and Welfare. This proved to be unsuccessful and I had a more significant breakdown where I contemplated suicide. Because I felt that my sessions at Health and Welfare were unsuccessful, I undertook treatment from a private psychologist recommended by my GP. I had approximately four months off work and then suffered heart issues which required surgery. When I eventually returned to work I had been off for approximately 10 months. The manager who I believed caused my issues had moved on and the work place had returned to a more productive and morale friendly environment… I served 18 years as a forensic specialist and crime scene examiner and witnessed many horrific crime scenes and traumatic incidents, for example: two plane crashes; and [attending the scene where] four sailors were trapped in the burning engine room of the naval vessel Westralia. I believe these experiences over a long period of time may have caused some level of psychological injury that could have contributed to my breakdowns";
- "[I suffered from] clinical depression/anger management commencing mid-2012 and continuing to the present, stemming from workplace bullying by a Superintendent whilst I was an OIC... This was compounded by the lack of an acceptable resolution from Assistant Commissioner level and the physical impact of the shift pattern at the new Perth Police Station (insomnia, sleep disturbances, migraine)";
- "Bullying in the workplace by OICs caused stress and anxiety";
- "It's not [necessarily] about the amount of fatalities/sudden deaths that I have attended… - it's the fact that being bullied inside the job and victimised, then not supported by [management]… affects my mentality and emotional state"; and

- "[I have attended too many traumatic incidents to remember]: bodies cut in half in car crashes, some vertically some horizontally; squashed bodies on work sites; hangings in back yards; suicides; … then the murder and rape of a 10 year old in a shopping centre, followed by verbal abuse and bullying from immediate supervisor".

Impact of illness/injury on personal life

Respondents were asked what impact their illness/injury has had on their personal life (relationships with family, friends and the community). The overall sentiment was that the impact of these traumatic events (and associated illnesses/injuries) had far-reaching and long-lasting effects on not just the officer's life but on the lives of those around them. Most officers noted they experienced:

- Social isolation (often of their own volition);
- Withdrawal from life;
- Anxiety, especially when faced with dealing people;
- A loss of confidence in themselves and their capabilities;
- Volatile mood swings, with a predisposition towards irrational anger, frustration, rage and fear;
- Poor sleep;
- Compulsive disorders;
- Loss of libido;
- Suicidal thoughts;
- Strained relationships with family members, with many citing divorce from their spouses or estrangement from their children;
- Depression;
- Financial hardships;
- Difficulty trusting others or forming bonds; and
- An increased dependency on alcohol.

The following comments represent a snapshot of the effects of the traumatic events and subsequent illnesses or injuries have had on Members:

- "I drink too much. I have trouble sleeping without the aid of alcohol. I get angry over silly things and sometimes can't stop crying";
- "Married and divorced twice. Prefer my own company. Not comfortable in the presence of others. Decline to catch up with friends. Loner. Health and dignity destroyed. Have given up on life";

- “I no longer communicate with some friends/family. Do not feel safe in the community. Police community has abandoned me… Angry. Resentful. Hurt”;
- “I have withdrawn into myself and have no contact with serving police officers and have not set foot in a police station since I retired. I still do not sleep well and suffer from bouts of depression and feelings that I wasted 33 years of my life as a police officer. Every time I see the [Commissioner of Police] on TV or the newspaper I feel a deep seated rage and extreme hatred”;
- “I can’t establish a long term relationship. Mood swings. Stressed… Impatient. No confidence. Speak out without thinking. I live alone”;
- “My illness has made me a person who even today still contemplates suicide… I trust no one and don’t rely on anyone. I have paranoia, believing that people, including police, are after me. I find that I weep over minor things and feel inferior and less than a man”;
- “[My illness] has caused me to attempt suicide and I still hope to die sooner than later, so the pain and mental anguish stops”;
- “My first wife and I divorced after 25 years. I have trouble being in large crowds. I cannot make decisions easily. I procrastinate on everything. I don’t want to be with people a lot of the time. As my wife says, I am becoming a hermit and have to force myself just to go to Perth to catch up with my family. Without the anti-depressants, I have trouble functioning properly. I have a short fuse and people annoy me easily. Day to day functions are hard. Being penniless doesn’t help”;
- “I have been suicidal. Have not been in a relationship for more than 12 years. Previous relationships lasting around eight months. Become isolated from friends and family. Hyper-vigilant when out in public, constantly focused on suspicious behaviour”;
- “I continue to struggle with life in general, I often wish it would all end”; and
- “I have been in three different clinics for six to eight weeks at a time. I do not like to go out and socialise anymore. I panic when the phone rings as this is a trigger. Think it’s a call out to a sudden death. I cannot watch or listen to the news as it’s also a trigger. Can’t open the door if anyone rings. Always worried that one of my family will be involved in an accident. I am a recluse. I am very bitter that I am suffering like this”.

Exacerbating the trauma – dealing with WA Police and affiliates

From Member feedback, it appears that the dealings with WA Police before, during and after the medical retirement process intensified feelings of despair, loneliness and helplessness. Members felt that WA Police and its affiliates could be distant, unsupportive and biased.

Experience with WA Police and affiliates

Respondents were asked a number of questions about their experience with WA Police Health and Welfare Services and affiliates before, during and after the medical retirement process.

Experience with WA Police and affiliates

The first question asked respondents what their experience with certain groups/organisations/departments was like (with respect to all aspects of their medical retirement) along a sliding scale of satisfaction (see Appendix 7B). The following was noted:

- The experiences with WA Police Health and Welfare Services were mixed. Of those who responded:
    - Approximately 42 per cent had either a negative experience, receiving little support and poor communication, or an adverse experience, receiving no contact or support, leaving Members feeling extremely dissatisfied;
    - Interestingly, approximately 31 per cent of respondents were either neutral (neither unhappy nor happy with support or advice provided) or found this service to be not applicable (service not available or I was not interested);
    - However, there were approximately 20 per cent of respondents who had a positive experience, receiving some support and sound advice.
- The experiences of Members with WA Police management was more extreme:
    - Approximately 59 per cent had either a negative or an adverse experience, receiving little to no contact or support from management;
    - Less than 10 per cent found their experience with management during the medical retirement process to be positive.
- WA Police's peer support program did not fare much better:
    - Approximately 30 per cent had a negative or adverse experience, receiving little to no contact or support from PSOs;
    - Only five respondents had a positive or very positive experience with their PSO;

    - Most respondents were either neutral about the experience (11.28 per cent) or found the service to be not available or were not interested in using a PSO (57.32 per cent).
- The majority of respondents had not utilised WA Police's Employee Assistance Program:
    - More than 55 per cent noted the service was not applicable to them (either it was not available or the Member was not interested);
    - Of those who had used it, more than 22 per cent had an adverse experience with the service and were extremely dissatisfied;
    - More than 10 per cent were neutral about the service offered and were neither happy nor unhappy;
    - Only 4.27 per cent found the experience to be positive (or very positive), with the EAP providing sound support and advice.
- Interestingly, the experiences of Members with the WA Police Chaplaincy were quite varied:
    - Almost 50 per cent had found the service not applicable; the service was either not available or Members' were not interested;
    - Surprisingly, just over 21 per cent of respondents had a negative or adverse experience with the Chaplaincy;
    - On the other hand, approximately 14 per cent of respondents had a positive or very positive experience;
    - There were approximately 16 per cent who were neither happy nor unhappy with the support provided by the Chaplains.
- Outside of WA Police, the Insurance Commission of WA (which manages the claims for the Former Police Officers' Medical Benefits Scheme) did not seem to be generally utilised:
    - Approximately 62 per cent of respondents found the service to be not applicable;
    - Of those who did note an experience with the Insurance Commission of WA, 14.81 per cent were neutral, just under 20 per cent had a negative experience and just under four per cent had a positive experience.
- Experiences with Members' superannuation funds were also canvassed:
    - Just under 50 per cent had not had an experience with their superannuation fund worth noting;
    - 18.65 per cent were neither unhappy nor happy with the service of their superannuation fund;
    - However, approximately 15 per cent had a positive or very experience, receiving good support and advice whilst just over 18 per cent had a negative or adverse experience, receiving no support and poor communication.

Member perceptions of WA Police Health and Welfare Services

Respondents were asked if they had notified Health and Welfare Services of the extent and severity of their injuries. Approximately 73 per cent of respondents said yes, whereas approximately 27 per cent indicated no. If respondents answered no, they were asked why they did not. The answers can be distilled as follows:

- Health and Welfare Services either didn't promote or Members were not advised of the available services.
- Members were concerned about how Health and Welfare Services would utilise this medical information. Members were deeply mistrustful and held concerns over how this would affect their career. For example:
    - "[Health and Welfare] use this information adversely and it will affect future employment/promotion";
    - "I had experienced their lack of confidentiality and did not trust them to keep my situation secure";
    - "Believe [the Health and Welfare Services] is a conduit to the hierarchy";
    - "Did not want there to be any adverse effects on my career such as medical transfers, light duties or non-operational positions";
    - "I have discovered that any information that was provided to them has not been kept confidential and was in fact used to add further stress to the situation. WA Police do not support the people working the frontline";
    - "Concern in relation to confidentiality and impact on promotional opportunities"; and
    - "It was a common perception [during my employment] that if this information came to light within the service it was likely to affect future promotions and the personal standing of the Member in his role within the service".
- The culture that existed and endures is one in which Members felt they had to "tough their illness out" or face embarrassment by admitting to what would be perceived as a 'failing'. For example:
    - "I felt embarrassed and did not really understand what the trigger may have been of the symptoms and my breakdown until a long time after the initial incident";
    - "I toughed it out as I was in a country posting and it didn't appear to be serious at the time";
    - "You would be seen as weak to ask for any assistance";

    - "I thought I could work through it and avoid having to be shamed. As I was once told by a senior officer 'you are a police officer wipe those tears and get out there and get on with it'… [It is] very hard to be open with these issues";
    - "I doubt they are aware to the full extent how it affects my working and private life as I have just tried to 'soldier on' over many years"; and
    - "In the early years I pretended everything was ok. Back then it was a sign of weakness to show your emotions".
- There were some who believed their injury or illness was not serious enough, at the time, to warrant notifying Health and Welfare Services (for example, one respondent noted that "[I] believed I could deal with the problem myself").
- There were those who were loath to involve Health and Welfare Services because they had previously had an adverse experience with the Branch. For example:
    - "They send a generic email out every time they are notified you have attended a 'traumatic' experience. Occasionally someone calls. Through my own experiences and through the testimonies of my colleagues, I have come to the conclusion that they really don't care about the welfare of officers";
    - "The police doctor referred to my health file as 'ridiculous' during more than one appointment. He had never seen such a large and involved file";
    - "Because they don't care, they are just interested in saving money";
    - "[Whilst] I acknowledge that I am not the type of person to go and seek help… I believe that Health and Welfare have no system in place to monitor the ongoing welfare of people involved in critical incidents (too big a workload with too few people)";
    - "They were notified of my injury but they seem disinterested, as though they were just going through the motions and ticking boxes"; and
    - "My wife (former officer) was open with her illness and due to the lack of support from WA Police they medically retired her. If given time and support she would still be able to work at a different work location. She was bullied and ostracised to the point she did not fight her medical retirement".

Despite the perception that Health and Welfare Services could not be trusted with sensitive information, only 25 respondents (or approximately eight per cent) noted they had experienced a breach of confidentiality during the medical retirement process.

Members were asked if they perceived there to be any conflicts of interest between the respective organisations/business units. A number of respondents *did* perceive conflicts of interest and several noted that there was a physician who was appointed to both the police medical board and the GESB superannuation board. One Member commented that "[the doctor] gave two differing opinions" about his illness and injuries and believed it was because the physician had two opposing agendas to fulfil. Another Member noted:

> "I felt the WA Police doctor at the time of my medical retirement was not open to opposing credible medical views except his own. I felt it was unsatisfactory that despite me having several medical reports from doctors who were very well regarded…, none of these reports were presented at my medical board hearing. Whether it happened or not I don't know, but it felt to me like he 'doctor shopped' another medical specialist to contradict all the other reports to get rid of me. This was also the only medical report tabled at my medical board hearing".

Overall, many Members felt that Health and Welfare Services always served the needs of the Agency before the needs of its employees:

- "[Health and Welfare Services were] very quick to isolate the Member to protect the Agency";
- "Rather than a collective attitude of looking after staff who were injured in the line of duty and who are doing what they can to heal, [the Agency's] attitude is more that of 'they got broke in your area, we don't want them until they are fixed'"; and
- "Health and Welfare are under the pump from the hierarchy to get the 'numbers' back on the road and therefore they are forceful in their approach to a return-to-work program. They only ever contact you when it suits them or they get a shove from upstairs. They don't seem to take into account every individual's circumstances".

Services upon separation/retirement

Respondents were asked questions about their experience with a number of services upon their retirement/separation.

Firstly, Members were asked if they were provided with certain services upon their retirement/separation. The services ran the gamut of advice and support that would enable a smoother transition into retirement or new employment (see Appendix 7C). Most notably, the only service that garnered a positive response was the provision of counselling (to which approximately 13

per cent of respondents indicated they had received). Every other service suggested by WAPU appeared to be either not offered or not accepted by separating Members.

Respondents were then asked:

> "If any of the above services were NOT available, which of the services would you have used if they HAD been provided? Please select all that apply."

The services that a majority of Members indicated they would have used if they had been provided to them upon their separation/retirement were health and lifestyle advice/management (70 per cent), financial advice (69.47 per cent), counselling (62.63 per cent) and advice/support services to your partners/family/carers (61.58 per cent) (see Appendix 7D for all).

Finally, respondents were asked if there were any other organisations (not previously identified) that they had associated with during or after their medical retirement with which they had a particularly positive or negative experience. The following organisations were noted as the saving grace for the health and happiness of a number of retired Members:

- The Medically Retired WA Police Officers' Association (MRWAPOA) – in the words of one Member, the MRWAPOA was the "only organisation [that was] positive in my recovery. To sit down with other officers in the same position and gain advice and direction on many levels has been fantastic";
- The Hollywood PTSD Clinic – one Member said they wished that they "had been sent there by WA Police over 10 years ago"; and
- The DVA and in particular, the Vietnam Veterans Counselling Service (VVCS) – one Member indicated that the "VVCS was the only organisation or medical person who took the time to explain to me what had happened to me (mentally)" and another noted "they were marvellous; I would not be here if it weren't for their intervention".

Other services or organisations that were credited with assisting retired or separated Members included: Volunteering WA; the Blue Knights; the Army Reserves; the Commonwealth Rehabilitation Service; WA Police Historical Society; and Member's own churches (with one respondent noting that "most people wouldn't think of a church as having anything to offer a person suffering emotional distress, but belonging to a community organisation and making a positive contribution is helpful to [bettering one's] mental health").

A number of respondents noted that they had negative experiences using Centrelink services, especially when accessing disability or invalidity benefits (one Member felt as if she had been "treated

like a dole bludger" as she stood in line with offenders to receive advice). Several Members also noted they felt as if they had been dismissed or forgotten by WAPU.

Support during and after medical retirement

Respondents were asked:

> "What support have you received since you were either:
>
> - notified of your impending medical retirement; or
> - since you were medically retired?
>
> That is, have you had support mainly from your family and friends? Support groups? WA Police? Peers? Please elaborate."

From the responses, only **three** Members indicated they had received *any* support from WA Police whatsoever. Family (including partners) were the biggest supporters of those who had traversed the medical retirement path. 90 respondents noted that their family were often their only support, 51 respondents noted their friends provided great assistance and most were disparaging about WA Police:

- "No support from police services at all, not even a phone call. Only support received [was] from family and friends";
- "Nothing offered or given, [WA Police] has no interest whatsoever in you after you retire";
- "Only [support] from family… nothing from the police… you were just thrown onto a rubbish heap";
- "I have heard absolutely nothing from WA Police since I was retired. The only support has been from my family and friends";
- "The only support I have is from family and friends. No one from WA Police have contacted me since my retirement. I have a strong feeling of 'out of sight, out of mind'";
- "Peers and family only, nothing from WA Police. I was notified via a phone call that I was boarded out… 'Hi mate, as of midnight you are no longer a copper, see ya', from Health and Welfare"; and
- "Family and friends have supported me to the extent they can. Nothing at all from WA Police".

Some Members noted their colleagues as supports, others relied heavily on their medical professionals ("No support from any party except my weekly ongoing visits to my psychiatrist"). The MRWAPOA was of great assistance to some respondents, whilst WAPU, the DVA and church groups all helped to bolster Members' spirits.

However, it was very concerning that 34 respondents noted they received no help or support whatsoever. One Member noted they felt "pretty much alone" whilst another commented that "no one else seems to understand or can't believe [this] is how I was treated and [WA Police either] can't offer support or don't care".

Police officer welfare training

Respondents were asked two questions about police officer welfare and training, the first being:

> "Did you receive any training about police officer welfare (regarding stress, PTSD awareness, psychological health) during your career?"

The responses were:

- Approximately 19 per cent said yes;
- Approximately 19 per cent said they cannot remember; and
- Approximately 62 per cent said no.

Of those 62 per cent who said they had *not* received police officer welfare training throughout their career, 65 per cent are currently employed by WA Police.

Respondents were then asked to elaborate. The majority of respondents indicated they recall receiving some training whilst a recruit at the Academy. A number recall undertaking some basic training during routine first aid refreshers or Critical Skills training. Several indicated they had undertaken the Mental Health First Aid course at the Academy, whilst others noted they had become PSOs and had therefore received training about identifying stress and other psychological health issues. Some simply noted their police officer welfare training had all occurred on the job.

Certain positions within the Agency warranted greater access to training courses (for example, being stationed at the Tactical Response Group), however, the approach to police officer welfare training appears to be ad hoc across the Agency.

Discussion

What can we ascertain from Members' experiences?

The daily rigours of policing

Our Members see the greatest atrocities in society as part and parcel of their daily workload: rape; murder; sudden deaths; paedophilia; assault; domestic violence; deaths involving infants or small children; fatal traffic crashes; and suicides. As first responders to situations that run the gamut from minor to life-threatening, man-made to natural disasters, it is inevitable and unavoidable that police officers are going to be exposed to violence, death, scenes of horror and brutality from both victims and offenders. What is *not* inescapable is the impact of witnessing such trauma, whether it be a single significant event or a culmination of incidents, because police officers are human and humans are not indestructible.

Of the officers who described their involvement in a myriad of traumatic incidents, they suffer in a multitude of ways; sometimes directly following a critical incident, other times years after the event, some for a short duration, most for the rest of their lives. The suffering manifests in a multitude of ways: PTSD; depression; nightmares and flashbacks; anxiety; compulsive disorders; alcoholism and other dependencies; paranoia; Crohn's Disease, Irritable Bowel Syndrome and other digestive disorders; permanent back, spine or limb injuries; and hypertension.

For many police officers, the impact of the traumatic incidents they have endured has resulted in being medically retired, or reaching a point where they believe it is inevitable they will be medically retired. For these officers, the feeling of being treated as 'scrap metal', of being cast aside, and of having no value within the organisation exacerbates the mental trauma they are dealing with, simply as a result of serving the community and upholding the law. A lack of accountability for the unsupportive and often dismissive attitude of the Agency (following either a single critical incident or a career filled with trauma) disheartens those Members who continue to suffer with unspeakable trauma.

It appears that there is an ad hoc approach to training police officers to be cognisant of mental health welfare. Either officers are receiving insufficient preparation whilst in the Academy, or they are not receiving the appropriate training as they progress through their career. This lack of training, combined with an unsupportive or dismissive police culture, does not bode well for the provision of appropriate and adequate assistance and support in a police officer's career.

Life following retirement/separation from WA Police

Long after retirement or separation from WA Police, the psychological and physical suffering of those Members affected by traumatic incidents persists. The repercussions of this suffering are immeasurable. The medical retirement process itself is protracted and harrowing. Members feel they do not receive sufficient support following the medical retirement, describing the situation as being completely cut-off from the organisation to which they dedicated their lives (and ultimately, their health and wellbeing).

For those who were able to secure some sort of disability benefit, via their superannuation or other means, these disability benefits are often short of being able to lead a comfortable life. Most are unable to re-engage in any type of meaningful permanent work, with the majority estimating their lost potential earnings as more than $1,000,000. This figure, on face value, sounds like a lot of money if considered in one lump sum. But many of these medically retired Members have separated from the Agency years before the recognised retirement age (being 55 years for a police officer). If Members had not retired, and had another 15 to 20 years of their career ahead of them, the average lost earnings equate to between approximately $61,000 and $81,000 a year.

How will this be different for the many hundreds of police officers who are currently serving and who are likely to be medically retired on the grounds of ill health? How will their experience, even if they separate via other means, be any different if the status quo does not change?

Currently, no Government organisation or Agency exists to provide post-service support and care to separated police officers and WA Police has no means of monitoring or tracking officers. Many officers describe a sense of loneliness, isolation, frustration and feeling adrift following their separation from the Agency. Many don't know where to turn for assistance and support, and whilst there are several associations that exist to aid serving and retired police officers that are seen as beneficial, retired officers are often left with no viable, professional and holistic support and assistance option.

Difficulties when dealing with WA Police and affiliates

There are a number of police officers who did not have access to Health and Welfare Services and affiliates because during their tenure, these branches or roles did not exist. For those who *were* able to access the services provided by WA Police, from Health and Welfare Services, PSOs, the EAP and/or the chaplains, it appears that more often than not, experiences with these services were adverse, with little to no support and poor or ineffective communication. Experiences with other organisations (which are outside of WA Police but who are integral to the retirement/separation process) were not

much different, with many Members reporting that encounters with the ICWA, Centrelink and/or superannuation funds were fraught with adversities.

The confidentiality of a police officer's medical information is of great concern to many Members. Not only did Members express their unease about the lack of discretion exercised with medical reports and assessments within the Health and Welfare Services, but Members perceived that any admission or acknowledgement of ill health (particularly that which was psychological in nature) jeopardised their career prospects. As such, many felt they soldiered on, not only harbouring their ill health from colleagues and management but taking financial responsibility of issues that should have been dealt with as work-related.

WAPU believes that Health and Welfare Services is severely understaffed. Currently, there are less than 40 professionals across five broad units that are designed to service more than 6000 serving police officers (and, for those in need of psychological assistance, an untold number of separated Members). WAPU is also concerned that there is, on the part of many Health and Welfare Services employees, an under-appreciation or inadequate insight as to what police officers are truly dealing with, because many employees do not have an intimate knowledge of the rigours of daily policing.

With little more than a generic email following attendance at a critical incident, dismissive responses from the hierarchy and individuals within Health and Welfare Services, and the proclivity for an admission of mental health concerns to affect future career prospects, there is no doubt that current responses from WA Police, whilst improving, are far from adequate in ensuring the health and wellbeing of police officers.

The impact of the police culture on traumatic experiences

The hyper-masculine, 'chin up', show no emotion police culture has an undoubted impact on Members' experiences of trauma. Many respondents reported being told "to dry their eyes", "to buck up", "you're a police officer, deal with it" and "to get on with it" after attending a critical incident that had deeply affected them. The existent police culture that views illnesses and injuries as a weakness or a failing leads officers to either hide their medical condition from peers and management or not acknowledge that a problem exists in the first place.

A perceived lack of support from management or the hierarchy, as well as any incidence of bullying, is believed to contribute to the propensity for Members to suffer psychological issues down the track.

How do Members' experiences correlate with the background data?

The toll of trauma on WA Police officers

The Community Development and Justice Standing Committee found, as a result of its 2011 inquiry, that emergency staff suffer great work stress, not necessarily because they have experienced a natural disaster, but simply because they attend traumatic incidents as a part of their daily work routine. The inquiry found that West Australian emergency responder processes for dealing with trauma were less advanced than other states and were in fact more likely to exacerbate trauma. The inquiry noted that WA Police had no system of tracking the number of traumatic events attended by police officers nor were there any systems in place to check the psychological health and wellbeing of separated officers. The inquiry further noted the importance of psychological first aid, the need for retired officers to be psychologically tested post-separation and the propensity for EAP staff to lack intimate knowledge of the policing culture and nature of the job.

From every example provided by our Members regarding traumatic incidents they experienced during their career, very few noted the rendering of assistance at a natural disaster site. This is not at all to say that these critical incidents do not contribute to the experience of trauma (in fact, a handful of respondents specifically noted the ordeal of disaster victim identification). But what this says is that the daily rigours of routine policing, of exposure to cumulative violent and traumatic deaths, accidents and assaults, of the numerous organisational stressors; these are what trigger the mental health concerns, the problematic, often psychological responses post-trauma.

Member accounts and experiences also point to poor and inadequate processes for dealing with trauma, processes that are often delayed or non-existent or highly impersonal. Members felt as if the Health and Welfare Services existed to service the needs of the Agency and not affected officers. The provision of appropriate and detailed police officer health and welfare training is non-existent and many officers feel unprepared for the psychological rigours of policing. Members expressed a general distrust of the Health and Welfare Services with respect to keeping medical conditions confidential and often felt that by acknowledging an illness or injury (especially those that were psychological), career prospects would be jeopardised due a perception that being unwell equalled being weak. Members *wanted* assistance post-separation, namely in the form of advice, support and counselling, because the status quo is to leave WA Police with any pay owing and nothing more.

Despite this, the Health and Welfare Services of WA Police has not since implemented a critical incident component to its systems (though is currently costing and evaluating the expense of doing so), believes that capturing the costs of individual employee preparation for critical incidents is too difficult, does not believe that psychological first aid is appropriate for larger critical incidents, does not plan to increase the number of chaplains or incentivise the PSO program, believes it does not need to change separation strategies and is concerned about the confidentiality of auditing the EAP.

The Watt Inquest

The Watt Inquest outlined the specific symptoms of Sergeant Watt's deteriorating mental health prior to his suicide, including irritability, withdrawal from relationships, volatility and depression. Many of the symptoms of psychological ill health that the Coroner observed are what were noted by our many Members, running the gamut of social isolation, anxiety, mood swings, depression and substance abuse. The Inquest also noted the stigma attached to acknowledging and admitting to mental health problems. This fact was reiterated by the Members as they talked about the culture of emotional passivity, lack of support and incidence of bullying.

The inquest outlined four recommendations for WA Police implementation, echoing the former parliamentary inquiry. As aforementioned, WA Police is still in the process of costing and implementing processes that track and record contact with at-risk officers and is yet to normalise any kind of objective, confidential and independent wellness reviews.

Psychological first aid, resilience training and interventions

WA Police does not support the implementation of a PFA approach (in order to prepare staff to deal with critical incidents) as it is its assertion that PFA is insufficient for the needs of DVI team members and only works for smaller, lower level critical incidents[279]. WA Police does not support the introduction of training processes (and subsequent refresher courses) that incorporate PFA because of the belief that police work is more complex than is considered by PFA and limited training in PFA could expose the Agency to risk if there is an expectation for officers to manage these responsibilities[280].

[279] As per Recommendation 10 in the Western Australian Government Response to the Toll of Trauma Inquiry, pp. 5 -6.
[280] As per Recommendation 19 in the Western Australian Government Response to the Toll of Trauma Inquiry, p. 10.

However, the PFA approach is not simply designed for use by police within the wider community following a disaster, but for police to use with one another following the attendance at a traumatic incident. In no way does the PFA approach purport to take the place of proper professional mental health assistance. Instead, the PFA approach aims to:

- Ensure that officers who have been exposed to a stressful situation are removed from the situation as far as is practicable and encourage listening and compassion;
- Promote connectedness, especially with support personnel and services, and offer practical help; and
- Encourage officers to engage with their own needs and reassure them that their feelings are normal.

The PFA approach does not diagnose an officer, does not require an officer to provide details about the trauma (and thus potentially relive the trauma and exacerbate the trauma side effects) and is not necessarily applicable for all officers who attend any critical incident. Adopting this approach for WA Police could assist in a cultural shift towards: acknowledging that a traumatic incident has been attended and that side effects may be suffered; fostering an environment that promotes connectedness between affected officers and support services; and encouraging an officer to engage with their feelings and needs (rather than dismissing any post-traumatic reaction).

Consequently, WAPU wonders why WA Police is so hesitant to apply this approach, especially when it has been adopted by other first responder agencies in other Australian jurisdictions and appears to work.

To date, WA Police does not offer any training that focuses exclusively on coping mechanisms or building resilience to traumatic incidents. Whilst the Devilly and Varker study indicated that resilience training may not have any statistically significant beneficial effects on police officer reactions to trauma, it did note that by incorporating cognitive behavioural therapy exercises, psycho-educational training and group skills training into the work regime, police officers learned important skills and strategies that helped them to deal with workplace stressors. Balmer et al. found that the police culture and current training programs were likely to hinder the effective expression of emotions. Balmer et al. also found that resilience was reduced in police officers as they increased in age, rank and length of service, most likely due to the cumulative effects of stress associated with policing and the increase in organisational stressors stemming from the responsibilities and demands associated with senior rank.

From the Member feedback, WA Police officer welfare training is either ad hoc and inconsistent, or learned on the job. For many officers, learning how to cope with trauma as they experience it is not ideal, as many formulate their own methods of coping, some of which are unhealthy and can contribute to psychological illnesses.

As for the necessity to develop effective interventions, again, the Agency is falling short of providing Members with: support services that monitor Members over long periods of time (and into retirement); and realistic, impartial feedback and reviews of responses to critical incidents.

The legislation surrounding police officer retirement and compensation

Medical retirement

The legislation currently in place that governs police officer medical retirement is perceived as unsatisfactory for the Members who endure the process, as the medical retirement process is not only convoluted and protracted but is associated with the stigma of the Commissioner losing confidence in an officer's capabilities. It appears that this sentiment is shared by WA Police as amendments to change the *Police Act 1892* under the guise of providing "police officers with a more dignified method of exit from the Agency" have been proposed as recently as April 2014[281]. Changes to the medical retirement process were also discussed in the Aurenda Report and WAPU has no doubt that the Workforce Optimisation Project will propose an overhaul to that process.

In the survey, Members indicated that more often than not, they experienced either a lack of communication or communication that felt highly impersonal and unfeeling during the stages of the medical retirement process that most necessitated personalised communication, empathy and open consultation. There were also concerns from the Members about conflicts of interest at the medical assessment stage.

WAPU not only agrees that the current utilisation of Section 33L of the *Police Act 1892* stigmatises, disappoints and confuses Members but fully supports the introduction of a mechanism for the removal of police officers on medical grounds that is independent of the Section 8 and Section 33L process[282].

[281] As per a letter to President George Tilbury from the Director of Human Resources at WA Police, entitled "Re: Amendments to the Police act 1982 (sic) to provide for the discharge of police officers on medical grounds", dated 28 April 2014.

[282] As was articulated to the Assistant Director of Health and Welfare at WA Police in a letter from President George Tilbury dated 9 June 2014, which was in response to the aforementioned letter dated 28 April 2014.

Former Officers' Medical Benefits Scheme

The Former Officers' Medical Benefits Scheme, enacted in 2008 and applying to eligible Members from 1 July 2007, did not seem to be utilised to the extent WAPU anticipated (62 per cent of respondents replied 'not applicable' to the service) and this may be because the majority of respondents were still employed by WA Police. However, given the volume of officers who expressed concern about accessing medical entitlements post-separation, as well as those who conveyed their financial hardship as a result of costly medical bills, there appears to be a large number of police officers who are not covered by the Former Officers' Medical Benefits Scheme and for no other reason than they did not suffer a workplace injury that incurred medical expenses after 1 July 2007. This not only creates financial difficulties for those police officers who are not eligible to receive the benefits, but facilitates a sense of worthlessness and rejection for those officers who have dedicated themselves (mentally and physically) to the job, have been broken as a result and have not received appropriate recognition and compensation.

Workers' Compensation and OSH

Police officers' working conditions are unique and different to other public sector employees, including other emergency services employees. They are specifically excluded from Workers' Compensation unless they suffer an injury and die as a result of that injury. Police officers are covered by the OSH Act but, again, are singled out as being unable to exercise Section 26 of the OSH Act when performing dangerous work in a covert or dangerous operation. The traditional approach to police employment regulation within Western Australia, has been to simply 'group' police with other public sector workers but then make exceptions based on the requirements of operational policing. WAPU believes this approach does not fully recognise the uniqueness of police officers' working conditions, nor do these exemptions present as beneficial 'concessions' to undertaking the dangerous and difficult work of police officers.

Members are always hesitant to discuss integration into a Workers' Compensation scheme when it means their current sick leave provisions will be reviewed (and, more likely than not, removed because of the Government's reluctance to allow the two entitlements to co-exist in any form). Only 18 respondents noted police officers' possible integration into a Workers' Compensation scheme within the survey – this doesn't necessarily reflect the sentiment across the Membership but it could be indicative of the hesitance of Members to be incorporated into the current Workers' Compensation legislation.

Whatever the eventual outcome, Members are adamant that their sick leave entitlements are preserved and officers are fairly compensated during and post police service, because the highly volatile nature of their work simply cannot be equated with other professions.

Presumptive legislation

Police officers face a range of hazardous and life-threatening situations on a daily basis. These dangerous, covert or life-threatening duties can expose police officers to a range of illnesses or injuries that they may experience at a greater rate than that of the general public. Dismantling clandestine drug labs, attendance of the Arson Squad officers at fire sites when toxicity is most acute, exposure to bodily fluids through frequent interactions with drug-affected individuals, witnessing the aftermath of murders, suicides, sudden infant deaths, fatal traffic accidents, sudden deaths which are precursors for PTSD: these are some of the highly dangerous and potentially lethal situations that police officers face on a daily basis.

Professional firefighters, who are exposed to carcinogens released during a fire, have had presumptive legislation introduced that reverses the onus of proof in favour of firefighters by providing that certain specified cancers are work-related, unless the employer can prove to the contrary[283]. If any amendments are made to Workers' Compensation legislation to incorporate police officer eligibility, or if a separate scheme is considered, something similar must be developed in recognition of the hazardous situations to which police officers are regularly exposed. This could be an acknowledgement of exposure to carcinogens whilst an officer performs Arson Squad duties, any long term impacts on health that dismantling clandestine drug labs may have on a police officer or a correlation between exposure to horrifying critical incidents and developing PTSD.

WAPU understands that, just like the presumptive legislation for professional firefighters, further research is required to demonstrate the incidence of certain ailments in police officers. However, current literature and patterns that are prevalent in separated Members prove that police officers are at a higher rate of suffering particular illnesses, especially psychological disorders such as PTSD, as a result of their work.

[283] *Workers' Compensation and Injury Management Amendment Bill 2013*, Second reading speech.

Recommendations

Member suggestions for a suitable compensation scheme

At the end of the Project Recompense survey, Members were asked the following:

> "In your opinion, what is the best way for you, and other police officers who are suffering from a work-related physical or psychological illness/injury, to be compensated for a potential loss of earnings, privately incurred medical expenses and pain and suffering?"

Almost 500 Members responded.

Many articulated that they felt as if their pain and suffering (on both a mental and physical level) could not be measured in order to be adequately compensated:

- "You can't compensate for it. There is no magic little pill that will make it all go away. The organisation needs to learn how to treat officers better and actually value them as people";
- "I'm not really sure [how best to compensate] as I feel no amount of money will fix my problem or other officers issues";
- "Nothing can compensate me for the loss of my life";
- "Currently I am feeling so angry, lost and confused, I have no answer to this, my loss is not measurable"; and
- "How do you compensate for pain and suffering in a thankless job".

Many suggestions were proffered and can be generalised as follows:

- Eligible Members to receive a pension upon retirement, similar to that of the DVA;
- Eligible Members to receive an ex-gratia payment or some other monetary compensation (lump sum or otherwise);
- All medical expenses for work-related illnesses and injuries to be paid for, regardless of when they were sustained;
- Possible integration of police officers into the Workers' Compensation scheme;
- Assistance with re-training and workforce rehabilitation; and
- WA Police's acknowledgement of any wrong-doing.

Monetary compensation

A police pension scheme

Approximately 57 respondents noted that a pension scheme, devised in a similar vein to the benefits received by war veterans, would assist in compensating broken police officers:

- "The ability for all police officers to retire after 25 years of service with a full pension. Frontline, operational officers are over-exposed to regular violent and traumatic episodes, in comparison to army, navy and air force personnel";
- "A retirement pension scheme [is needed]. It would be good if there was some system in place (such as that of the army) that allowed people who are burnt out a way to retire and still have some income and dignity";
- "[Police officers need] a pension that is not the disability [pension], similar to current VET gold card members… Disability is demeaning. I am/was a proud officer and this had been taken from me";
- "A pension scheme [is required] whereby officers can be supported through a medical pension if required or have the opportunity to retire after a determined length of service… With the current superannuation, we will end up with a large number of older officers of 60 plus years of age still working with WA Police and expected to carry out frontline duties because [superannuation] does not provide them with the financial security to retire"; and
- "A police pension is the only fair and equitable answer. [The DVA] already have a system in place for their affected soldiers".

Some Members also noted that having similar counselling and support services as those run by the DVA would benefit many retired police officers.

Ex-gratia/lump sum payments

More than 110 respondents advocated for either an ex-gratia payment or other payment (lump sum or otherwise) for officers who were physically or psychologically broken by the job:

- "[Eligible officers need] a lump sum payment to compensate for pain, suffering and loss of past and future earnings, separate to superannuation. [It should be] more generous for the younger officers who are medically retired as they will be more asset poor and will likely be starting to raise families. Calculated back to medical retirement";
- "First and foremost, there needs to be compensation in some form for officers retired unfit suffering from psychological illnesses incurred as a result of doing their duty. I believe the best form would be persons who are forced into retirement in the future be paid their full wage equivalent to their retirement rank until [retirement age]. For former officers abandoned by

all concerned, there has to be a lump sum compensation payout… [This would] provide a platform where former officers receive some form of financial stability";

- "There should be compensation (lump sum) to the person for the incident/trauma they suffered, as well as lifelong support… Where else can you get the opportunity to constantly put your life on the line, get smashed up well and often, lose your family because of your work/lifestyle and then when you break down you get thrown away without a thought";
- "An ex-gratia payment after dealing with a traumatic incident may go some way to compensating an officer"; and
- "[There must be] compensation. [When I joined WA Police], never once was I advised if you are injured or suffer a work-related mental illness and can no longer work as a police officer, you are worthless… The compensation should not be an insult to the medically retired officer, the personal trauma is beyond debate. Police, daily, are subjected to being seriously hurt if not killed and can develop a lifelong mental illness [as a result]… If this is not recognised and police are not supported, there will be less recruits willing to step forward and sacrifice. I would never have joined all those years ago if I knew the huge toll it would have on my life and that of my family, I feel as if I have lost 24 years of my life".

<u>Payment of all work-related medical expenses</u>

Despite the existence of the Former Officers' Medical Benefits Scheme, a surprising number of officers (approximately 88) noted the importance of having all of their work-related medical expenses provided for, *regardless of when the illness or injury occurred*:

- "In my case, I would greatly appreciate financial assistance with my ongoing medical treatment";
- "Medical expenses should be paid no matter when the illness/injury occurred";
- "I believe that once diagnosed, there should be no question that [the ICWA] continue to pay medical expenses as long as it relates to a work-related illness or injury";
- "Any illness/injury should be fully paid for whenever medical expenses are incurred, continuing until the issue is resolved or you die… If [your illness/injury] ruins your health/career, why would it not be sufficient to give you the best chance to carry on living worry free and without having to 'make do'"; and
- "WA Police needs to become much better at paying medical expenses from the moment [the illness/injury] is known to be work-related".

Retraining and workforce rehabilitation

25 respondents indicated they would like to see WA Police invest in re-training non-operational police officers to either move into other areas of the organisation or to assist in a transition to other positions in the public sector. Many of these respondents believed that injured or non-operational officers still had value as workers, but both the stigma of being non-operational and the medical retirement process meant that there were officers whose skills were simply not being utilised. The sentiment from these respondents was that if they had been emotionally or physically damaged in the line of duty, WA Police had a responsibility to ensure job security or assist with some vocational rehabilitation:

- "[There should be] preferential employment opportunities for sick officers as they recover";
- "[There should be a] guarantee of non-operational positions for those that are deemed non-operational but capable of attending to office related duties";
- "Training should be afforded to officers forced into retirement from work-related illness/injury to assist that officer gain employment in the private sector";
- "[WA Police should] offer suitable challenging roles within the Agency – a number of these roles are now either civilianised or conducted by [police auxiliary officers]. Ensure officers who are medically non-operational are treated fairly and not made to feel like they are a waste of space and a burden to the Agency";
- "[There should be] employment assistance and re-training either towards public sector or private employment if recovery cannot be back to full operational requirements";
- "[WA Police should] allow us to stay in the job performing appropriate work while we are able to, even if not operationally fit, i.e. a non-frontline role. To say after 27 years, 'thanks but we don't need you anymore, go retire' after [suffering] injuries caused by the job is insulting at best"; and
- "If Members are unable to continue serving as frontline operational Members (as the Commissioner is pushing for) then they [should] be offered either suitable non-frontline positions acknowledging their skills and experience or a mutually agreeable separation program that doesn't impact the financial capacity of Members".

Acknowledgement and recognition

Approximately 20 respondents expressed their desire to have their dedicated service, ill health and tenuous situations simply acknowledged by the Agency. A number of respondents also expressed their concern that WA Police did not adequately recognise the propensity for officers to be exposed to highly traumatic incidents and the subsequent proclivity for mental health issues. For example:

- "WA Police should recognise the effects of highly stressful situations on people. WA Police should not put people who have been in highly stressful situations back into the same or similar positions. WA Police should look after the mental health of staff a lot better than it currently does";
- "[There needs to be a] public apology for the poor treatment of all sick WA Police, especially so for the medically retired officers";
- "[WA Police] ought to be held accountable for managing dysfunctional organisational units that contribute to the psychological illness of their staff the same way other organisations are";
- "While money and some form of lump sum payment is required, acknowledging the illness/injury and providing ongoing medical assistance and support [is most important]… This job is a very traumatic one and the pain, suffering and injuries we see and experience affects us for the rest of our lives. We give our work lives to protecting the community and it has an impact on us and our families for the rest of our lives and the Agency needs to support us once we have retired";
- "A profound and *genuine* apology for the lack of assistance provided whilst in the service of WA Police would be more than appropriate";
- "My view is that the Department places you at an unnecessary risk due to poor management which it blames on funding. When you become sick they provide zero support… and accept no responsibility themselves"; and
- "[There needs to be] acknowledgement and understanding of the circumstances surrounding the incident and the ongoing impact".

Post-service counselling, Health and Welfare Services and police culture

Other changes respondents wanted to see enacted were the provision of post-service counselling for police officers, changes to the Health and Welfare Services and a change in WA Police culture, namely recognising, valuing and supporting those with illnesses or injuries. Some of the responses were:

- "We should not be thrown on the scrap heap and forgotten. Decades of police work protecting the community [is then just] thrown out the window";
- "There has to be recognition that PTSD exists within the police service and that it is a lifetime sentence that may (if you're lucky) be treated with the aid of medication and at best, will subside to a level where you can function on a daily basis and enjoy life as the remainder of the public do";

- "[WA Police should be] implementing a system where debriefing [occurs] immediately after critical incidents, rather than days or even weeks later. Paperwork [seems to always be] the priority when taking 20 minutes to speak with colleagues… would be far more beneficial and maybe avoid some of the stress relating to these incidents";
- "[WA Police need to offer] counselling and support. I think the police department should look at the DVA's programs of dealing with stress and depression";
- "To have the support of the service in recognising the symptoms [of PTSD] and supporting the Member either with continued employment… allowing the Member to come off active service into a protective work environment";
- "Officers need to be supported by the organisation, not ostracised and treated like a malingerer. They should receive real emotional and financial support from the department, be treated like a person and not a number";
- "[Officers need] to be supported by WA Police, not rushed to return to work or be labelled as a problem child"; and
- "[There needs to be] more support than the obligatory 'she'll be right made – we'll look after you' and you never see them again. WA Police need to realise injured officers still have a lot to offer".

Recent redundancy packages

A number of Members expressed their disappointment and distress at the recent redundancy packages offered by WA Police to eligible serving Members. Some respondents perceived that those who had received the redundancy packages were treated more favourably than those who had been medically retired. For example:

- "If they can hand out redundancy packages hand over fist, where is the justice when no payment is being made to those being medically retired"; and
- "[Any compensation] should be the same as the redundancy package that has just been distributed. Makes me sick to see perfectly healthy and happy police officers get paid so much to leave voluntarily, when I get thrown out not because I wanted to but because they said I was no good to them anymore, and got almost nothing for 35 years of work".

Recommendations

Recommendation 1

That WA Police acknowledge there are Members who have suffered immeasurable trauma as a result of attending a number of critical incidents without the appropriate support from the Agency, and that this trauma has been life-changing for those affected.

From the Member feedback, it is indisputable that there are police officers (both serving and retired) who have suffered immeasurable trauma as a result of attending a number of critical incidents throughout their career. In the majority of these cases, not only has involvement in these incidents resulted in life-changing psychological or physical injuries or illnesses, but it appears that WA Police have failed to provide the appropriate support to adequately and holistically assist Members during and after their service.

Throughout this report, Members have spoken of the innumerable traumatic incidents they experienced over their careers and the lasting effects of witnessing unspeakable tragedies. Of those who had any dealings with management, the Health and Welfare Services or other WA Police affiliated organisations, the assistance rendered was often felt to be unsupportive, uncommunicative, disinterested and in the interest of the organisation (with little consideration for the employee). Contact with officers affected by a critical incident was felt to be inadequate (delayed or absent entirely) and often very impersonal (for example, sending a generic email).

Our Members have simply asked that WA Police acknowledge:

- The difficult, traumatic and often life-threatening situations Members face on a daily basis;
- The fact that, despite the daily rigours of policing (beyond what a layperson could comprehend), Members continue to dedicate themselves to the service, often until the Agency believes they are no longer of value to the organisation;
- That as a result of the number and nature of critical incidents police officers are exposed to, there are Members who have been so deeply affected by these experiences that they have subsequently suffered psychologically; and
- That WA Police has not adequately or appropriately supported and assisted these affected Members during their service, the medical retirement process or post-service.

As such, WAPU contends that WA Police acknowledge, to current serving and retired Members, that: the environment police officers work within on a daily basis is hostile, fraught with danger and unpredictable; police officers undoubtedly face copious traumas as part of their duties and that there have been (and still are) numerous deficiencies in the way police officers receive post-trauma support (because of an often unsympathetic police culture, inadequate mental health assistance, lack of follow-up support, inability to identify at risk officers due to inefficient tracking/notifying systems, et cetera). As a result, there are a large number of police officers who have endured, and are still enduring, the devastating effects of trauma-induced illnesses and injuries. Any apology and acknowledgement from WA Police would be an instrumental step in the healing process for Members.

Recommendation 2

That WA Police further explore the benefits of resilience training, greater mental health awareness and psychological first aid and implement these initiatives immediately.

Whilst WA Police asserts that it "provides training to all recruits on how to manage a critical incident via academy training and mortuary-based learning", Members have indicated that WA Police-provided training is insufficient, infrequent and underprovided. At this point in time, when WA Police officer welfare training is ad hoc and inconsistent, it is WAPU's belief that something is better than nothing and any improvements to welfare training are welcome.

As such, WAPU believes the following is imperative for WA Police to consider:

- Whilst resilience training doesn't necessarily predict sound mental health following a traumatic event or decrease the incidence of mental health issues, it *can* aid in the development of skills that assist with dealing with workplace stress. Given the prevalence of bullying in the workplace and perceived lack of support from management following a critical incident, unless the police culture shifts massively in a short period of time, introducing adequate and consistent resilience training into officer training and development could alleviate these sources of stress;
- Resilience has been found to decrease in police officers as they increase in age, rank and length of service, and this is most likely due to the cumulative effects of stress associated with policing and the increase in organisational stressors stemming from the responsibilities and demands associated with senior rank. WA Police must consider how the introduction of resilience training for all police officers, not just recruits, could benefit the psychological health of employees;

- WA Police need to implement more strategies that increase police officer mental health awareness. Whilst the Academy provides important training that addresses mental health, the focus of this training is generalised and for application for members of the public. Whilst aspects of this Academy-based training *can* be applied to police officers, the fact that police officers face a myriad of situations that the general population are unlikely to ever encounter and are exposed to multiple traumatic incidents as part of their daily duties warrants a thorough exploration of mediums that raise awareness about mental health issues typical of policing;
- It is vital that WA Police offer the appropriate mental health awareness training throughout an officer's career, not just at the Academy as a recruit-in-training or ad hoc online (Blackboard) training. Given that approximately 62 per cent of survey respondents indicated they had not received *any* training about police officer welfare (regarding stress, PTSD awareness and psychological health) throughout their career and almost 65 per cent of those respondents are currently employed by WA Police, it is imperative that the Agency consider introducing a broader scope of courses that raise awareness about police officer health and welfare. It is most important that this is introduced at recruit level so that a culture of mental health awareness is fostered at the outset of an officers' career. However, it is essential that as WA Police implement training programs, it continues to offer refresher courses throughout an officer's career so that understanding and recognising mental health issues becomes ingrained; and
- Psychological first aid (PFA) has been adopted by other first responder agencies in other Australian jurisdictions and appears to work, yet WA Police seem hesitant to apply this approach. WA Police say that PFA only works for smaller scale incidents, yet only refer to the DVI team for which this approach may not be applicable. However, WAPU believes that if WA Police adopt this approach, it could assist Members by:
    - Encouraging the acknowledgement of attendance at a traumatic incident and that side effects may be suffered as a result of attendance;
    - Fostering an environment that promotes connectedness between affected officers and support services; and
    - Encouraging an officer to engage with their feelings and needs (rather than dismissing any post-traumatic reaction).

It is therefore recommended that WA Police explore the benefits of resilience training for police officers in order to assist with the development of skills that can aid in dealing with workplace stress.

It is also recommended that WA Police implement a broader range of mental health awareness programs, especially those which focus on the effects that trauma has on police officers, as well as introducing the PFA approach. However, it is imperative that these initiatives are expanded beyond recruit level, so that officers are aware of, understand and recognise mental health issues throughout their careers.

Recommendation 3

That WA Police ensure appropriate interventions are administered during an officer's career to mitigate the likelihood of developing psychological illnesses.

WA Police currently operate on a reactive basis with respect to the incidence of psychological illnesses amongst Members. Rather than develop appropriate interventions and methods that confidentially and impartially 'tracks' each individual officer's critical incident trajectory to mitigate the likelihood of developing a psychological illness, WA Police has a generalised, ad hoc and inconsistent process of managing police officer health and welfare. This may be a result of chronic under-staffing and inadequate funding in the Health and Welfare Services Unit and/or a culture that is inherently dismissive of mental health concerns. As such, the current situation that police face is one that barely acknowledges the affect that attendance at a critical incident can have on an officer and that is quick to dismiss those who are broken by what they have endured. However, it is the belief of WAPU that if WA Police implemented effective and appropriate interventions for Members, including adequate training, the provision of support services and impartial review mechanisms following a critical incident, the Agency may be able to mitigate the impact on an officer following their attendance at a traumatic incident.

Presently, police officer mental health awareness training is inadequate and inconsistent and increasing awareness about welfare issues that are specific to police officers is vital for encouraging an understanding and recognition of warning signs that may predispose an officer to mental health problems. Early intervention in these situations is imperative for not only alleviating potentially devastating illnesses but ensuring rehabilitation and continued investment in those officers who still have much to offer WA Police.

Different support is offered for those in recognised high stress situations (such as those who perform DVI or covert operations) and whilst WAPU unreservedly supports this, more support *must* be offered to all police officers as every officer is undeniably exposed to traumatic incidents as part of their work duties. WA Police needs to increase the number of support staff and ensure that a component is based

in Regional WA, as per the Toll of Trauma Inquiry recommendations. Education, assistance and support to all areas of the State should be ongoing and collaborative between the Agency and staff.

Enhancing support services can occur by increasing the number of PSOs, especially across Regional WA. WA Police should increase the number of chaplains it employs, especially in regional locations where neither of the two chaplains currently employed by WA Police reside. WA Police must also increase the numbers of psychologists and counsellors it employees to better service Members across the State. Chaplains, PSOs and police-centric psychologists or counsellors are better placed to understand the intricacies of policing than an EAP service. If WAPU was granted funds to provide counselling services to its Members, it is more likely that officers would seek assistance for their mental health and wellbeing from an independent source that understands the minutiae of policing. The increased likelihood of police officers accessing WAPU-provided services stems from the fact that there is a belief that Health and Welfare Services will misuse the information officers provide them. Nonetheless, the number of staff presently employed to offer support services is not sufficient for the current workforce and, without changes, will certainly not be sufficient for the Government's projected increase in police officers[284].

In conjunction with better, more cohesive and considerate support systems, critical incident tracking, as recommended by the Toll of Trauma Inquiry and the Watt Inquest, *must* be implemented without delay. The tracking of critical incident attendance must be confidential, with access restricted only to Health and Welfare Services and must *not* in **any** way form part of an officer's performance management process.

It is also vital that WA Police offer police officers the appropriate training throughout their careers, not just at recruit level. Training that assists a police officer to acknowledge and recognise warning signs that precipitate deteriorating mental health, both in themselves and in others, is invaluable in mitigating the incidence of psychological illnesses and injuries. In conjunction with a PFA approach, appropriate and realistic training opportunities for police officers throughout their careers are likely to assist and support officers as they face trauma and critical incidents in their work lives.

[284] The Liberal Party of Western Australia made an election promise in 2013 to boost police resources and infrastructure over their four year term, which included recruiting a total of 720 officers (170 in the year 2013/2014 as per an earlier election promise plus 550 additional officers).
Media Release, *Liberals to increase police resources*, Liberal Party of Australia, Western Australian Division, West Perth, 2013. < https://wa.liberal.org.au/sites/default/files/plans/Police%20Enhanced%20Response%20Program%20(PERP)%20(MH%20FINAL).pdf >.

A thorough assessment of the police culture is necessary, to ensure that care is offered not just from the Agency's support service but from within the ranks. As Members spoke of the impact of bullying and lack of managerial support following attendance at a critical incident, it has become clear that whilst progress is being made with respect to a culture of de-stigmatising mental health, there is still much to surmount in terms of encouraging frank discussions about the impacts of trauma and associated feelings of vulnerability.

Consequently, WAPU recommends that WA Police:

- Increase and enhance, in tandem, the support services offered by Health and Welfare Services and training offered through the Academy. This must be achieved collaboratively so that police officers not only have an awareness and understanding of the impacts of trauma on mental health but when they seek assistance for any recognised symptoms of trauma, there is ample, confidential support from a team that understands the intricacies of policing;
- Implement a critical incident tracking system immediately. The tracking of critical incident attendance must be confidential, with access restricted only to Health and Welfare Services. This system, which must not only note police officer attendance at critical incidents but also any perceived impacts of trauma and professional follow-up, must be entirely confidential and must not in *any way* form part of an officer's performance management process;
- Introduce appropriate and mandatory police officer-specific health and welfare training that occurs not just at recruit level but throughout an officer's career, so that understanding and recognising mental health issues becomes an accepted part of the police culture; and
- Execute these changes with respect to ingraining a culture that de-stigmatises mental health issues and encourages a sense of support and concern amongst all ranks.

Recommendation 4

That WA Police increase the number of support staff in its Health and Welfare Services. Currently, there are approximately 33 members of staff across several units (including psychologists, claims management staff, chaplains, vocational rehabilitation staff and peer support employees) that are intended to service more than 6,000 police officers. If WA Police is to apply the appropriate interventions, increase training and awareness and connect more effectively with both current and retired Members, there is an urgent need to increase support staff across the various units.

Currently, within the Health and Welfare Services there are approximately 33 FTE staff employed to service more than 6,000 police officers across WA. Health and Welfare Services is made up of several

units, including psychologists, claims management, welfare (being peer support and chaplaincy), corporate health and vocational rehabilitation, all of which employ not only professionals within the respective fields but administrative officers and managers. These numbers are not sufficient to adequately and holistically provide the appropriate support to such a large group of employees (a group of employees who, let's be reminded, face a higher risk of stress-related physical and psychological illnesses than most other professions).

In order to provide police officers with the appropriate support and assistance by:

- Implementing the necessary training and awareness programs;
- Ensuring suitable interventions following traumatic incidents and throughout the career of our Members; and
- Connecting more effectively with current and separated Members;

it is imperative that the number of FTE employees in the Health and Welfare Services increase to match service needs.

WAPU completely supports the Toll of Trauma Inquiry recommendation to place more staff and resources providing trauma-related services in regional WA[285]. It is not good enough that the Health and Welfare Services has made only one truly concerted effort (undertaken in 2014) to travel to regional locations to promote the services it offers. WAPU recognises that Western Australia is a vast State and that it may not always be feasible to travel to all remote locations on a regular basis. However, it is vital that in efforts to increase and enhance support services, regional WA is considered as equally as the metropolitan area, especially given approximately 40 per cent of all police officers are stationed in regional WA.

As such, WAPU recommends that WA Police increase the number of FTE employees in the Health and Welfare Services, paying particular attention to the psychology unit, the vocational rehabilitation unit and the welfare unit, in order to adequately and appropriately service all WA Police officers. WAPU supports Recommendation 12 of the Toll of Trauma Inquiry and recommends that WA Police fund additional chaplaincy services that are full time and based within each police district, particularly for staff located in regional WA.

[285] As per Recommendation 5 of the Toll of Trauma Inquiry.

Recommendation 5

That WA Police initiate a connection with separated Members, especially those who have been medically retired, so that mental health and welfare can be monitored once an officer has exited the Agency.

Currently, there are no WA Police–centric services available to retired officers and police officers' health (mental or physical) ceases to be monitored once they have separated from the Agency. The Toll of Trauma Inquiry even noted that WA Police failed to keep track of its staff and their health outcomes once they had left the Agency. Members feel that once they have left WA Police, particularly if they have been medically retired, they have been discarded, forgotten about, overlooked and as if their dedicated service was for nothing. For some Members, it is not until they have left WA Police that the toll of post-traumatic stress seizes them. For others, the illnesses and injuries suffered as a result of work-related incidents are exacerbated by the medical retirement process.

WA Police do not believe that its exit strategies need to change because it believes police officers are not leaving due to stress or trauma suffered in the job. However, Member feedback indicates there are multiple stressors in the workplace, including attendance at traumatic incidents, lack of managerial support, bullying and the pressures of internal investigations, many of which have contributed to the ill health experienced by Members. Members also spoke of the distress they experienced upon separating, namely because of the hugely impersonal and distressing manner under which the separation took place.

Just because an officer has separated from the Agency does not mean that WA Police does not bear any responsibility for the mental health outcomes that result from having endured horrific traumas on the frontline without the appropriate support within the workplace. And yet it appears that WA Police do *not* bear any responsibility for its separated officers as the Agency is not only quick to sever ties with former employees but has not initiated any formal channels of contact with them beyond the separation process, regardless of how many years of service the officer has dedicated.

Many officers noted they have found solace and camaraderie in the MRWAPOA and other organisations dedicated to assisting both serving and retired Members in times of difficulty. However, all of these organisations rely on the goodwill of donations, bequests and the time of volunteers. Membership or solicitations of assistance are entirely voluntary, and there are no systems within any of these organisations to track the mental health and wellbeing of those officers it has assisted – nor should there be as it is not within the jurisdiction of these associations to do so. Whilst WA Police may

have assisted with the establishment of some of these organisations, neither WA Police nor the Government fund the activities of these organisations or monitor the progress of any of its members.

As such, WAPU recommends the following:

- That WA Police initiate a connection with retired/separated Members. Contact with these Members will not only give WA Police an insight into the mental health and welfare of separated officers but will also demonstrate to those no longer employed by WA Police that the Agency does care for its ex-members and consider their service and contributions to be valuable;
- That WA Police initiate this connection, first and foremost, with both a formal presence and active participation within the RPOA and the MRWAPOA; and
- As WA Police implement its critical incident tracking system, it ensures that this extends to Members who medically retire or separate from the date of the system's implementation. Any critical incident tracking system that monitors separated Members must flag the number and type of critical incidents attended, any help that was sought, physical and mental health history and grounds of retirement/separation so that officers who may be at risk can be readily identified as necessary; and
- In implementing the aforementioned, it is imperative that WA Police review its exit strategies (as per Recommendation 20 of the Toll of Trauma Inquiry). WA Police exit strategies must be reinvigorated so that the Agency has a clear and impartial understanding of why an officer is exiting, including if stress or trauma play a role in the decision to separate. The process surrounding an officer separating from the Agency, especially when it is a medical retirement, must be reviewed because (despite the procedures in place regarding notification of a medical board decision) currently the experience is impersonal and unpleasant.

Recommendation 6

That WA Police, with the assistance of the Government, implement, as part of its vocational rehabilitation system, a program that invests in re-training human resources so that they may be utilised in other employment areas (be it within the public sector or the private sector).

Feedback from Members indicated that a re-training program for non-operational officers is desperately needed, so that those who are deemed non-operational can develop, hone and utilise their skills to either move seamlessly into other areas within WA Police or to transition into other positions in the public sector. In the 'worst-case scenario' instances where a police officer is medically

retired before the retirement age, access to vocational rehabilitation programs was viewed as a service that would greatly assist those who had been broken by their police duties and were consequently unable to secure viable employment post-service. Providing some kind of re-training or vocational rehabilitation to medically retired officers would provide those who had served the community with some chance of earning a living wage before they could access any of their superannuation component.

Transitioning to a public sector role is not a unique occurrence across the Australian policing jurisdictions. Legislation exists in Queensland whereby a police officer who is identified as no longer being able to perform their duties can be transitioned into other work, including through host employment.

As such, WAPU recommends that WA Police, with the assistance of the Government where necessary, implement, as part of its vocational rehabilitation system, a program that invests in re-training non-operational police officers so they may be utilised in other public sector roles (including within WA Police) or transition readily to the private sector should they be retired medically unfit.

Recommendation 7

That WA Police share the 2011 PricewaterhouseCoopers review of the Health and Welfare Services with WAPU and other relevant stakeholders.

To date, WA Police has not shared with WAPU (or any other relevant stakeholder) the PricewaterhouseCoopers (PWC) review of the Health and Welfare Services that was undertaken in 2011. Given the PWC report is said to suffice the request made in Recommendation 1 of the Toll of Trauma Inquiry, WAPU firmly believes this report should be disseminated for analysis by the appropriate parties who have a vested interest in any of the recommended (and actioned) outcomes. WA Police has previously provided copies of internal reviews to WAPU (for example, the Aurenda Report and the Workforce Optimisation Project) but has refused to do so with this report, for reasons unknown.

Therefore WAPU recommends that WA Police share the 2011 PWC review of the Health and Welfare Services with WAPU and with other stakeholders so that the relevant parties are aware of the proposals (and subsequent amendments) that will undoubtedly impact the services offered to police officers.

Recommendation 8

That WA Police reassess its response to the Community Development and Justice Standing Committee's *The Toll of Trauma on Emergency Staff and Volunteers* report.

WAPU considers the Government's response to the Toll of Trauma Inquiry to be completely inadequate, especially given the size and nature of the inquiry. The responses to each recommendation were extremely brief, with little proffered in the way of an explanation or rationale behind each decision to either support or not support the recommendations. Not only does WAPU disagree with a number of assertions made by WA Police, but WAPU is deeply dissatisfied with the peremptory response from Government.

Consequently, WAPU recommends that Government, specifically WA Police, reassess its formal response to the Toll of Trauma Inquiry and counter with a document that is considered, timely and detailed.

Recommendation 9

That the Former Officers' Medical Benefits Scheme be amended to encompass officers who suffered a work-related illness or injury before 1 July 2007 and to provide for vocational rehabilitation.

Currently, the Former Police Officers' Medical Benefits Scheme enables former officers to access payment for medical and other expenses incurred **on or after 1 July 2007**. However, there are many officers both serving and retired that did not incur their workplace illness or injury (and subsequent expenses) after the specified date and, for those officers who have since separated from WA Police, they are left to pay numerous medical bills without any assistance from Government. For some officers, whose illnesses or injuries are permanent and inhibitive, the cost impost of the associated medical bills is vast and oftentimes, overwhelming and unmanageable. This situation has also created a sense of inequity and injustice for those officers who have suffered immeasurably and do not have access to appropriate medical recompense.

Based on Member feedback, WAPU recommends the *Police (Former Officers' Medical and Other Expenses) Act 2008 (Act)* be amended to backdate the payment of medical and other expenses for injuries incurred **before** 1 July 2007 (as per Section 4 (1)). WAPU also recommends that this piece of legislation be amended to allow for police officers to receive the vocational rehabilitation entitlement (as per Schedule 1 clause 17 subclause (1a) of the Workers' Compensation Act, an entitlement which

eligible officers currently do not receive). Undertaking this recommendation would require a concerted dialogue between WA Police, WAPU and Government.

Recommendation 10

That an organisation similar in intent and structure to that of the Department of Veterans' Affairs, and independent of the Health and Welfare Services of WA Police, be established for police officers. This organisation must encompass units that: remunerate eligible members appropriate benefits; provide a range of health care and support services for eligible members; and offer specialised, free counselling.

Currently, no Government-organised agency exists to support police officers who have served the WA community. There are numerous NGOs that have been established to support both serving and retired officers but there is not one centralised, police-centric support service that a retired/separated member can attend to submit claims or inquire about restitution, seek assistance (be it counselling for psychological concerns or in-home assistance due to a physical ailment) or obtain support to be rehabilitated vocationally.

From the Member feedback, as well as a general sentiment that has been expressed over the years, interest has piqued in the Department of Veterans' Affairs (DVA) and what it offers eligible members. The DVA works to maintain and enhance the financial and physical wellbeing, quality of life and self-sufficiency of veterans by providing a variety of benefits and services for eligible persons. There is a focus on rehabilitation and compensation of eligible persons, both designed to assist a member if they are made ill or are injured as a result of their service. These are exactly the types of services our retired/separated Members require to assure not only that their welfare is being monitored and assisted, where appropriate, but ensure that they are aware of the (albeit few) benefits available to them. This would also enable eligible members to attend one service centre rather than rely on various disparate organisations to assist them where necessary.

As such, WAPU recommends that an organisation similar in intent and structure to that of the DVA be established for police officers that encompasses, at the very least:

- A unit that provides financial advice and assistance, and remunerates where applicable (for example, the integration of the insurance provider of the Former Officers' Medical Benefits Scheme);
- A unit that provides a range of health care and support services for eligible members;

- A unit that provides vocational rehabilitation, to enable members to have appropriate and fulfilled careers beyond policing, especially in cases where a physical or psychological illness or injury may otherwise impede employability; and
- Specialised and free counselling services for members and their immediate families.

Recommendation 11

That a service similar to Operation *Life*, and linked to the National Suicide Prevention Strategy, is developed for WA police officers.

Operation *Life* is the overarching framework for suicide prevention initiatives and mental health promotion strategies for the Australian veteran community. Operation *Life* aims to promote resilience, mental health and wellbeing, enhance protective factors that reduce the risk of suicide and develop partnerships with other organisations that offer support and education. Operation *Life* run workshops that promote mental health and suicide prevention through education, training and self-awareness.

This report has outlined the prevalence for police officers to suffer psychological illnesses during and post service, and the rate at which Members *in this survey alone* noted feelings of despair, helplessness and suicidal thoughts attests to the pervasiveness of work-related mental health issues. WAPU believes a service that is police-centric with the same aims as Operation *Life* would benefit and bolster the police community by increasing mental health awareness and fostering support networks. A service that is separate from Health and Welfare Services is vital for nurturing trust, as a lack of confidence in the discretion exercised in the Branch is preventing officers from disclosing vital health information to anyone at WA Police. However, WAPU believes this service should be a Government initiative with the capacity to appropriately monitor and track the health outcomes of separated officers (in the vein of the independent reviews run by Dunt and McKay et al. for the DVA).

As such, WAPU recommends that a service similar to Operation *Life* be established for police officers that is linked to the National Suicide Prevention Strategy. This service must promote mental health and wellbeing and suicide prevention through education, training and self-awareness via suitable police-centric workshops. The service must be independent of the Health and Welfare Services but maintain the appropriate capacity to monitor the health outcomes of separated officers.

Recommendation 12

That a compensation scheme for police officers, similar in intent and structure to the Workers' Compensation scheme, is thoroughly explored and an appropriate proposal is developed in conjunction with the relevant invested parties. The proposal must maintain appropriate sick leave provisions (both work and non-work related) similar to those currently in place for serving officers and take into consideration that police officers and their work duties are unique in comparison to all other workers.

Currently, WA police officers are exempt from the *Workers' Compensation and Injury Management Act 1981* unless they suffer an injury and die as a result of that injury. Police officers' current sick leave provisions are devised in lieu of standard Workers' Compensation arrangements yet there are disparities between the *Western Australia Police Industrial Agreement* and *Police Force Regulations 1979* and Workers' Compensation entitlements, such as the fault or conduct of the worker and injury management procedures. Furthermore, police officers are not entitled to receive compensation or certain ongoing payments for permanent or partial disabilities or incapacities beyond their tenure with WA Police, unlike employees in other professions. This illustrates that despite the existence of alternate sick leave provisions, police officers are treated inequitably with respect to illness or injury compensation and management.

WAPU is wary of simply integrating police officers into the current Workers' Compensation scheme because the work (and working conditions) that police are subjected to differs vastly from that of the general public (including other emergency service employees). Any compensation for work-related illness or injuries that is devised for police officers must take into consideration the uniqueness of the working conditions and industrial rights of police officers.

As such, WAPU recommends that thorough consideration be given to devising a compensation scheme for police officers who suffer an illness, injury and impairment that is psychological and/or physical. This scheme must be similar in intent and structure to the current Workers' Compensation scheme, as Workers' Compensation provides for (amongst many things) medical expenses, loss of wages, rehabilitation, injury management and compensation for an impairment. WAPU believes that any proposal developed must maintain appropriate sick leave provisions similar to those currently in place and take into consideration that police officers and their work duties are unique in comparison to all other workers.

Recommendation 13

That, in conjunction with Recommendation 12, as a compensation scheme similar to Workers' Compensation is explored for police officers, presumptive legislation (similar to that for professional firefighters) is considered for police officers with respect to a range of specific illnesses and injuries.

With respect to the possible development of a compensation scheme (similar to Workers' Compensation) for police officers, WAPU believes that consideration must be afforded for the development of presumptive legislation pertaining to police officers and a range of specific illnesses and injuries, like that for professional firefighters.

Police officers face a range of hazardous and life-threatening situations on a daily basis. These dangerous, covert or life-threatening duties can expose police officers to a range of illnesses or injuries that they may experience at a greater rate than that of the general public. Dismantling clandestine drug labs, attendance of the Arson Squad officers at fire sites when toxicity is most acute, exposure to bodily fluids through frequent interactions with drug-affected individuals, witnessing the aftermath of murders, suicides, sudden infant deaths, fatal traffic accidents, sudden deaths which are precursors for PTSD: these are some of the highly dangerous and potentially lethal situations that police officers face on a daily basis.

If legislation has been passed that protects professional firefighters who are exposed to carcinogens released during a fire, something similar *must* be considered in recognition of the hazardous situations to which police officers are regularly exposed. This could be an acknowledgement of exposure to carcinogens whilst an officer performs Arson Squad duties, any long term impacts on health that dismantling clandestine drug labs may have on a police officer or a correlation between exposure to horrifying critical incidents and developing PTSD. There is an undeniable correlation between mental illness and the repeated exposure to traumatic incidents, and this must be recognised in the form of similar presumptive legislation for police officers.

As such, WAPU recommends that as a compensation scheme (similar to Workers' Compensation) for police officers is explored and developed, presumptive legislation (like that for professional firefighters) is introduced for police officers with respect to a range of specific illnesses and injuries.

Recommendation 14

That the Government establish an ongoing scheme, similar in structure to Redress WA, that adequately and appropriately financially compensates those police officers who have been injured in the line of duty who are ineligible for other benefits and reinvigorated support services.

From our survey, we ascertained there were many police officers who had been medically retired from the Agency with inadequate compensation (be it from their superannuation or a pension or some other legal remedy like Criminal Injuries Compensation), injuries or illnesses that were so severe they were unable to pursue other meaningful, permanent employment and no support or services to assist a transition away from the Agency.

As our recommended changes are made to both existing legislation and WA Police governance of police officer health and welfare, for those retired/separated officers who have 'fallen through the gaps', a compensation scheme must be established to adequately and appropriately acknowledge the physical, psychological, emotional and financial hardships that have been faced as a result of extremely traumatic work undertaken and complete lack of support proffered during their careers.

Whilst money cannot make amends for all wrongdoings, it is the first step in acknowledging:

- That there have been a number of police officers who have faced copious traumas as part of their duties and put their bodies on the line for their work;
- That there have been (and still are) numerous deficiencies in the way police officers have received post-trauma support; and
- Resulting from this, there are a large number of police officers who have endured, and are still enduring, the devastating effects of trauma-induced psychological illnesses.

Financial compensation will not only recognise the above, but will assist those retired/separated officers with their medical expenses and any financial shortfall that has occurred because they have been unable to access their superannuation or they have been unable to re-engage in meaningful, steady, paid work.

As such, WAPU recommends that Government establish an ongoing scheme (to be referred to as **Recompense WA**), similar in structure to Redress WA, which adequately and appropriately financially compensates those police officers who have been injured in the line of duty who are ineligible for other benefits and reinvigorated support services.

Appendices

Appendix 1A

Legislated provisions for ex-gratia payments – *Financial Management Act 2006*

s.80. Act of grace payments[286]

(1) If the Treasurer is satisfied that it is appropriate to do so because of special circumstances, the Treasurer may authorise an amount to be paid to a person even though the payment would not otherwise be authorised by law or required to meet a legal liability.

(2) The Treasurer cannot authorise the payment under this section of an amount that exceeds the amount prescribed by the regulations for the purposes of this subsection unless that payment is approved by the Governor.

(3) A payment under this section may be made subject to conditions and, if any such condition is breached, the amount paid may be recovered as a debt due to the State in a court of competent jurisdiction.

(4) A request or recommendation to make a payment under this section may be made to the Treasurer in accordance with the Treasurer's instructions.

Appendix 1B

Legislated provisions for ex-gratia payments – *Financial Management Regulations 2007*

s. 8. Maximum amount for act of grace payments by Treasurer without Governor's approval (s. 80)[287]

For the purposes of section 80(2) of the Act, the amount is $250 000.

[286] State Law Publisher, *Financial Management Act 2006*, version 00 as at 18 December 2013, Government of Western Australia, Department of Premier and Cabinet, Perth, 2014, p. 52. < http://www.slp.wa.gov.au/pco/prod/FileStore.nsf/Documents/MRDocument:25798P/$FILE/Financial%20Management%20Act%202006%20-%20[03-a0-00].pdf?OpenElement >.

[287] State Law Publisher, *Financial Management Regulations 2007*, version 2 as at 11 December 2010, Government of Western Australia, Department of Premier and Cabinet, Perth, 2014, p. 5. < http://www.slp.wa.gov.au/pco/prod/FileStore.nsf/Documents/MRDocument:20695P/$FILE/Financial%20Management%20Regulations%202007%20-%20[00-d0-02].pdf?OpenElement >.

Appendix 1C

The Treasurer's Instructions regarding ex-gratia payments

319 ACT OF GRACE PAYMENTS[288]

BACKGROUND

Act of Grace payments are those payments that are not payable in pursuance of the law or are not payable under a legal liability. Although not legally bound, the government makes these payments when it considers that it is appropriate to do so because of special circumstances even though the payment would not otherwise be authorised by law or required to meet a legal liability.

Section 80(1) and (2) of the Act provides that the Treasurer may approve Act of Grace payments up to an amount prescribed by regulation and, where that payment exceeds the prescribed amount prior approval of the Governor must be sought. Financial Management Regulation 8 sets the limit that may be approved by the Treasurer at $250,000. Under section 74(1) of the Act the Treasurer has delegated to Ministers of the Crown the authority to approve Act of Grace payments up to $250,000. Amounts in excess of $250,000 require the prior approval of the Governor.

Where a Minister has delegated authority to approve such payments, accountable authorities shall cause all such requests to be addressed to the Treasurer and delivered to the responsible Minister to ensure compliance with section 80(1) of the Act. This reflects that the Minister is acting under a delegated power from the Treasurer, and that the power to approve payments remains a function of the Treasurer. The Minister, acting as delegate of the Treasurer, must personally approve each payment made under section 80 prior to the making of such payments.

TREASURER'S INSTRUCTION

(1) All submissions for Act of Grace payments pursuant to section 80(1) of the Act shall provide details of the proposed payment including full details of the incident or occurrence which gave rise to the request for the Act of Grace payment.

[288] Department of Treasury, *Treasurer's Instructions*, as 26 June 2009, Government of Western Australia, 2009, p. 131.
<http://www.treasury.wa.gov.au/cms/uploadedFiles/_Treasury/Legislation/FAB_Update_No_68_02_11_12_FESA.pdf>.

(2) Where a delegation from the Treasurer under section 74(1) of the Act so provides, requests for Act of Grace payments up to $250,000 shall be addressed to the Treasurer and submitted to the responsible Minister for approval.

(3) Submissions for Act of Grace payments in excess of $250,000 seeking the prior approval of the Governor in accordance with section 80(2) of the Act shall be forwarded through the responsible Minister to the Under Treasurer.

(4) The agency shall maintain a register of all Act of Grace payments made pursuant to section 80.

(5) All Act of Grace payments are to be disclosed in the annual report of the agency.

GUIDELINES

Requests for an Act of Grace payment arise from many and varied situations and each request will be assessed on the circumstances associated with that particular request. Requests for Act of Grace payments should be reviewed for reasonableness by the agency prior to being submitted for approval. Where consideration is being given to a person who has suffered damage, loss or injustice as a result of an act or omission of the agency, or that person's employment by the agency, the following criteria may be used in the assessment of claims for Act of Grace payments:

(i) any contributory negligence on the part of the claimant;

(ii) any defect or fault on the part of the government;

(iii) the purchase price and current value of the article lost or damaged;

(iv) the cost of repairing or replacing the article; and

(v) is approval likely to create a precedent with unintended consequences?

Where there is a reasonable possibility that further claims for similar payments will be received as stated in point (v) above, the accountable authority should refer the matter to the State Solicitor's Office before any approval is sought.

Where a request for an Act of Grace payment is not directly attributable to actions of the agency, and the matter is considered to be contentious, complex and uncertain, the Minister should seek the Cabinet's approval before seeking the Treasurer's approval. Where injustice is suffered, agencies are to ensure that all relevant avenues have been pursued in settling the matter, and that the advice of the State Solicitor's Office has been obtained as to the appropriateness and quantum of compensation.

Where appropriate, agencies should consult with Treasury prior to preparing any request for Act of Grace payments.

The State Solicitor has advised that costs to be met in relation to the following matters are not in the nature of Act of Grace payments:

(i) payments to satisfy a judgment; or

(ii) payments arising from out of court settlements, which stand in lieu of judgments and which may be evidenced by deeds of release, or the filing of documents in court where legal action has commenced.

Where an agency is involved in litigation and the litigation is not covered under professional indemnity and public liability insurance cover, the agency must immediately seek the State Solicitor's assistance with settlement of the matter. Claims for breach of contract, breach of copyright or defamation are examples of actions that would not be included under professional indemnity or public liability insurance cover.

When an act of grace payment is made as a result of:

(i) a moral obligation to compensate for damage, loss or injustice as a result of an act or omission, or that person's employment by the agency or related body or affiliated body; or

(ii) responsibility to relieve a person from financial hardship and that it would be proper and fair to do so the payment should be funded from the agency's existing budget allocations.

However, where supplementary funding is considered necessary, Ministers must obtain the Treasurer's approval to such funding in accordance with Treasurer's instruction 302 'Supplementation of Appropriations' prior to making a payment.

It should be noted that as agency appropriations are to "deliver services", any Act of Grace payment should be linked to, or be incidental to, the services delivered by the agency. In cases where there is no apparent linkage it will be necessary to seek guidance from Treasury as to the appropriate funding arrangements.

Responsible Minister

The reference to Minister in section 74(1) of the FMA includes Ministers Assisting.

Individual or grouped

For the purpose of this instruction, act of grace payments are to be individually approved. Where there are a number of requests for consideration, the agency may prepare a single submission for consideration by the Treasurer or a delegate.

Appendix 2A

WA Police-relevant findings (including those that pertain specifically to Project Recompense in blue) from the Toll of Trauma Inquiry

Finding 2

All of the State's emergency agencies have no mechanism for tracking their staff and the number of traumatic events they have attended over a particular period.

Finding 3

Most of the resources allocated by the State's emergency agencies to address staff trauma from critical incidents are located in Perth.

Finding 4

The State's main emergency agencies have difficulty identifying exactly what are their costs from staff trauma and what they spend on preparing their staff for trauma flowing from critical incidents.

Finding 6

All of the State's emergency responder agencies are currently not using the industry standard approach of Psychological First Aid in preparing their staff to deal with the trauma of critical incidents, but are still applying a debriefing approach that research has shown is either not useful or actually exacerbates the stress of some staff who participate in it.

Finding 8

The State's main emergency agencies are undergoing a cultural change as they employ additional younger members and women. This should ensure that more staff engage with the support services offered by their welfare and health branches.

Finding 9

The State's emergency agencies managers may not understand the possible impact of trauma on staff in a disciplinary situation.

Finding 10

Emergency agencies across Australia have struggled to fund compulsory annual physical well-being tests for their staff. Efforts to provide a voluntary psychological component to these tests have not been well-supported by their staff.

Finding 11

The State's emergency agencies use similar processes to deliver programs to their police, firefighters, paramedics and volunteers to address issues of trauma. Their staff attend the same critical incidents (eg car crash or fire) and train to support each other during a disaster.

Finding 12

There should be economies of scale if Western Australian emergency agencies combine to jointly deliver their welfare programs aimed at reducing staff trauma.

Finding 13

Chaplains play a critical role in preparing emergency agency staff for, and in responding to, stress from a disaster or critical incident. However, Western Australia Police and FESA welfare sections have fewer chaplains (both full-time and volunteer) than similar services in other Australian jurisdictions. The Department for Child Protection and the Department of Environment and Conservation currently do not employ a chaplain.

Finding 15

The peer support officer programs of Western Australia Police and the Fire and Emergency Service Authority appear to be less well-resourced than similar organisations in other Australian jurisdictions.

Finding 16

The State's emergency agencies undertake regular planning, exercises and simulations for the most likely disaster, not one posing the worst outcome for the State.

Finding 18

The ability to remain in contact with their family remains an important issue for deployed emergency agency staff. This is very important where a deployment period exceeds a regular shift or where staff are deployed to a very large disaster.

Finding 20

A robust database to record staff activity at the scene of a prolonged disaster is paramount to the proper fatigue management of staff and to monitor any overexposure to trauma.

Finding 21

Chaplaincy services, peer support officers and employee assistance providers all undertake important, but different, roles in supporting staff responding to critical incidents or disasters. The deployment of these supporting services should follow a well-developed plan that has been regularly reviewed and exercised.

Finding 22

The compensation received by first responders in Western Australia is currently skewed towards staff who receive a physical injury rather than those suffering mental trauma.

Finding 23

Medical records for the past five years indicate that WAPOL's medical retirement rate for stress-related illness is about seven times that for FESA.

Finding 24

There are a small number of chaplains employed by the State's emergency agencies. Their work is a very important part of agency programs to assist staff deal with trauma after a critical incident, but their face-to-face activities are mainly confined to the metropolitan region.

Finding 25

Except for the Department for Child Protection and the Fire and Emergency Services Authority, the State emergency response agencies' peer support programs seem to be the strongest element of their processes to reduce staff trauma following critical incidents.

Finding 26

The use of retired emergency staff as mentors or peer supporters has proven valuable overseas and is well-supported by all agencies which gave evidence to the Committee.

Finding 27

Currently State emergency agencies do not audit their EAP providers as to the veracity of information provided in invoices for payment.

Appendix 2B

WA Police applicable recommendations from the Toll of Trauma Inquiry

Recommendation 1

The Ministers for Emergency Services, Environment and Police ensure their departments undertake a formal review by 30 June 2013 of the welfare services addressing stress and trauma provided to both their career and volunteer members.

Recommendation 3

Departmental chief executives of the Western Australia Police, Department of Environment and Conservation and the Fire and Emergency Services Authority should be made personally responsible for the psychological health (as a result of critical incident trauma) of their staff and volunteers. This obligation should be reflected in their performance agreements.

Recommendation 4

The Ministers for Emergency Services, Environment and Police ensure that their departments develop as a high priority a computer system for tracking their staff and the number of traumatic events they have attended over a particular period.

Recommendation 5

The Ministers for Emergency Services, Environment and Police request their departments to place some of their staff and resources providing trauma-related services in regional Western Australia.

Recommendation 7

The Ministers for Emergency Services, Environment and Police ensure their departments include in their annual reports the expenditure they have incurred on preparing their staff for critical incidents, and for managing their response to these incidents.

Recommendation 10

The Ministers for Emergency Services, Environment and Police provide additional funds in the 2013-14 Budget so that the State's emergency response agencies can implement a Psychological First Aid approach to preparing staff to deal with critical incidents and disasters, as is used in other Australian jurisdictions.

Recommendation 11

The Ministers for Health, Police, and Emergency Services ensure that the Western Australia Police, the Fire and Emergency Services Authority and St John Ambulance establish a formal platform to share their knowledge and experience in delivering programs to their staff and volunteers to address issues of stress from disasters and critical incidents, as is done in other Australian jurisdictions.

Recommendation 12

The Ministers for Environment, Police, Child Protection and Emergency Services fund additional chaplaincy services, particularly for staff and volunteers based in rural and regional Western Australia.

Recommendation 14

The Minister for Emergency Services and the Minister for Police provide additional resources so that the Fire and Emergency Services Authority and the Western Australia Police can at least double their number of peer support officers, with an aim to increase the number in regional areas of the State.

Recommendation 15

The Ministers for Health, Emergency Services, Environment and Police provide additional funds to their agencies so that a detailed exercise is held on a regular basis based on a disaster that will create the worst outcome for the State.

Recommendation 19

The Minister for Police immediately instigate processes to ensure that the psychological well-being of officers is at the forefront of the Western Australia Police's staff planning. These processes should include all officers being trained in psychological first aid, with subsequent regular refresher courses. Senior officers should be the first priority for psychological first aid training.

Recommendation 20

The State's emergency response agencies should offer exit interviews to all of their staff and volunteers and use the information they gather to improve their trauma management procedures.

Recommendation 22

The Fire and Emergency Services Authority, Department of Environment and Conservation and Western Australia Police explore the usefulness of using retired staff as mentors or peer supporters, either directly employed or through a suitable nongovernment organisation.

Recommendation 23

The Ministers for Emergency Services, Environment and Police ensure their departments include provisions for regular external audits of invoices for payment in their next round of Employee Assistance Program contract negotiations.

Appendix 2C

Government response to the Toll of Trauma Inquiry

Recommendation	Response
Recommendation 1	**Supported** …In June 2013, Western Australia Police (WAPOL) began a strategic reform process. As part of this process, all procedures in Health and Welfare Services (H&WS) were reviewed. It was agreed that the overarching service requirement for H&WS is to provide proactive and preventative measures/services to front line employees. Proposals, including programs to address resilience in police employees, are currently being prepared to be evaluated as part of the Service Delivery Resource Model implementation process…
Recommendation 4	**Supported** WAPOL… already have computer systems that record all critical incidents. Work is currently being undertaken within both departments to enable more comprehensive tracking of individual officers' critical incident attendance…
Recommendation 5	**Supported** WAPOL's H&WS has been undertaking extensive visits to regional locations in 2014. To date, a Welfare Officer and a Chaplain have visited regional areas to provide education, assistance and support to police employees… WAPOL also has 21 peer support officers in regional WA. WAPOL has contracted an EAP provider, PPC Worldwide who has regional associates across

	the state which permits officers to receive generic counselling locally in many areas. Police specific critical incidents are attended to by staff from WAPOL's internal Psychology Unit.
Recommendation 7	**Not supported** …[Activities for the preparation of critical incidents] are integrated and normalised into standard operation procedures and could not be readily extracted and quantified, which makes the accurate capturing of these costs difficult. The Western Australian Government is of the view that establishing systems to record these costs may not necessarily be an effective indicator of the delivery of these services.
Recommendation 10	**Supported in part** …WAPOL provides training to all recruits on how to manage a critical incident via academy training and mortuary based learning. This is supported by H&WS through the Chaplains and provision of education programs by the Psychology Unit. The Police Academy has also recently implemented a new Mental Health training package in consultation with the H&WS Psychology Unit. MHFA is a nationally accredited program with two trainers at the academy and one H&WS trainer… Psychological First Aid is appropriate for smaller, lower level critical incidents but is considered insufficient for the needs of specialist disaster victim identification (DVI) team members… Personnel involved in DVI receive psychological preparation from the initial selection of staff and

	during training…, deployment…, and then debriefing and counselling upon return.
Recommendation 11	**Supported in part** Information-sharing about issues of stress from disasters and critical incidents currently occurs on an informal basis. The relevant agencies are committed to continued communication in the future…
Recommendation 12	**Supported** …WAPOL… have established their own chaplaincy networks throughout regional WA to assists chaplains and agency personnel involved in critical accidents or similar situations and to provide services to regional workers in the event a full time Chaplain is unable to respond…
Recommendation 14	**Supported in part** …WAPOL PSOs are able to provide confidential support and assist employees to seek appropriate assistance. The current structure, using volunteers undertaking the role in addition to their regular duties, has proved successful: employees have trust that PSOs are not 'working for the organisation' and have their best interests at heart. A paid role would require more formal negotiation around payment, duties, reporting requirement and responsibility and may attract applicants to the role for the wrong reasons. In 2014, the training for the peer support program for WAPOL was reviewed and revamped to provide more training around confidentiality and communication skills…

Recommendation 15	**Not supported** …As the number of persons involved is small, the value of exposing personnel to pressure or trauma situations is also limited…
Recommendation 19	Not supported Psychological First Aid is a sound introduction to mental health and psychological duty of care matters but the situation is far more complex for a workforce such as WAPOL's, given the large number of high risk activities in which staff are engaged. It is therefore essential that well trained and experienced mental health clinicians continue to oversee this matter. Limited training in PFA could expose the agency to risk if there is an expectation for officers to manage these significant responsibilities.
Recommendation 20	**Supported** All agencies have existing exit interview processes for staff. These processes may involve online exit surveys or meeting with employees to ensure their separation decisions are fully informed…
Recommendation 22	**Not supported** …WAPOL does not support directly employing [retired members] as mentors or PSOs. The Medically Retired WAPOL Officers Association provides a support network to ex-police officers as part of their purpose.
Recommendation 23	**Supported in part** …WAPOL is currently finalising the tender for EAP services. Strategies for audit are being looked at with procurement and the Department of Finance, however issues around client confidentiality and provision of services to

	family members of employees create a level of complexity to be considered in implementing an audit process.

Adapted from the "The Western Australian Government Response to Community Development and Justice Standing Committee Report No. 19: *The Toll of Trauma on Emergency Staff and Volunteers*". The recommendations noted above are the recommendations that pertain specifically to WA Police.

Appendix 3A

Schedule 2 of the *Workers' Compensation and Injury Management Act 1981*

Schedule 2 — Table of compensation payable[289]

Part 1

Item	Column 1 Nature of injury or impairment	Column 2 Ratio which the sum payable herein bears to the prescribed amount. %
	EYES	
1.	Total loss of sight of both eyes	100
2.	Total loss of sight of an only eye	100
3.	Total loss of sight of one eye	50
4.	Total loss of sight of one eye and serious diminution of the sight of the other eye	75
5.	Loss of binocular vision	50
	HEARING	
6.	Total loss of hearing	75
	SPEECH	
7.	Total loss of power of speech	75
	BODY AND MENTAL	
8.	Permanent and incurable loss of mental capacity resulting in total inability to work	100
9.	Total and incurable paralysis of the limbs or of mental powers	100
	SENSORY	
10.	Total loss of sense of taste and smell	50
11.	Total loss of taste	25
12.	Total loss of smell	25
	ARM	
13.	Loss of arm at or above elbow	90
14.	Loss of arm below elbow	80
	HAND	
15.	Loss of both hands	100
16.	Loss of a hand and foot	100
17.	Loss of hand or thumb and 4 fingers	80
18.	Loss of thumb	35
19.	Loss of forefinger	17
20.	Loss of middle finger	13

[289] As per Schedule 2 of the *Workers' Compensation and Injury Management Act 1981*, pp. 380-385.

Item	Column 1 Nature of injury or impairment	Column 2 Ratio which the sum payable herein bears to the prescribed amount. %
21.	Loss of ring finger	9
22.	Loss of little finger	6
23.	Total loss of movement of joint of thumb	17
24.	Total loss of distal phalanx of thumb	20
25.	Total loss of portion of terminal segment of thumb involving one-third of its flexor surface without loss of distal phalanx	15
26.	Total loss of distal phalanx of forefinger	10
27.	Total loss of distal phalanx of	
	— middle finger	8
	— ring finger	6
	— little finger	4
27A.	Total loss of distal phalanx of each finger of the same hand (not including the thumb) in one accident	31
	LEG	
28.	Loss of leg at or above knee	70
29.	Loss of leg below knee	65
	FEET	
30.	Loss of both feet	100
31.	Loss of foot	65
32.	Loss of great toe	20
33.	Loss of any other toe	8
34.	Loss of 2 phalanges of any other toe	5
35.	Loss of phalanx of great toe	8
36.	Loss of phalanx of any other toe	4
	BACKS, NECK AND PELVIS	
36A.	Permanent loss of the full efficient use of the back (including thoracic and lumbar spine).....	60
36B.	Permanent loss of the full efficient use of the neck (including cervical spine)	40
36C.	Permanent loss of the full efficient use of the pelvis	15
	MISCELLANEOUS	
37.	Loss of genitals	50
38.	Severe facial scarring or disfigurement to a maximum of	80
39.	Severe bodily, other than facial, scarring or disfigurement to a maximum of	50

Part 2

Item	Column 1 Nature of injury or impairment	Column 2 Ratio which the sum payable herein bears to the prescribed amount. %
	EYES	
40.	Impairment of sight of both eyes	100
41.	Impairment of sight of an only eye	100
42.	Impairment of sight of one eye	50
43.	Impairment of binocular vision	50
	HEARING	
44.	Impairment of hearing	75
	SPEECH	
45.	Impairment of power of speech	75
	BODY AND MENTAL	
46.	Impairment of mental capacity	100
47.	Impairment of spinal cord function	100
	SENSORY	
48.	Impairment of sense of taste and smell	50
49.	Impairment of sense of taste	25
50.	Impairment of sense of smell	25
	ARM	
51.	Impairment of arm at or above elbow	90
52.	Impairment of arm below elbow	80
	HAND	
53.	Impairment of both hands	100
54.	Impairment of hand and foot	100
55.	Impairment of hand or thumb and 4 fingers	80
56.	Impairment of thumb	35
57.	Impairment of forefinger	17
58.	Impairment of middle finger	13
59.	Impairment of ring finger	9
60.	Impairment of little finger	6
61.	Impairment of movement of joint of thumb.....	17
62.	Impairment of distal phalanx of thumb	20
63.	Impairment of portion of terminal segment of thumb involving one-third of its flexor surface without loss of distal phalanx	15
64.	Impairment of distal phalanx of forefinger	10
65.	Impairment of distal phalanx of	
	— middle finger	8
	— ring finger	6
	— little finger	4

Item	Column 1 Nature of injury or impairment	Column 2 Ratio which the sum payable herein bears to the prescribed amount. %
66.	Impairment of distal phalanx of each finger of the same hand (not including the thumb) in one accident	31
	LEG	
67.	Impairment of leg at or above knee	70
68.	Impairment of leg below knee	65
	FEET	
69.	Impairment of both feet	100
70.	Impairment of foot	65
71.	Impairment of great toe	20
72.	Impairment of any other toe	8
73.	Impairment of 2 phalanges of any other toe	5
74.	Impairment of phalanx of great toe	8
75.	Impairment of phalanx of any other toe	4
	BACK, NECK AND PELVIS	
76.	Impairment of the back (thoracic spine or lumbar spine or both)	75
77.	Impairment of the neck (including cervical spine)	55
78.	Impairment of the pelvis	30
	MISCELLANEOUS	
79.	Impairment of genitals	50
80.	Impairment from facial scarring or disfigurement	80
81.	Impairment from bodily, other than facial, scarring or disfigurement	50
82.	AIDS	100

Appendix 3B

Leave and entitlements relating to sick leave in the *Western Australia Police Industrial Agreement*

33. ENTITLEMENT TO LEAVE AND ALLOWANCES THROUGH ILLNESS OR INJURY

(1) An employee who becomes incapacitated shall as soon as possible:

(a) notify the employee's Officer in Charge of that fact and of the his or her whereabouts; and

(b) notify the Manager of the nature of the illness or the nature and cause of the injury, as the case may be.

(2) Except in respect of a day on which an employee becomes incapacitated while on duty and for the first 5 single day absences in a calendar year, an application for leave by an employee on account of incapacity shall be supported by a certificate of a medical practitioner or, where the incapacity involves a dental condition, by a certificate of a dentist. Save that where the employee is stationed in a remote or rural locality and there is no medical practitioner within that locality, a certificate from an attending registered nurse or certification of the incapacity by the employee's Officer in Charge shall suffice. Where the Employer has good reason to believe that the absence may not be legitimate, the Employer may request that evidence be provided. Should an employee become incapacitated while on duty, an application for leave on account of that incapacity does not require a supporting certificate.

(3) The application shall be:

(a) in a form approved by the Employer; and

(b) submitted to the Manager, and the certificate in its support shall be -

(c) submitted to the employee's Officer in Charge.

(4) Subject to subclause (2) of this clause, and the compliance of the employee with subclause (3) (a), (b) and (c) of this clause, the Employer may grant to an employee in respect of the employee's incapacity leave of absence with pay:

(a) for up to one hundred and sixty eight days in a calendar year; and

(b) if so recommended by the Manager and subject to any terms or conditions recommended by the Manager, for a further period.

(5) Except where an employee is incapacitated through the employee's fault or misconduct, an employee is entitled to receive in respect of a period of leave or absence approved under subclause (4) of this clause and subject to any terms and conditions imposed under subclause (4) (b) of this clause, any special allowances which the employee would have received under the Agreement if the employee had not been incapacitated.

(6) The district allowance prescribed by *District Allowance (Government Officers) General Agreement 2010* ceases to be payable:

(a) after an incapacitated employee and the family of that employee have been absent from the employee's region for a continuous period exceeding six weeks; and

(b) for so long thereafter as that absence continues.

(7) (a) An employee who suffers illness or injury through the employee's fault or misconduct is not entitled to paid leave contained within the provisions of subclause (4) (a) and (b) of this clause, in respect of absence from duty resulting from that illness or injury.

(b) An employee who suffers illness or injury through the employee's fault or misconduct is not entitled in respect of that illness or injury to receive the benefits contained under clause 35 - Work Related Medical and Hospital Expenses or clause 36. – Non Work-Related Medical and Pharmaceutical Expenses of this Agreement.

(c) Where the incapacity of an employee results from the carrying on by the employee of an occupation for which the employee received or expected to receive remuneration, outside of the employee's duties as an employee the Employer may grant or refuse to grant paid leave to the employee in respect of the incapacity or may grant the employee leave at a reduced rate of pay.

(8) An incapacitated employee shall not during the employee's absence from duty engage for reward in any other occupation or activity.

(9) An employee who has been absent from duty because of incapacity for longer than four weeks shall, before returning to duty, submit to the Manager evidence of the employee's medical fitness to return to duty.

(10) (a) The Employer may direct an employee to submit to examination, at the expense of the Employer, by one or more medical practitioners nominated in each instance by the Employer and the employee shall obey such a direction.

(b) Where an employee has been examined under subclause 10 (a) of this clause, and the examining medical practitioner expresses the opinion in writing to the Employer that the employee is unfit for duty because of illness or injury, the Employer may direct the employee, to apply for leave on that ground and the employee shall obey such a direction.

(11) An employee who is required to travel to Perth or a location other than his or her locality for medical treatment arising from a work related illness or injury is entitled to travel allowances in accordance with Clause 27. – Travelling Allowances.

35. WORK RELATED MEDICAL AND HOSPITAL EXPENSES

Subject to the provisions contained within subclause (7) (b) of Clause 33. - Entitlement to Leave and Allowances Through Illness or Injury of this Agreement, the Employer shall pay the reasonable medical, dental, medical aides, hospital and travelling expenses incurred by an employee as a result

of illness or injury arising out of or in the course of the employee's duties or suffered by the employee in the course of travel to or from a place of duty.

36. NON WORK-RELATED MEDICAL AND PHARMACEUTICAL EXPENSES

Medical and Pharmaceutical Expenses

(1) Subject to the provisions contained within subclause (7) (b) of Clause 33. - Entitlement to Leave and Allowances through Illness or Injury of this Agreement, the Employer may pay the reasonable medical illness or injury related expenses (less the amount of any Medicare benefits and private health insurance or other benefit fund, paid or payable) of an employee who receives:

(a) any consultation, treatment or other service by a medical practitioner; or

(b) any X-ray or other service not provided by a medical practitioner but provided under a referral given by a medical practitioner.

(2) An employee is entitled to reimbursement by the Employer of the cost of a medicine supplied by a pharmacist on the prescription of a medical practitioner if the medicine was at the time of issue of the prescription specified in Pharmaceutical Benefits Schedule for Consumers.

Exclusions

(3) Without affecting by implication the meaning of "medical illness or injury related expenses" in subclause (1), above, the Employer shall not be liable for any medical or pharmaceutical expenses referred to in subclause (1) and (2), above, associated with the following:

(a) All Dental procedures performed by a Dentist or Surgeon.
(b) Elective surgery for cosmetic (eg. breast implants, liposuction, gastric banding), contraception, and conception procedures.
(c) Illness or injury caused through the employee's fault or misconduct.
(d) Obstetrician costs in excess of $2000 per financial year.
(e) Illness or injury caused by Secondary Employment.
(f) Illness or injury due to participation in the following sporting activities:
    (i) Racing, other than on foot;
    (ii) Diving with an artificial breathing device (unless the employee has an open water diving certificate or is being directly supervised by a qualified diving instructor);
    (iii) Hang-gliding, skydiving or activities involving a parachute;
    (iv) Mountaineering or rock climbing;
    (v) Hunting;
    (vi) Yachting which involves sailing in international waters;
    (vii) Any sporting activity played in a professional capacity for which the employee receives a financial sponsorship or other financial reward.
(g) Illness or injury that occurs during a period of leave without pay.
(h) Experimental surgery for which there is no Medicare Number at the time of the surgery.
(i) Medical and pharmaceutical expenses incurred by officers whilst outside of Western Australia on paid or unpaid leave.

Making a Claim

(3) A minimum amount to be reimbursed of $200 must be accumulated in medical and pharmaceutical expenses before a claim is to be submitted to Health and Welfare Services, provided that on termination of an employee's employment, all outstanding amounts will be paid. A rolling date of 24 months from the date of treatment is allowed for employees to claim reimbursement.

(4) An employee claiming reimbursement of expenditure shall submit with his or her claim:

(a) in the case of expenditure of a kind referred to in subclause (1) of this clause -

(i) a receipt for the amount paid;

(ii) a statement of the amount received as Medicare benefits;

(iii) a statement of the amount received from a private health insurer or other benefit fund;

(iv) where applicable, documentary evidence that the health service not provided by a medical practitioner was provided under a referral given by a medical practitioner; and

(b) in the case of expenditure of a kind referred to in subclause (2) of this clause, a receipt for the amount paid, and the Employer, before approving payment, may require the employee to supply additional information as to the identity of the person treated, the amount paid or, where applicable, the prescription.

Appendix 3C

Comparison between Workers' Compensation and WA Police sick leave and entitlements

Entitlement	Workers' compensation (limited to work related injury and disease)	Western Australian police sick leave and medical regulations (covers work and non-work related conditions)
Weekly payments	Provided for under the *Workers' Compensation and Injury Management Act 1981* (WA) up to a maximum of the prescribed amount of $206,742.00 as at 1 July 2013	Regulation 1304 provides for 168 days wages with an extension subject to the Commissioner's discretion. Entitlements cease on termination of employment: Regulation 1402(4)
Medical expenses	*Workers' Compensation and Injury Management Act 1981* (WA) up to a maximum of the prescribed amount of $62,023.00 as at 1 July 2013[290]	Paid for work- and non-work related conditions. Non-work related medical entitlements cease on termination of employment. See also *Western Australian Police Industrial Agreement 2011* WAIRC 01097 (clauses 35–37) Reasonable work related medical expenses are provided for by the *Police (Medical and Other Expenses for Former Officers) Act 2008.*
Rehabilitation allowances	*Workers' Compensation and Injury Management Act 1981* (WA) up to a maximum of the prescribed amount of $14,472.00 as at 1 July 2013	No structured assistance; some departmental assistance for return to work
Employment protection provisions	*Workers' Compensation and Injury Management Act 1981* (WA) section 84AA. 12-month prohibition on dismissal while on compensation	No formal protection while on sick leave, although some protection under industrial laws

[290] An additional amount of up to $50,000 may be ordered by an arbitrator where a worker's social and financial circumstances justify it. An additional amount, up to $250,000 and beyond the $50,000 may be ordered by an arbitrator in circumstances described in Schedule 1, subclause 18A(2aa) of the *Workers' Compensation and Injury Management Act 1981* (WA). WorkCover WA, *Variations in Prescribed Amount and Other Workers' Compensation Payments*, Government of Western Australia, 2013, p. 1. < http://www.workcover.wa.gov.au/NR/rdonlyres/B399D1E6-D024-478B-A3BE-6BEDB09D5BAE/0/Prescribed_Amount_Schedule_201301.pdf >.

Injury management policy and procedures	*Workers' Compensation and Injury Management Act 1981* (WA) provides a statutory obligation to attempt to return worker to work subject to worker's capacity.	No formal obligation in relation to return to work
Payment of lump sums for permanent impairment	*Workers' Compensation and Injury Management Act 1981* (WA) provides for payment up to $206,742.00. Available to all workers; calculated in accordance with medical assessment and statutory schedules.	No provision for this entitlement
Payment to dependants on death of worker	Provided for under *Workers' Compensation and Injury Management Act 1981* (WA)	Provided for under *Workers' Compensation and Injury Management Act 1981* (WA)
Journey claims coverage (to and from work)	Not covered under *Workers' Compensation and Injury Management Act 1981* (WA)	Regulation 1306 provides coverage. Entitlements cease on termination of employment. See also *Western Australian Police Industrial Agreement 2011* WAIRC 01097 clauses 35–37

This table has been extracted and updated from R Guthrie, "The Industrial Relations of Sick Leave and Workers' Compensation for Police Officers in Australia", National Research Centre for Occupational Health and Safety Regulation, the Australian National University, 2009, pp. 21-23.

Appendix 4A

Diseases recognised under the presumptive legislation for professional firefighters

7. Provisions relating to diseases[291]

(8) If an employee:

(a) suffers a disease mentioned in the following table; and

(b) before the disease was sustained, was employed as a firefighter for the qualifying period mentioned for that disease; and

(c) was exposed to the hazards of a fire scene during that period; and

(d) in the case of a cancer of a kind covered by item 13 of the following table—satisfies the conditions (if any) prescribed for such a cancer; the employment is, for the purposes of this Act, taken to have contributed, to a significant degree, to the contraction of the disease, unless the contrary is established.

Item	Disease	Qualifying period
1	Primary site brain cancer	5 years
2	Primary site bladder cancer	15 years
3	Primary site kidney cancer	15 years
4	Primary non-Hodgkins lymphoma	15 years
5	Primary leukemia	5 years
6	Primary site breast cancer	10 years
7	Primary site testicular cancer	10 years
8	Multiple myeloma	15 years
9	Primary site prostate cancer	15 years
10	Primary site ureter cancer	15 years
11	Primary site colorectal cancer	15 years
12	Primary site oesophageal cancer	25 years

[291] As per the *Safety, Rehabilitation and Compensation Act 1988*, no. 75 as amended 14 June 2014, Australian Government, ComLaw, Commonwealth of Australia. < http://www.comlaw.gov.au/Details/C2014C00198 >.

Item	Disease	Qualifying period
13	A cancer of a kind prescribed for this table	The period prescribed for such a cancer

(9) For the purposes of subsection (8):

(a) an employee is taken to have been employed as a firefighter if firefighting duties made up a substantial portion of his or her duties; and

(b) an employee who was employed as a firefighter for 2 or more periods that add up to the qualifying period is taken to have been so employed for the qualifying period; and

(c) an employee is taken to have been employed as a firefighter only if he or she was (disregarding the effect of any declarations under subsection 5(15)) employed as a firefighter by the Commonwealth, a Commonwealth authority or a licensed corporation.

(10) Subsection (8) does not limit, and is not limited by, subsections (1) and (2).

Appendix 4B

Presumptive legislation for professional firefighters as it appears within the *Workers' Compensation and Injury Management Act 1981*

Division 4A — Injury: specified diseases contracted by firefighters[292]

[Heading inserted by No. 21 of 2013 s. 4.]

49A. Terms used

In this Division —

date of injury has the meaning given in section 49D(1);

qualifying period, for a specified disease, means the period specified in Schedule 4A column 2 opposite the specified disease;

specified disease means a disease specified in Schedule 4A column 1.

[Section 49A inserted by No. 21 of 2013 s. 4.]

49B. Application of Division

This Division applies to a worker who has contracted a specified disease if —

(a) the date of injury is on or after the day on which the *Workers' Compensation and Injury Management Amendment Act 2013* section 4 comes into operation; and

(b) on the date of injury the worker is a member or officer of a permanent fire brigade established under the *Fire Brigades Act 1942*.

[Section 49B inserted by No. 21 of 2013 s. 4.]

49C. When employment as firefighter taken to contribute to specified disease

(1) If a worker to whom this Division applies —

(a) before the date of injury, was employed as a firefighter for at least the qualifying period for the specified disease; and

(b) was exposed to the hazards of a fire scene in the course of the employment; and

(c) in the case of a cancer of a kind mentioned in Schedule 4A item 13, satisfies the conditions (if any) prescribed by the regulations for such a cancer,

the employment is, for the purposes of this Act, taken to have been a contributing factor and to have contributed to a significant degree to the specified disease, unless the employer proves the contrary.

[292] As per the *Workers' Compensation and Injury Management Act 1981*, pp. 62-65.

(2) A worker who was employed as a firefighter for 2 or more periods that in aggregate equal or exceed the qualifying period for a specified disease is taken to have been employed as a firefighter for at least that qualifying period.

(3) For the purposes of this section, a worker was employed as a firefighter if —

(a) the worker was a member or officer of a permanent fire brigade established under the *Fire Brigades Act 1942*; and

(b) firefighting duties made up a substantial portion of the worker's duties.

[Section 49C inserted by No. 21 of 2013 s. 4.]

49D. Date of injury

(1) The date of injury, in relation to a worker who has contracted a specified disease, is the earlier of these days —

(a) the day on which the worker becomes totally or partially incapacitated for work by reason of the specified disease;

(b) the day on which the worker is first diagnosed by a medical practitioner as having contracted the specified disease.

(2) If, for the purposes of this Act, it is necessary to determine, in the case of a worker to whom this Division applies, when the worker's injury occurred, the injury is taken to have occurred on the date of injury as described in subsection (1).

[Section 49D inserted by No. 21 of 2013 s. 4.]

49E. Review of Division

(1) The Minister must carry out a review of the operation and effectiveness of this Division as soon as practicable after every 5th anniversary of the day on which the *Workers' Compensation and Injury Management Amendment Act 2013* section 4 comes into operation.

(2) The Minister must prepare a report based on the review and, as soon as practicable after the report is prepared, cause it to be laid before each House of Parliament.

[Section 49E inserted by No. 21 of 2013 s. 4.]

Schedule 4A — Specified diseases for firefighters

[s. 49A and 49C(1)(c)]

[Heading inserted by No. 21 of 2013 s. 5.]

	Column 1	Column 2
Item	**Disease**	**Qualifying period**
1.	Primary site brain cancer	5 years
2.	Primary site bladder cancer	15 years
3.	Primary site kidney cancer	15 years
4.	Primary non-Hodgkin's lymphoma	15 years
5.	Primary leukaemia	5 years
6.	Primary site breast cancer	10 years
7.	Primary site testicular cancer	10 years
8.	Multiple myeloma	15 years
9.	Primary site prostate cancer	15 years
10.	Primary site ureter cancer	15 years
11.	Primary site colorectal cancer	15 years
12.	Primary site oesophageal cancer	25 years
13.	A cancer of a kind prescribed by the regulations for the purposes of this Schedule	The period prescribed by the regulations for such a cancer

[Schedule 4A inserted by No. 21 of 2013 s. 5.]

Appendix 5A

Powers to remove both commissioned and non-commissioned officers

8. Commissioned and non-commissioned officers, removal of

(1) The Governor may, from time to time as he shall see fit, remove any commissioned officer of police, and upon any vacancy for a commissioned officer, by death, removal, disability, or otherwise, the Governor may appoint some other fit person to fill the same; and the Commissioner of Police may, from time to time, as he shall think fit, suspend and, subject to the approval of the Minister, remove any non-commissioned officer or constable; and in case of any vacancy in the Police Force by reason of the death, removal, disability or otherwise of any non-commissioned officer or constable, the Commissioner of Police may appoint another person to fill such vacancy.

(2) The powers of removal referred to in subsection (1) can be exercised only if the Commissioner of Police has complied with section 33L and that removal action has not been revoked under section 33N(1).

(3) Subsection (2) does not apply where a person is removed from a commissioned office to be appointed to another commissioned office so long as that appointment —

(a) is to an office at a level not less than the level of the office from which the person was removed; or

(b) is made with the consent of the person.

(4) Subsection (2) does not apply to the removal of a police probationary constable.

[Section 8 amended by No. 24 of 1969 s. 3; No. 7 of 2003 s. 4.]

Appendix 5B

Loss of confidence proceedings

Division 2 — Removal of members

[Heading inserted by No. 7 of 2003 s. 6.]

33L. Notice of loss of confidence to be given before removal action is taken

(1) If the Commissioner of Police does not have confidence in a member's suitability to continue as a member, having regard to the member's integrity, honesty, competence, performance or conduct, the Commissioner may give the member a written notice setting out the grounds on which the Commissioner does not have confidence in the member's suitability to continue as a member.

(2) If a notice is given to a member under subsection (1), the member may, before the expiration of the period of 21 days after the day on which the notice is given or such longer period as is allowed by the Commissioner of Police, make written submissions to the Commissioner of Police in respect of the grounds on which the Commissioner has lost confidence in the member's suitability to continue as a member.

(3) After the end of the period referred to in subsection (2), the Commissioner of Police shall —

(a) decide whether or not to take removal action; and

(b) give the member written notice of the decision.

(4) The Commissioner of Police shall not decide to take removal action unless the Commissioner —

(a) has taken into account any written submissions received from the member under subsection (2) during the period referred to in that subsection; and

(b) still does not have confidence in a member's suitability to continue as a member, having regard to the member's integrity, honesty, competence, performance or conduct.

(5) If the Commissioner of Police decides to take removal action —

(a) the notice under subsection (3)(b) shall advise the member of the reasons for the decision;

(b) except to the extent that the regulations otherwise provide, the Commissioner shall, within 7 days of giving the notice of the decision under subsection (3)(b), provide to the member a copy of any documents and make available to the member for inspection any other materials that were examined and taken into account by the Commissioner in making the decision; and

(c) the removal action may be taken when, or at any time after, the notice under subsection (3)(b) is given.

[Section 33L inserted by No. 7 of 2003 s. 6.]

Appendix 5C

The medical retirement process – information from WA Police

MEDICAL RETIREMENT OF POLICE OFFICERS AND ABORIGINAL POLICE LIAISON OFFICERS	
Decision is made to proceed with the medical retirement of an employee	The decision is made by the WA Police Occupational Health Physician or Consultant Psychiatrist for employees who are on extended periods of sick leave and deemed to be unable to perform their duties as a police officer or aboriginal police liaison officer.
Employee notified and provided with information	Health and Welfare Services notify the employee of the decision to proceed with medical retirement. The employee's manager/supervisor and District Office are also notified.
Information requested from employee's treating medical practitioners	The employee's treating medical practitioners are requested to provide information in relation to the employee's medical condition. The employee is requested to sign an "Authority to Release Information" in reference to these reports. It should be noted that confidentiality is assured in all cases. Should the employee refuse to sign the "Authority to Release Information" the Commissioner may suspend any entitlement to paid sick leave.
Recommendation made by the WA Police Occupational Health Physician or Consultant Psychiatrist	The Occupational Health Physician or Consultant Psychiatrist makes a recommendation to the Assistant Director Health and Welfare Services that the employee appears before a medical board to determine his/her fitness for further service in the Western Australia Police. Should the employee's treating medical practitioners and the Occupational Health Physician or Consultant Psychiatrist feel that the employee should not be retired on the grounds of ill health; the employee will be advised accordingly. The employee will then be put on a return to work program.
Request made to the WA Health Department to convene a medical board	The Assistant Director Health and Welfare Services makes a request to the Executive Director of Public Health that a medical board be convened under *1402 of the Police Force Regulations 1979* to determine the employee's fitness for further service in the Western Australia Police.

Decision made by Health Department to convene a medical board	The Executive Director of Public Health disseminates the medical information to the chair person of the medical board who decides whether there is sufficient evidence to proceed with a medical board. Health and Welfare Services are advised of the time and location of the appointment and send a letter to the employee advising him/her of the appointment details. If the chair person of the medical board decides that there is insufficient evidence to proceed with a medical board, he/she will contact the Assistant Director Health and Welfare Services and provide an explanation for the decision and request further medical evidence. Health and Welfare Services consult with the employee in relation to further medical assessment. Where no further medical evidence is available a return to work program is developed. Should the employee fail to comply a decision is made with respect to his/her ongoing paid sick leave entitlements.
Medical board meeting	If the case is to proceed, the employee attends the medical board where three medical specialists make a determination as to the employee's fitness for further service in the Western Australia Police. A Health and Welfare Services representative attends the medical board meeting to offer support.
Application to the Government Employees Superannuation Board (GESB)	A number of GESB forms are posted to the officer (or handed to the officer on the day of the medical board), for completion and forwarding to the GESB. It is imperative that these forms are completed and sent as soon as possible to allow the GESB to make a determination concerning the employee's disability benefits. This information should be received by the GESB prior to the medical board decision.
Determination of medical board	The report from the medical board is sent to the Assistant Director Health and Welfare Services (the medical board normally report their findings within 10 working days). Health and Welfare Services inform the employee of the medical board decision. The employee's Assistant Commissioner is advised so that he/she can ensure that the employee's workplace keeps in contact with the employee throughout the process.
The Government Employees Superannuation Board advised	The Assistant Director Health and Welfare Services advises the GESB of the medical board decision and provides copies of the medical reports. This is done to assist the employee have the matter resolved as close to the date of retirement as possible. The GESB may request further documented medical evidence from the employee's treating medical practitioners or may require the employee to attend an assessment to determine the employee's level of disability. If the employee is dissatisfied with the GESB's final assessment, it is the employee's responsibility, should he/she desire, to provide any additional

	information they require to reconsider the decision. ***The GESB process is independent of WA Police and Health and Welfare Services are not involved. The WA Police Union offer their members assistance in this matter.***
Recommendation made to the Commissioner to medically retire the employee	Once the medical board has determined that the employee has a permanent disability or the Commissioner does not have confidence in the employee's suitability to continue his/her duties as a police officer or aboriginal police liaison officer because of the employee's medical condition, the employee will be served with a Notice of Intention to Remove from the Police [33L (1) of the Police Act 1892]. Through this process the Commissioner acknowledges that the employee is no longer fit to serve in his/her chosen career and that is the reason for retirement.
Employees invited to respond	Employees are invited to respond to the Notice of Intention to Remove from the Police and advise the Commissioner within 21 days from the service of the notice why he should not recommend to the Minister for Police the employee's removal from the WA Police. At the expiration of this 21 day period the employee will be served with a Notice of Decision Under [33L(3)(b) of the Police Act 1892]. This notice is advice that the Commissioner intends to immediately recommend to the Minister for Police that he approve the employee's removal on medical grounds.
Minister's approval requested	A recommendation is sent to the Minister for Police that he approves the employee's removal on medical grounds. The employee's retirement takes effect on the date of the Minister's endorsement. The employee will receive a maintenance payment for a period of 28 days after the date of the endorsement by the Minister. [33M (1) of the Police Act 1892]
Employee informed of Minister's approval	Upon the Minister's approval, the Assistant Commissioner of the employee's Region/Portfolio is advised of the details of the employee's retirement. The Assistant Commissioner arranges for a suitable Commissioned Officer to attend at the employee's home. The Commissioned Officer presents and explains the contents of a letter from the Director Human Resources that outlines the proceedings to be followed for retirement and removal from WA Police.
Retirement process completed	The Manager Personnel Services sends a letter to the employee in regard to the employee's eligible termination payment. Personnel Services also attends to other matters relating to finance and outstanding leave. A Certificate of Service and letter from the Commissioner (subject to integrity testing) will be delivered to the retiree by the Assistant Commissioner or representative. The retiree may opt to receive these documents at a Police Graduation Ceremony at the Police Academy.

Appendix 5D

The medical retirement process – information from WA Police

INFORMATION REGARDING RETIREMENT ON MEDICAL GROUNDS
(POLICE OFFICER)

This form details procedures adopted by the Western Australia Police in relation to medical retirements. As you have decided, or been recommended to pursue medical retirement from the Western Australia Police, it is requested that you read the following in full.

Occupational Health Physician

After consultation with the Police Occupational Health Physician or Consultant Psychiatrist in regards to medical retirement, he/she will write to your specialist's and doctor's requesting information in relation to your medical condition. An "Authority to Release Information" will be signed by you in reference to these reports. It should be noted that confidentiality is assured in all cases. The Occupational Health Physician must have all the available medical information to proceed with his/her assessment of your fitness to continue to perform your duties as a police officer.

Specialists/Medical Reports

As soon as all the information is received from your nominated specialist/s and general practitioner's recommending your medical retirement, the Occupational Health Physician will forward a memo to the Assistant Director, Health and Welfare Services recommending that you appear before a Medical Board to determine your fitness to remain in the Western Australia Police.

Should your nominated specialist's and/or your medical practitioners and the Occupational Health Physician feel that you should not be retired on the grounds of ill health, you will be advised accordingly.

Medical Board

The Assistant Director, Health and Welfare Services will forward to the Executive Director of Public Health at the Health Department a report outlining your medical condition together with a copy of all appropriate medical reports. The Manager will request that a Medical Board be convened under Regulation 1402 of Police Force Regulations to determine your fitness for further service in the Western Australia Police.

If the Executive Director of Public Health deems there is sufficient evidence to proceed with a Board meeting, the Health Department will forward correspondence stating the time and location of the appointment. A letter will be forwarded to you advising you of the appointment details.

If the Executive Director of Public Health deems there is insufficient evidence to proceed with a Medical Board, he/she will contact the Assistant Director, Health and Welfare Services and provide an explanation for the decision and request further medical evidence. (In these instances each file is assessed individually and acted upon accordingly).

If the case is to proceed, you will attend the Medical Board where three medical specialists will make a determination as to your fitness to continue in the Western Australia Police. A member of Health and Welfare Services will attend at the Medical Board venue on the day to offer support.

The report from the Medical Board will be forwarded to Health and Welfare Services in due course and you will be advised of their findings.

Application to the Government Employees Superannuation Board

At the conclusion of the Medical Board hearing a number of Government Employees Superannuation Board (GESB) forms will be handed to you for completion and forwarding to the Superannuation Board. It is imperative that these forms are completed and sent as soon as possible to allow the GESB to make a determination concerning your disability benefits. This information should be received by the GESB prior to the report of Health and Welfare Services and the decision of the Medical Board regarding your fitness for work.

The GESB may request further documented medical evidence from you or may require you to attend an assessment to determine your level of disability. If you are dissatisfied with the GESB'S final assessment, it is your responsibility, should you desire, to provide any additional information they require to reconsider their decision.

Retirement and removal from the Western Australia Police (Section 8 Police Act)

33L. Notice of loss of confidence to be given before the removal action is taken If the Commissioner of Police does not have confidence in a member's suitability to continue as a member, having regard to the member's integrity, honesty, competence, performance or conduct, the Commissioner may

give the member a written notice setting out the grounds on which the Commissioner does not have confidence in the member's suitability to continue as a member.

Once the Medical Board has determined that you have a permanent disability or the Commissioner does not have confidence in your suitability to continue your duties as a Police Officer because of your medical condition, you will be served with a Notice of Intention to Remove from the Police (Section 33L(1) of the Police Act). Through this process the Commissioner acknowledges that you are no longer fit to serve in your chosen career and that is the reason for your retirement.

You are invited to respond to this Notice and advise the Commissioner within 21 days from the service of the Notice why he should not recommend to the Minister of Police your removal from the Police.

At the expiration of this 21 day period you will be served with a Notice of Decision Under Section 33L(3)(b) of the Police Act. This notice is advice that the Commissioner intends to immediately recommend to the Minister for Police that she approve your removal on medical grounds.

Minister's approval

Advice is forwarded to the Minister for his approval. Your retirement on the grounds of ill health will take effect on the date of his endorsement. You should also be aware that changes to legislation now provide that an officer will receive a maintenance payment for a period of 28 days after the date of the endorsement by the Minister.

Upon approval, the Portfolio/Branch Head will be advised of the details of your retirement and a letter explaining the proceedings to be followed will be delivered to you.

The Manager of Personnel Services will forward a letter to you in regard to your eligible termination payment. This office also attends to other matters relating to finance and outstanding leave.

Appendix 5E

***Police (Compensation for Injured Officers) Amendment Bill 2006* – proposal for compensation**

135C. Payment of lump sum compensation amount

(1) Subject to subsection (2), the Commissioner of Police shall pay to a former member who resigned from, retired from or otherwise left the Police Force as a consequence of an injury suffered on duty an amount calculate din accordance with subsection (3).

(2) A former member who reigned from, retired from or otherwise left the Police Force as a consequence of an injury suffered on duty which was suffered through the former member's fault or misconduct is not entitled to receive the benefits provided for in subsection (1).

(3) The Commissioner of Police shall pay to the former member (or his spouse in circumstances in which the former member is dead) or to the personal representatives of the former member, an amount in accordance with the formula:

A = S x CF x I

Where:

A = the amount to be paid to the former member or his personal representatives;

S = the annual salary of the former member at the date of the former member's resignation, retirement or other departure from the Police Force;

CF = the capitalisation factor prescribed for the purposed of this section by the regulations, for the sex of the former member and for the age of the former member on the day on which he or she retired, resigned or otherwise left the force; and

I = the extent of the former member's permanent loss of earning capacity, determined by the Commissioner of Police and expressed as a percentage, as a consequence of the injury suffered on duty.

(4) Without limiting any other factor the Commissioner of Police may take into consideration when determining a former member's permanent loss of earning capacity as referred to in subsection (2), a psychological or psychiatric injury sustained by a former member as a consequence of an injury suffered on duty provided that such injury is demonstrable and permanent.

Appendix 6A

South Australia's *Workers' Rehabilitation and Compensation (General) Regulations 1999* – loss of earnings payment formula

$$X = \frac{(K \times P)}{(1 - 1 / (1 + K)^{N}) \times (1 + K)}$$

Where—

X is the amount of each instalment

K equals $((1+ I)^{1/M} - 1)$ where—

M is the number of instalments to be paid per year or, if the instalments are to be paid less frequently than annually, M is an amount calculated as follows:

$$M = \frac{1}{\text{Number of years duration of each particular instalment}}$$

I is the prescribed discount rate (expressed as a decimal number) plus the prescribed inflation rate (expressed as a decimal number) for the period to which the assessment relates (see subregulation (3))

P is the lump sum assessment of capital loss

N is the total number of instalments to be paid over the period to which the assessment relates.

Appendix 6B

New Zealand Police Trauma Policy – specified critical incidents

Referral following critical incidents[293]

A referral **must** (bolding is Agency's own) be made in these situations:

- Injury or threat to the employee's life on duty;
- Disaster victim identification incidents and multiple deaths;
- Delayed discovery of body/bodies;
- Multiple or bizarre homicides;
- Attendance at a high number of critical incidents over a short period of time;
- Operational incidents involving the loss of a police employee's life;
- Incidents where police interventions fail to prevent loss of life or injury to others, e.g. domestic incidents, failed negotiations
- Death or serious injury involving a baby or small child or where attending employees have family members of a similar age
- Attending incidents that involved other police employees or their family members;
- Unpleasant or stressful duties, e.g. protracted enquiries, cases where aggravated and/or unpleasant factors exist.

[293] As per the Trauma Policy of the New Zealand Police.

Appendix 7A

WAPU newsletter to Members

WAPU NEWSLETTER 2014/11
8 April 2014

Project Recompense needs your input

Project Recompense is a WA Police Union-initiated research project that intends to secure a fair outcome for all Members who have suffered trauma during the course of your employment with WA Police and have been, will be or could be medically retired.

Project Recompense aims to identify and build a case to advocate for a fair and sustainable process that can be put in place to compensate our Members without the need for ad hoc ex-gratia payment applications.

We are now at the stage where we require input from Members. We wish to ascertain information including: the physical or psychological illnesses or injuries suffered; the accumulation of medical expenses arising from the work-related illness/injury; and your experience of the medical retirement process.

We invite all serving and retired WAPU Members to participate in a survey that will assist us to make a case for adequate compensation for work-related trauma.

The confidential survey can be accessed by clicking on the link. We encourage you to forward this survey to former officers who may be able to contribute to this research.

We encourage participants to answer all questions openly and honestly. If you find there is inadequate space within the survey to answer a question, documents can be supplied to WAPU Research Officer, Jane Baker, via email or posted to WAPU HQ, 639 Murray St, West Perth, 6005.

The survey closes at 4pm, Wednesday, 7 May 2014.

Securing an adequate and fair compensation system for Members who have been broken at work is one of our top priorities and we will continue to work on your behalf.

George Tilbury
President

Strength in Unity

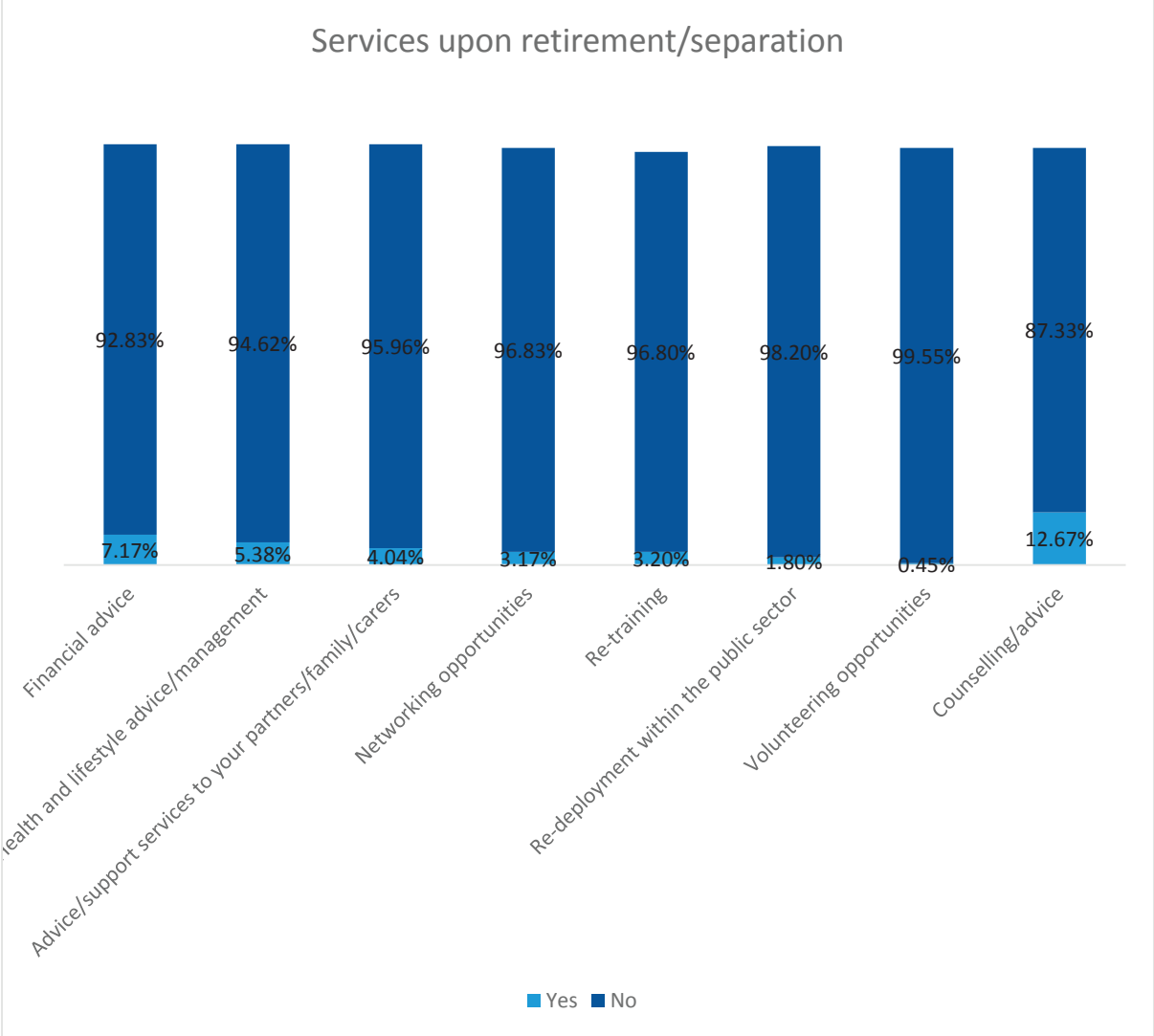
Appendix 7B

Q. 29 What has been your experience with the following groups/organisations/departments, with respect to all aspects leading up to your medical retirement?

–	Very positive - provision of constant support and excellent advice –	Positive - provision of some support and sound advice –	Neutral - neither happy or unhappy with support or advice provided –	Negative - little support and poor communication –	Adverse - extremely dissatisfied, no contact or support –	Not applicable - this service was not available or I was not interested –	Total –
WA Police Health & Welfare	7.29% 25	20.41% 70	18.08% 62	21.87% 75	19.83% 68	12.54% 43	343
Insurance Commission of WA (for the Former Police Officers' Medical Benefit Scheme)	0.31% 1	3.40% 11	14.81% 48	6.79% 22	12.65% 41	62.04% 201	324
Your superannuation fund	3.98% 13	11.01% 36	18.65% 61	8.26% 27	9.79% 32	48.32% 158	327
WA Police management	2.10% 7	9.61% 32	15.32% 51	23.72% 79	34.83% 116	14.41% 48	333
WA Police employee assistance program (EAP)	1.22% 4	3.05% 10	10.37% 34	7.62% 25	22.56% 74	55.18% 181	328
WA Police chaplains	5.14% 17	9.06% 30	15.71% 52	6.65% 22	14.80% 49	48.64% 161	331
WA Police peer support officers (PSO)	0.30% 1	1.22% 4	11.28% 37	7.32% 24	22.56% 74	57.32% 188	328

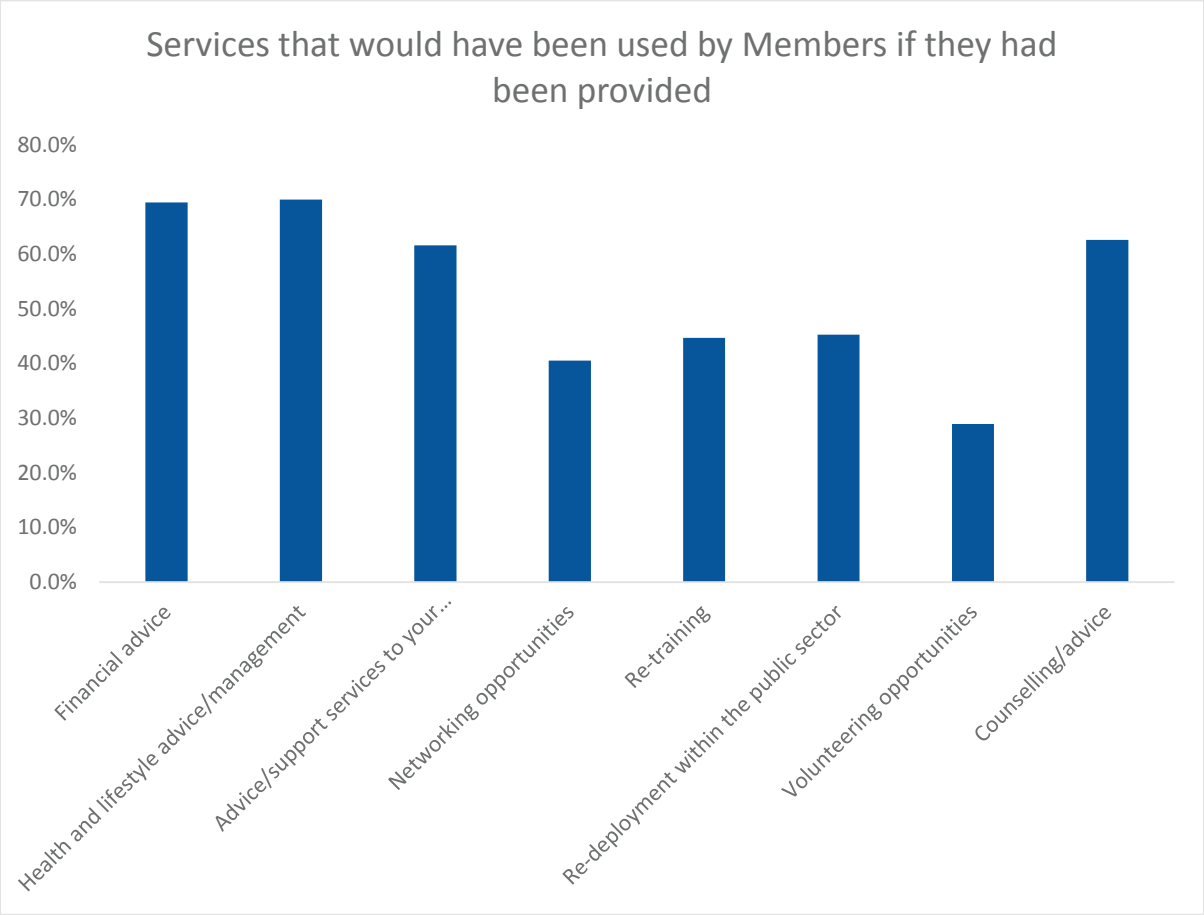
Appendix 7C

Q. 34 Were you provided with any of the following services upon your separation/retirement? Please answer yes or no to each service.



Appendix 7D

Q. 34 If any of the above services were NOT available, which of the services would you have used if they HAD been provided? Please select all that apply.



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