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

State Health
Emergency Response Plan

health.wa.gov.au

Version 2.0

Contents

Foreword

The WA health system is one of the Hazard Management Agencies (HMA) or a combat agency for another HMA in emergency responses required in the State of Western Australia. Because of our expertise and specialist knowledge, the WA health system has been prescribed as a combat agency under the Emergency Management Regulations 2006 with responsibility for providing health services. Historically, our roles and responsibilities have sometimes extended beyond our jurisdictional boundaries through the provision of medical assistance when disasters occur interstate or overseas.

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

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

Dr Andrew Robertson CSC PSM

CHIEF HEALTH OFFICER

ASSISTANT DIRECTOR GENERAL
PUBLIC AND ABORIGINAL HEALTH

Authorisation

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

Approved

Dr Andrew Robertson CSC PSM

CHIEF HEALTH OFFICER

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Amendment certificate

Version		Detail of amendment / review	Amended by
No	Date		
1.0	September 2017	Initial release	
1.1	February 2023	Scheduled review. Changes summarised as: - Confirmed and updated linked references - Statement of fact changes from the previous version. - Annex I: Terrorist Act realigned to a Hostile Act	L. Clifton
1.2	March 2024	Health Emergency Management Committee (HEMC) as proving strategic direction in response phase. HEMC replaces State Health Business Continuity Leadership Team from previous versions. Added Annex Q: Cybersecurity	L. Clifton
2.0	April 2024	Updated Annex E: WAMAT Endorsed HEMC and published	L. Clifton

Part 1: Introduction

The State Health Emergency Response Plan (SHERP) is an all-hazards plan which describes the strategic intent and the operational framework for the WA health system. The plan describes how the WA health system is to fulfil its role as an HMA or combat agency as prescribed in section 26 of the Emergency Management Regulations 2006.

Within the WA health system, the chief executive officer (Director General) of the Department of Health is the Hazard Management Agency (HMA) for three hazards:

- Heatwave,
- Release of biological substance, and
- Human epidemic.

The roles and responsibilities are outlined in the Emergency Management Act 2005 and are delegated to the State Health Coordinator (SHC). The SHC role is referred to throughout this document as the lead role when health is fulfilling its combat agency role, with an Incident Controller appointed by the HMA.

The WA health system regularly manages large volumes of patient activity and various emergencies. This plan focuses on an imminent or actual incident that requires a significant and coordinated approach to ensure the health system can effectively respond to support the community, whether the response is in support of another Hazard Management Agency (as a combat agency), as the Hazard Management Agency, or when dealing with internal emergencies.

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

Definitions used in this document are consistent with the State Emergency Management Glossary.

1.1 Aim

To apply emergency management principles and doctrine and outline how the management of a scalable and proportionate health response, with appropriate and timely interventions, communications, and allocation of resources, to minimise the health consequences of a disaster or emergency.

1.2 Strategic objectives

To ensure a safe, effective, and coordinated health response to an emergency or disaster by:

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

1.3 Hazard definition

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

1.4 Scope

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

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

1.5 Emergency Management Policy and relevant legislation

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

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

- Public Health Act 2016 (WA)
- Health (Miscellaneous Provisions) Act 1911 (WA)
- Health Services Act 2016 (WA)
- Emergency Management Act 2005 (WA)
- National Health Security Act 2007 (Commonwealth)
- Biosecurity Act 2015 (Commonwealth)

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

1.6 Related policies and plans

Australian Government

- Australian Government Disaster Response Plan (COMDISPLAN 2020)
- National Health Emergency Management Response Arrangements 2011
- Australia's Domestic Health Response Plan for All-Hazards Incidents of National Significance (AUSHEALTHRESPLAN)
- Domestic Health Response Plan for Chemical, Biological, Radiological or Nuclear Incidents of National Significance (CBRN Plan)
- National Response Plan for Mass Casualty Incidents Involving Australians Overseas (OSMASCASPLAN 2017)
- Australian Government Overseas Disaster Assistance Plan (AUSASSISTPLAN)
- Australian Government Plan for the Reception of Australian Citizens and Approved Foreign Nationals Evacuated from Overseas (AUSRECEPLAN)

State

- State Emergency Management Plan
- State Emergency Management Policy
- Hazard-specific State Hazard Plans
- Infectious Disease Emergency Management Plan (IDEMP)
- St John Ambulance (SJWA) Emergency Management Plan (AmbPlan)
- Royal Flying Doctor Service (RFDS WO) Western Operations – Critical Incident and Emergency Management Plan

Regional (district)

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

Hospital (local)

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

Part 2 : Response

When an emergency or disaster occurs, the WA health system may be requested to fulfil its responsibilities under various legal instruments.

2.1 Standby phase

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

2.2 Notification

The State Health Coordinator (SHC) is to be formally notified of any actual or potential incident or emergency by telephoning (08) 9328 0553 (On Call Duty Officer - 24 hours).

2.3 Authority to escalate

Authority to modify the phase of the plan from STANDBY to RESPONSE or STANDDOWN rests with the State Health Coordinator.

2.4 Triggers for esalation

Key triggers for the escalation from STANDBY to RESPONSE may include, but are not limited to:

- a risk, or actual occurrence of an incident in WA, which results in large numbers of casualties (mass casualty incident – MCI) and requires resources beyond local or regional capabilities.
- any incident or occurrence that results in a significant disruption to the delivery of key health services.
- a risk or actual public health incident that may cause or contribute to serious adverse effects on the wider health and wellbeing of the community.
- notification from the National Incident Centre (NIC) - Department of Health (Australian Government) of an interstate Mass Casualty Incident (MCI), which has resulted in the activation of the AUSHEALTHRESPLAN and may require WA Health assistance.
- notification by the NIC of an international MCI that has resulted in the activation of OSMASCASSPLAN, which may require WA Health assistance.
- set triggers listed in the functional annexes (see annex triggers); and/or
- other circumstances, as deemed necessary by the State Health Coordinator.

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

E – Exact location of incident

T – Type of incident

H – Hazards present

A – Access to incident site

N – Number and type of casualties

E – Emergency services present and required

2.5 Incident coordination

This plan recognises Health's role as a combat agency. The SHC will command and coordinate the use of all WA Health resources within WA and exercises this authority through the State Health Incident Coordination Centre (SHICC). Refer to the State Hazard Plan's Heatwave or Human Biosecurity along with the State Emergency Plan for Incident Coordination structure.

2.6 Strategic direction

The Health Emergency Management Committee (HEMC) will be activated for large and / or significant events to provide strategic oversight of the incident. By definition, incidents, (events, occurrences) are largely unpredictable. Strategic direction particularly applies to resolution of business continuity or incidents internal to the WA health system that are deemed significant in nature and have the potential to impact more than one health service provider. When required, the Incident Controller or State Health Coordinator convene the out of session HEMC.

2.7 Phases of escalation of the SHERP

A summary of strategic actions is listed in each phase.

Phases		
STANDBY PHASE (DEFAULT PHASE)	**RESPONSE PHASE**	**STANDDOWN PHASE**
Synopsis of situation • There is no ongoing emergency or incident that requires a coordinated response from SHICC. **Strategic actions** • The SHICC remains in a state of readiness. • The situation is monitored. • Normal business activities are undertaken. • Training and exercising continue. • Prevention and preparedness activities continue.	**Synopsis of situation** • An emergency is imminent or has occurred. • An incident has occurred that requires a coordinated response from SHICC. **Strategic actions** • The SHC assumes command of required health resources. • The SHICC is mobilised and gathers operational intelligence. • Under the direction of the SHC, health services and hospitals deploy resources, assets, and personnel in response to the incident. • The SHICC liaises with key local, regional, and Australian Government, non-government and private stakeholders. • SHICC provides situational awareness through briefings and dissemination of situation reports. • Specified responses are undertaken, as outlined in functional annexes. • The SHICC may seek assistance from the Australian Government, non-government and private entities and can delegate operational responsibilities to regional or local health services, where appropriate.	**Synopsis of situation** • The emergency has abated or resolved, and a SHICC-coordinated health response is no longer required. • All incident management actions requiring State coordination have been completed (acknowledging recovery activities will be occurring). • On-going recovery activities are not a determinant for the duration of this phase. **Strategic actions** • Deployed resources are recovered. • Health services enter recovery mode or transition to normal business processes. • Recovery activities commence or continue.

2.8 Post incident activities

Upon completion of the STANDDOWN phase, the SHC will descalate the SHERP to STANDBY phase.

The following post incident activities are undertaken:

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

2.9 Functional annexes

Upon escalation of the SHERP to response phase, the State Health Coordinator will trigger the necessary annexes of this plan required to respond to the incident.

Annex A : Pre-hospital incident site coordination

Introduction

In large scale and/or remote area incidents, the State Health Coordinator may liaise with key partner agencies to provide emergency healthcare provision in the pre-hospital setting.

Key partners

1. St John Western Australia Ltd (SJWA) is the contracted State-wide provider of pre-hospital health care and is prescribed in the Emergency Management Regulations 2006 as a combat agency for the emergency management activity of providing health services. SJWA has articulated its emergency management arrangements in the Ambulance Emergency Management Plan (AmbPlan).
2. The Royal Flying Doctor Service Western Operations (RFDS WO) provides 24/7 emergency aeromedical services, primary healthcare clinics and vital services to rural and remote communities across WA. In additional to contractual arrangements with the Federal Government for primary retrievals, RFDS WO is contracted by WACHS to provide operational coordination services, aeromedical patient transfer services and major incident planning, preparedness and recovery.

Methodology

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

Casualty distribution

In metropolitan incidents where ambulance transport is occurring prior to the SHICC becoming operational, the System Flow Coordinator from the State Health Operations Centre (SHOC) will determine casualty distribution. Once the SHICC is activated, patient flow and allocation will become a SHICC operational function via a deployed officer from the SHOC.

Command

Metropolitan area

The decision as to whether a pre-hospital health response is required is at the discretion of the State Health Coordinator following recommendations of the incident management team (IMT). Assistance may be requested by SJWA. The mobilisation of a Health Response Team (HRT) is detailed in Annex C. In a complex incident, an Ambulance Commander would be established and work alongside a Health Commander (when deployed).

Remote site coordination

When an incident occurs in a remote area accessed primarily by aeromedical assets the State Health Coordinator may request RFDS WO to appoint an officer to undertake the role of Health Commander following discussion with the Regional Health Disaster Coordinator (RHDC). This may be a temporary appointment until a senior Health clinician arrives, or last throughout the duration of the incident until all casualties have been cleared from the incident site. The State Health Coordinator may request RFDS WO to deploy a liaison officer to the SHICC.

More information on the role of the Health Commander is listed in Annex C.

Annex B : Health Liaison Officers

Introduction

A Health Liaison Officer (LO) is a critical enabler and facilitator between agencies involved in emergency responses.

Role and responsibilities

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

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

Key responsibilities of an LO include:

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

Authority to deploy

LOs usually deploy at the request of the HMA that has overall responsibility for managing the incident.

In the metropolitan area and State-level incidents, the State Health Coordinator is responsible for authorising the deployment of an LO. In regional areas, this responsibility is devolved to the Regional Health Disaster Coordinator (RHDC).

Communication

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

Supporting documents

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

Annex C : Health Response Teams

Introduction

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

Personnel deploying to an incident site as part of a HRT are expected to have completed a Major Incident Medical Management (MIMMS) Team or Advanced level competency.

Authorising the deployment of a HRT

In the metropolitan area, any HRT deployment, including specialist teams, must be authorised by the State Health Coordinator. In regional areas, the deployment of a HRT to an incident site must be authorised by the RHDC.

Specialist teams (e.g. burn, trauma) may deploy as autonomous hybrid teams, or to augment HRT composition. Where more than one HRT is deployed they may be referred to as A (Alpha), B (Bravo) or C (Charlie) teams

Needs assessment

Following the occurrence of an incident, a brief needs assessment should be conducted by the IMT to assess whether a HRT is required. As a minimum, the needs assessment should use the mnemonic ETHANE (see section 2.4 – Triggers for escalation). The initial needs assessment is only relevant to time it has been conducted, and remains a dynamic process of constant re-evaluation, at a frequency dictated by local circumstances.

HRT composition

The composition of the team reflects the flexibility required to a context-specific response and may change during the response phase. At all times, hospitals and health services are to provide a maximum HRT capability in line with their Clinical Service Framework (CSF) 2014 - 2024 capability.

CSF level (disaster response capability)	Hospital / health service	Team	Composition / maximum deployable requirements
CSF Level 6	Metropolitan tertiary hospitals	Team A	Doctor x 2 Nurse x 4
	Perth Children's Hospital	Team B	Doctor x 2 Nurse x 3
CSF Level 5, 4, & 3	Metropolitan general hospitals with emergency departments, Regional Resource Centres, Rural and remote hospitals	Team C	Doctor x 1 Nurse x 2
Varies	Dependent on location, nature, and magnitude of incident.	Specialist team	Assessed on a case-by-case basis.
Note: The above team compositions are the maximum deployable requirements; however, the SHC/RHDC may request an abridged or hybrid team to deploy, depending upon the nature of the incident. Hospitals and health services should arrange staffing profiles to fulfil the maximum deployable requirements.			

Specialised teams

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

- environmental health.
- burns management.
- trauma; and/or
- other co-opted specialty disciplines, as deemed necessary by the SHC.

Environmental Health Team

An environmental health team may be deployed to support the local government, Health Service or Population Health Units.

An environmental health team may also be deployed during a public health emergency. Advice, assistance and direction may be provided upon issues relating to:

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

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

Specialist burns management team

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

The composition of the specialist burns management team will be decided following the results of the needs assessment. As a minimum, the team will comprise of burn expertise and members should be capable of performing burn triage, and initial burn management including resuscitation, analgesia, and dressings.

Specialist trauma team

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

- perform field interventions on trapped victims; or
- provide surgical management at the scene, if the number of patients overwhelms the capacity to transport victims to hospital.

Appointment of HRT Health Commander

Where possible the Health Commander is to be appointed prior to the departure of an HRT to an incident site by the appointing authority. It is an operational position responsible for coordinating the HRT(s) and is responsible to the HMA's Commander at the Incident Site. The Health Commander has dual reporting responsibilities for both the incident site hierarchy and to the State Health Coordinator via the SHICC in metropolitan Perth, or the RHDC via the REOC in WACHS regions. This role also liaises with other agencies at the incident site.

The Health Commander role may fall to the RFDS WO in remote and difficult to access locations, where there is no SJWA footprint (such as the Karijini National Park or the Dampier Peninsula) or HRT presence, or alternatively where the HRT composition lacks appropriate seniority.

Appointment of other HRT positions for Team A and B

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

- Senior Doctor (responsible for overseeing the Casualty Clearing Station (CCS[1]) in conjunction with SJWA); and
- Senior Nurse.

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

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

Use of expectant category

In MCI, the principle of doing the most for the most applies, due to the need to rationalise and prioritise scarce resources. The expectant category (MIMMS triage sort priority 4 - blue) may be invoked for casualties whose injuries are either so severe that they are unlikely to survive, or the resources needed to treat them are either unavailable without compromising the care of others or the responders would be put in dangerous situations for their own health and safety. In Western Australia, the State Health Coordinator is the single approving authority for use of the expectant category. The use of the expectant category should be reviewed regularly during the incident and revoked once resources allow for all survivors to be adequately treated[2] .

[1] The Casualty Clearing Station is normally established by the ambulance service and supported by other clinicians. It serves as a focus for secondary triage and the treatment of casualties. The only absolute requirement is that the area needs to be safe. Access from both the scene and to the evacuation routes, shelter, light and size also need to be considered. Ideally, the area is located adjacent to the Ambulance loading point. (MIMMS manual, 4th ed. 2023, pp. 76)

[2] *adequate* implies a system, process, procedure, or quantity that will achieve a defined response objective.

Communication

Prior to the departure of the HRT, the SHICC/REOC is responsible for ensuring a clear line of communications is established and maintained with the Health Commander to ensure command, control and coordination is maintained. The SHICC and REOC, or SHICC and relevant Hospital EOCs, will maintain a clear line of communication with each other.

Communication platforms may include mobile telephone, satellite telephone, and/or Ultra High Frequency (UHF) radio. For regional incidents, communication may need to be facilitated via the HMA Incident Controller

Transport

SJWA is responsible for road transporting the HRT to and from the incident site, as articulated in the AmbPlan. Alternative forms of transport may be utilised in difficult access areas and should be negotiated with the HMA.

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

A Mass Casualty Incident (MCI) in a remote or regional area may require the mobilisation of aeromedical resources to facilitate the transport of patients. Where the number of casualties exceeds the availability of aeromedical assets see Annex D.

Sustainability

HRTs should be used for short-term deployments (for example 24 – 36 hours). Where there is a requirement for a sustained pre-hospital response, the State Health Coordinator may consider using a WA Medical Assistance Team (refer to Annex E).

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

HRT personnel are only to deploy with appropriate Personal Protective Equipment and communications equipment (refer to the Pre-hospital Handbook)

Annex D : Mass casualty aeromedical transport

Introduction

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

Responsibility

Upon activation of this Annex, the RFDS Western Operations will, in addition to their normal aeromedical transport duties, activate its Critical Incident & Emergency Management Team (CIEMT) to manage RFDS WO's incident response; this includes coordination of all aeromedical assets required and involved in the mass casualty aeromedical transport of patients from an incident site(s). The location of the incident, jurisdictional responsibility, number of casualties and types of pathologies will determine the type of aeromedical response required.

In remote and difficult to access locations (such as remote Kimberley and east of Kalgoorlie), the HMA's Incident Controller will assume the coordination role for air assets (including aeromedical aircraft). In such circumstances, the HMA may be requested to deploy Liaison Officers to the SHICC.

Strategies

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

- use a combination of rotary and fixed wing aircraft to evacuate casualties;
- consider distributing patients to Darwin for incidents in north-eastern WA;
- utilising South Australian resources for remote sites east of Kalgoorlie;
- establish a temporary medical hub for initial triage and treatment, prior to transportation; and
- utilise land or marine vehicles to transfer medical personnel and casualties from the site to a suitable location where aircraft can land.

MCI exceeding WA aeromedical availability

Should the number of casualties overwhelm the available aeromedical resources in WA, it may be necessary to request assistance from the Australian Government. The HMA is responsible for initial contact with the supporting State or Territories, as outlined in the relevant State Hazard Plan. Early identification of this requirement should be considered.

Supporting documents

- RFDS WO Critical Incident & Emergency Management Plan (external document).

Annex E : WA Medical Assistance Team (WAMAT) response

Introduction

The DoH Disaster Preparedness and Management Directorate (DPMD) is the custodian of the Western Australian Medical Assistance Team (WAMAT) volunteer base and deployable resources in Western Australia.

WAMAT is staffed by experienced and trained WA Health employed Registered Nurses, Nurse Practitioners, Midwives, Doctors, specified Allied Health professionals, private General Practitioners and Department of Fire and Emergency Services (DFES) Health Logisticians.

WAMAT deploys to sudden onset events, disasters, emergencies and complex health operations in response to a surge demand on Health services, as well as to State supported planned events.

Capability

WAMAT can deploy a range of self-sustaining capabilities and provide outpatient and inpatient care, operating from temporary deployed field clinics or existing structures.

WAMAT has the capability to triage and treat a range of adult, paediatric and obstetric presentations including:

- initial and field triage
- basic and advanced life and trauma support, resuscitation, and stabilisation
- initial wound care
- burns first aid and pain relief
- basic fracture management
- initial assessment and stabilisation of spinal cord injuries
- screening for communicable diseases
- basic outpatient chronic disease care
- basic emergency obstetric and neonatal care
- basic primary healthcare
- local anaesthesia and pain control
- facilitate referrals and transfers.

Authority to deploy

The authority to deploy WAMAT is under the direction of the State Health Coordinator (SHC) using provisions made available in the State Health Emergency Response Plan (this plan).

The authority to deploy WAMAT may also be at the approval of the Chief Health Officer (CHO), where a planned health response to a State supported event is required.

Supporting documents

The preparation, pre-deployment, deployment, and post-deployment arrangements for WAMAT are described in the WAMAT Concept of Operations.

National coordination and assistance

Where state-based WAMAT resources are insufficient or overwhelmed by a local disaster or emergency, it may be necessary to request assistance from the Australian Government, including the provision for deploying Australian Medical Assistance Teams (AUSMAT) as an enabler under the National Health Emergency Response Arrangements (the NatHealth Arrangements).

Annex F : Surge management

Introduction

The concept of medical surge forms the cornerstone of preparedness planning efforts for major medical incidents.

Medical surge describes the ability to provide adequate[3] medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community.

Surge capacity is different from surge capability.

Medical surge capacity

Medical surge capacity refers to the ability to evaluate and care for a markedly increased volume of patients (challenges or exceeds normal operating capacity). The surge requirements may extend beyond direct patient care to include extensive laboratory studies or epidemiological investigations.

Medical surge capability

Medical surge capability refers to the ability to manage patients requiring unusual or very specialised medical evaluation and care, including specialised medical services (expertise, information, procedures, equipment, or personnel) that are not normally available at the location where they are needed (i.e., paediatric care provided at non-paediatric facilities). Surge capability also includes patient problems that require special intervention to protect medical providers, other patients, and the integrity of the healthcare facility.

Scope

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

Strategies

Strategies required to manage surge capacities and capabilities require a systems-based approach underpinned by interdisciplinary coordination and based at the local level. Strategies can be broadly categorised into four key components:

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

Altered levels and ceilings of care

By definition, a disaster, including an MCI, is a situation in which there is an overwhelming imbalance between available resources and demand. The prioritisation and allocation of scarce resources will follow the principle of prioritisation placed on serving those who are most likely to survive. Consequently, there is a need to set a lower ceiling of care than in normal circumstances. The ceiling of care is reviewed dynamically throughout the incident, based on changes in resources available and clinical situation.

[3] *adequate* implies a system, process, procedure, or quantity that will achieve a defined response objective.

Activation and governance

Upon activation of this annex by the State Health Coordinator, hospitals and health services will be authorised to make decisions to amend the level of care delivered to patients, as deemed appropriate for the local circumstances of the incident and hospital.

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

- incrementally increasing patient-to-staff ratios;
- altering thresholds and ceiling of care for clinical interventions on casualties (e.g. blood transfusion, intubation);
- rationalising and prioritising imaging and laboratory requests;
- implementing strategies to manage demand on the operating theatres (e.g. surgical triage, damage control surgery);
- maintaining the ability to respond to the non-affected population medical needs; and
- managing staff welfare during the response and immediate recovery period.

Annex G : Trauma response

Introduction

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

In normal operations, Royal Perth Hospital (RPH), as the adult State Trauma Centre, and Perth Children's Hospital (PCH), as the paediatric State Trauma Centre, receive major trauma patients (Level 6 according to Clinical Services Framework).

Patients may be distributed to hospitals according to triage category. For example, low priority casualties may be directed to a secondary hospital close to the incident with high priority patients to single tertiary hospital.

The overarching patient distribution doctrine is the right patient, at the right location, the first time, every time.

Patient distribution

Metropolitan trauma services

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

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

Burn patients would be allocated age-wise to PCH and Fiona Stanley Hospital (FSH); neurosurgical trauma would be distributed across Sir Charles Gairdner Hospital (SCGH), RPH and PCH.

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

- general hospitals (Level 4 on CSF).

Regional trauma services

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

Regional Resource Centres (Level 4 on CSF)

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

Regional, remote, and rural (Level 3 on CSF)

Sites without a surgical and/or orthopaedic capability cannot provide emergency surgery, but can provide the following services:

- participate in resuscitation of a moderate and major trauma patient, with rapid transfer on to the next level where definitive management can be provided.
- stabilise minor trauma patients and consider transferring out to Regional Resource Centre or metropolitan trauma services.
- increased level of support from the Emergency Telehealth Service.

Annex H : Burn response

Introduction

The State Health Coordinator may activate the Burns response.

The burn response is reflected in the capabilities expressed in the CSF (2014 – 2024). PCH provide the paediatric State Burns Service with FSH providing the adult State Burns Service.

Provision of specialist advice

All sites should be current with the first aid and initial care of thermal burns and have access to the required equipment and medical supplies. Following first aid, expert advice should be sought from the State adult and/or paediatric burn services.

Additional support or advice may be sought from SJWA and DFES in non-thermal burns (i.e., HAZMAT scenarios)

Burn capacity

A large influx of burn patients may overwhelm the normal capacity of metropolitan specialist burns units. In such circumstances, burn units and Intensive Care Units (ICUs) should implement departmental surge management strategies to increase bed capacity.

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

Note: The above table reflects the capacity of the two tertiary burn units, and not the current occupancy. FSH and PCH incident management staff will be requested to complete a current and projected occupancy template to reflect their capability to receive burn patients to inform SHICC.

Distribution of burn casualties

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

Triggers and thresholds

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

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

The following thresholds provide guidance.

Less than 5 severe burn patients

- Managed by the State's tertiary burn units using local resources, infrastructure, and surge plans.

5 – 10 severe burn patients

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

10 – 20 severe burn patients

- Activation of the SHERP Burn response annex.
- In consultation with the Director, State Burns Service, the SHC via the HMA may request activation of AUSHEALTHRESPLAN to request interstate patient transfer and/or assistance from interstate burns taskforce.

Greater than 20 severe burn patients

- Activation of the SHERP Burn response annex.
- Activation of AUSHEALTHRESPLAN as requested by the SHC to facilitate interstate patient transfer and/or mobilisation of interstate burns taskforce.

Deployment of specialist burn response teams

- Refer to Annexes C and E.

Annex I : Hostile act

Introduction

In an emergency that results from a hostile act, additional strategies may need to be implemented to ensure the safety of staff, patients and visitors, and the protection of critical infrastructure. WA Police Force is the HMA and exercises overall command and control of the response to the hostile act. The WA Commissioner of Police will make a determination as to whether a hostile act is a terrorist incident.

Response

The Health response to a hostile act may include:

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

Security at health facilities

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

- restricted access and security screening and cordoning;
- enhanced proof of identify measures for staff and patients accessing the premises;
- restricted or denied visitor acces;
- inability to utilise certain clinical areas due to security concerns or contamination and
- enforcing lockdown procedures.

National Coordination

In the event of a hostile act intrastate, interstate, or overseas, which results in large numbers of casualties, AUSHEALTHRESPLAN may be activated to provide national coordination in respects to intelligence, advice, patient distribution, and resource management.

Other issues

Other issues that may arise in a hostile incident include:

- media and political pressure that may distract Health staff from other roles; and/or
- immediate and / or prolonged business continuity issues.

Annex J : CBRN/HAZMAT hospital response

Delineation between CBRN and HAZMAT

CBRN and HAZMAT incidents can be delineated by the underlying motive behind the release of the agent:

CBRN events are usually associated with a deliberate release of a hazardous material.

HAZMAT incidents are usually considered accidental.

While both CBRN and HAZMAT incidents are managed using the same principles, additional security and evidentiary considerations should be considered in CBRN incidents (refer to Annex I).

Release of a biological agent

For the purpose of this annex, there will be no delineation between a biological agent within the scope of HAZMAT. Where the agent is biological, the responsible agency becomes the Department of Health, who will appoint an Incident Controller. References in this section to SHC would be undertaken by the IC in biological release situations.

Activation of this annex

Upon activation of this annex, hospitals involved in the response are to activate their CBRN / HAZMAT plans. Direction to commence these measures may come from the State Health Coordinator, the HMA or via hospitals pre-emptively activating measures as a result of information from presenting casualties. This may entail:

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

Detection and agent management

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

Treatment regimens for the agent and patients are to be based on expert advice from appropriate specialists, and in accordance with CBRN/HAZMAT treatment protocols. This may include the State Health Coordinator authorising the deployment of special antidotes.

Public Information

Timely, accurate communication to the public is a critical response activity for CBRN/HAZMAT incidents.

The responsibly for preparing and disseminating public information resides with the HMA.

However, the Chief Health Officer may have obligations under the Public Health Act (2016) to support the public safety strategy. The SHICC and communications advisors will work closely with the HMA on a consistent messaging approach.

For these reasons, hospital sites are to refrain from direct media engagements and refer all requests to SHICC.

Supporting documents and treatment guidelines

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

- Abrin and Ricin Emergency Management Plan
- Anthrax: Public health Response Plan for Australia
- Australian Clinical Guidelines for Acute Exposures to Chemical Agents of Health Concern
- Australian Clinical Guidelines for Radiological Emergencies
- Domestic Health Response Plan for chemical, biological, radiological and Nuclear incidents of National Significance
- Smallpox Emergency Management Plan
- Communicable Disease Network Australia - Series of National Guidelines (SoNGs)

State Arrangements

- State Hazard Plan HAZMAT
- State Hazard Plan HAZMAT Annex A Radiation Escape from a Nuclear Powered Warship (NPW)
- State Hazard Plan – HAZMAT Annex B Space Re-entry Debris

Annex K : Environmental Health response

Introduction

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

Capability

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

Release of a biological agent

Advice or assistance may be provided upon issues relating to:

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

Authorisation

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

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

Public health serious incident and emergency powers

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

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

Supporting documents

An environmental health response may be requested under the auspices of State Hazard Plans (various) where bespoke health advice is required.

Annex L : Management of the deceased

Introduction

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

Management of the deceased

Management of deceased at the incident site is the responsibility of WA Police under the State Disaster Victim Identification (DVI) Plan. The Department of Health along with PathWest manage the Mass Fatality Mortuary Sub-Plan (Official Sensitive). Depending on the number of fatalities, and the storage capacity of the State Mortuary, there may be a requirement for temporary mortuary facilities to be utilised.

Victims who die en route to, or at a health care facility should remain at the health facility mortuary (or equivalent) until such time as WA Police can arrange transfer to the State Mortuary. The hierarchy of preservation of life, property and the environment should be followed. The arrangements should not hinder the continued provision of healthcare at the facility for other patients, especially emergency and acute care.

Mass fatalities

The management of a mass of fatalities, particularly within a brief period, is challenging and requires strong interagency coordination and communication, as well as support and leadership from all levels of government.

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

Activation

Upon activation of this annex, the WA Health system will work with partner agencies, including WA Police, the State Coroner, the Metropolitan Cemeteries Board, and other agencies, to implement strategies to accommodate surge fatalities.

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

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

Supporting documents

This annex may be activated in conjunction with the WA Mass Fatality and Disaster Victim Identification Plan (WA Police) and the WA Mass Fatality Mortuary Sub-Plan (Official Sensitive).

Annex M : Mental health response

Introduction

In an emergency, a substantial number of people may be exposed to a traumatic event, provoking an array of psychological reactions, and / or exacerbation of previous psychological and mental health conditions.

The Department of Communities (DoC) is the prescribed support organisation with responsibility for providing personal relief and support in an emergency, including the initial psychological first aid.

Where overwhelming and/or sustained numbers of people seek psychological and mental health assistance, which is beyond the surge resources of DoC, the State Health Coordinator may, at the request of the DoC supplement their response by activating this annex.

Scope of response

In emergencies and disasters, people presenting with psychological and / or mental health symptomatology should be managed within their own community, using existing pathways and resources. Where the local service's surge capacity is exhausted, the regional/ area mental health service is responsible for facilitating additional supports and resources to the local service in line with their business continuity plans.

DoC may ask the State Health Coordinator to assist relief and support agencies to augment the early provision or psychological support and crisis counselling. As a minimum, the provision of a referral or self-presentation pathway for people in acute crisis requiring emergency mental health assessments will be required.

Response capability

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

Variables which may influence a mental health response

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

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

Annex N : Media and public information

It is likely that the occurrence of the event is captured and broadcast through social media channels before it is officially confirmed and declared. Therefore, intense media and public interest is always present in relation to an emergency or disaster.

Responsibility

Overall responsibility for media request management and the approving of media statements resides with the State Health Coordinator. The coordination of media inquiries during an emergency is performed by the Department of Health - Communications Media Manager or nominated delegate, who will coordinate activities at a state level, including:

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

Media process during an emergency

- The On Call Operations Officer must advise Communications Directorate (9222 4333 - 24 hours) as soon as they become aware of a significant emergency or disaster.
- The State Health Coordinator is responsible for the approval of emergency public information for the WA health system.
- Preparation of WA health system media statements, including social media, and coordination of media inquiries during an emergency lies with Department of Health's Media Manager or nominated delegate.
- All media responses and spokespeople must be approved by the State Health Coordinator.

Hospital, health service and regional public relations

- All official media contact, queries with, and comments to the media during a major health crisis is to be directed to the Department of Health media query line and will be managed by the Department of Health's Communications Directorate.
- It may be appropriate for selected hospital or health staff to speak to the media, but this should be done in consultation with the Communications Directorate and with the approval of the State Health Coordinator.
- Condition reports can be given to the media as per current protocols.
- These arrangements are to be observed by all WA health staff.

State Emergency Public Information

The State Emergency Management Plan provides additional media relations support for the health emergency management functions, if required. The State Health Coordinator, with advice from the Media Manager, is responsible for determining if such assistance is required.

Annex O : Other Health response considerations

Registration and reunification

The WA health system has an obligation under the State Support Plan Emergency Relief and Support to identify, track and record all patients admitted to hospitals in a disaster or major incident. The exchange of information by the WA health system is detailed under section 72 of the Emergency Management Act 2005.

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

The State Health Coordinator may authorise the activation of a Patient Administration System (PAS) disaster flag to capture details of presenting patients who have been involved in a disaster. Hospitals should have processes to determine and record the reason for presentation in relation to a disaster or emergency when the disaster flag is activated.

Financial arrangements

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

The SHICC and Health Service Providers should have a process to establish and / or activate dormant emergency response cost centres to track all expenses.

In the event of major emergencies, where financial expenditure has been incurred to the extent that core health services are at risk to be affected, the affected Health Service(s) should prepare a case for reporting on cost pressures. Hospitals and Health Service Providers should not assume that all costs will be reimbursed.

Funding for disaster response, where and when available, is often not applicable to State government agencies. Nevertheless, HMAs may request information on agency expenditure to inform their response, for which the expenditure information should be tracked through discrete cost centres.

Business continuity

The Health Emergency Management Committee (HEMC) supports the DG, or the SHC as their delegate, during business continuity disruption. The HEMC provides strategic advice and direction in concert with the SHC and SHICC.

The purpose of the HEMC is to provide counsel and act as an advisory platform to the DG or SHC on significant business continuity incidents that are affecting or imminently going to affect the WA Health system (i.e., more than one Health Service Provider) and to support a consistent, coordinated response across the WA Health system.

Annex P : WA Blood Supply Contingency Plan

Redcross Lifeblood is a national organisation that accept blood product donations and manage the distribution of blood products to States and Territories. Lifeblood have established mechanisms to coordinate a national response to blood product shortages and other threats to the blood supply. Refer https://blood.gov.au/nbscp

Arrangements for Western Australia

The Department has developed the WA Blood Supply Contingency Plan (WABSCP) (internal document) as an interface linking the State with National arrangements. The WABSCP details the actions to be taken to manage the supply of blood and blood products in the event of a surge in demand of these products, generally at the time of a significant event.

PathWest maintain a network of clinical locations within the public hospital system facilitating the logistical aspect of blood management.

The Chief Medical Officer (CMO) is nominated authority to engage with Lifeblood on matters relating to blood supply.

The WABSCP details triggers, thresholds and actions restrictions that may be employed to manage blood resources.

Annex Q : Cyber incident

The management of a cyber security incident is included in the all-hazards approach to emergency management. The State Hazard Plan Cyber Security (under development) embeds an emergency management framework on the response to cyber incidents.

While the State Hazard Plan Cyber is awaiting endorsement, the principles of WA whole of government cyber security framework govern response actions.

The State Hazard Plan Cyber Security defines:

> Cyber security as "actions required to preclude unauthorised use of, denial of service to, modifications to, disclosure of, loss of revenue from, or destruction of critical systems or informational assets".
>
> A cyber incident as an occurrence that
>
> - actually or imminently jeopardises, without lawful authority, the integrity, confidentiality, or availability of information or an information system, or
> - constitutes a violation or imminent threat of violation of law, security policies, security procedures, or acceptable use policies."

For the purposes of this Plan, the hazard of cyber security refers to a cyber incident that has the potential of causing:

- loss of life, prejudice to the safety, or harm to the health, of persons or animals; and / or
- destruction of, or damage to, property or any part of the environment.

A cyber incident may affect IT systems, electronic devices that have a form of programming to operate, or the effect may be on the supply of an essential service such as power or water.

Incident management

A cyber incident may directly impact health infrastructure, or the Department may be advised of an external incident by the Department of Premier and Cabinet Office of Digital Government.

Forecasting the full impact of a cyber incident is challenging and will be managed through pre-established business continuity management systems. The emergency management of a cyber incident aligns to State plans within the State emergency management framework. The objectives will focus on consequence management, supressing and eliminating the threat, public information and communication, and recovery actions.

Health Support Services (HSS) have operational plans and processes they will enact for security triggers that affect information systems under their management.

The trigger for activating this annex is when a level 2 cyber incident occurs, that being *successful compromise of individual agency security controls that requires corrective action*.

The incident management structure for a cyber incident remains consistent with those used within the State Health Incident Coordination Centre (SHICC). The incident management team and cellular structure will remain flexible to respond to the evolving circumstances and include technical and subject matter experts.

Annex R : Glossary of terms/acronyms

The State Emergency Management Glossary should also be referred to.

AUSMAT	**Australian Medical Assistance Team** An Australian Medical Assistance Team (AUSMAT) is an official Australian Government multidisciplinary healthcare team deployed in response to national or international disasters where assistance is requested by the impacted government.
CBRN	**Chemical, Biological, Radiological and Nuclear**
CCS	**Casualty Clearing Station** An area adjacent to an incident site that is used to perform secondary triage, treatment and preparation for transport.
CSF	**Clinical Services Framework** The principal, government endorsed clinical service planning document for Western Australia's public health system.
DACC	**Defence Assistance to the Civil Community** Assistance to the community provided by Department of Defence personnel in the event of natural disaster or civil emergency.
Disaster	A serious disruption to community life which threatens or causes death or injury in that community and damage to property which is beyond the day-to-day capacity of the prescribed statutory authorities, and which requires special mobilisation and organisation or resources other than those normally available to those authorities
DoC	**Department of Communities** A support agency under section 32 the Emergency Management Regulations (2006) with responsibility for providing relief and support services during an emergency.
DVI	**Disaster Victim Identification**
Emergency	An event, actual or imminent, which endangers or threatens to endanger life, property or the environment, and which requires a significant and coordinated response.

FSH	**Fiona Stanley Hospital**
Hazard	Any event, situation or condition that is capable of causing or resulting in: • loss of life, prejudice to the safety, or harm to the health or persons or animals; or • destruction of or damage to property or any part of the environment
HAZMAT	**Hazardous materials**
HMA	**Hazard Management Agency** A public authority or other person who or which, because of that agency's functions under any written law or specialised knowledge, expertise and resources, is responsible for emergency management, or the prescribed emergency management aspect, in the area prescribed of the hazard for which it is prescribed.
HRT	**Health Response Team** A deployable team that can be sent to an incident site to augment the pre-hospital response or to provide specialist procedures and advice.
IC	**Incident Controller** The person(s) who is responsible for the overall management and control of an incident and the tasking of agencies in accordance with the needs of the situation.
LEOC	**Local Emergency Operations Centre** A local facility established to provide local coordination across a WA Country Health Service hospital or health service during an incident or emergency.
LO	**Liaison Officer** A representative of an agency or organisation who deploys at the request of the controlling agency to establish communication between the host agency and the agency they represent.
MIMMS	**Major Incident Medical Management and Support** A licensed methodology that teaches health care professionals how to respond to a major incident in the pre-hospital setting. It involves the principles of command and control, safety, communication, assessment, triage, treatment, and transport.

MCI	**Mass Casualty Incident**
NIC	**National Incident Centre** – Department of Health (Australian Government)
PCH	**Perth Children's Hospital**
PPE	**Personal Protective Equipment**
RFDS WO	**Royal Flying Doctor Service – Western Operations**
REOC	**Regional Emergency Operation Centre** A regional level facility established to provide coordination across a WA Country Health Service region during an incident or emergency.
RHDC	**Regional Health Disaster Coordinator** A designated senior officer who has the authority to command and coordinate the use of all resources with a WA Country Health Service region during an incident.
RPH	**Royal Perth Hospital**
RRC	**Regional Resource Centre**
SCGH	**Sir Charles Gairdner Hospital**
SEC	**State Emergency Coordinator** The State Emergency Coordinator is the Commissioner for Police and is responsible for coordinating the response to an emergency during a State of Emergency.
SHC	**State Health Coordinator** The role delegated by the Director General for the purpose of responding to imminent or actual emergencies or disasters.
SOP	**Standard Operating Procedure** A set of directions detailing what actions could be taken, as well as how, when, by whom and why, for specific events or tasks

SHICC	**State Health Incident Coordination Centre** The State-level centre responsible for the strategic coordination of the Health response to an incident.
SHOC	**State Health Operations Centre** Facility to enhance coordination across health services in WA, including selected WA Health system programs such as the WA Virtual Emergency Department (WAVED), the Patient Transport Coordination Hub and System Flow Centre
SJWA	**St John Ambulance Western Australia Inc.**
WA	**Western Australia**
WA Health system	Western Australia's public health care system which comprises of: • The Department of Health (the system manager) • health service providers • contracted health entities
WACHS	**WA Country Health Service**
WAMAT	**WA Medical Assistance Team** State-based civilian medical assistance team with self-sustaining field deployment capabilities, that can be deployed in response to incidents across Western Australia
WAPOL	**WA Police**

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