WA Health System Emergency Management Arrangements

Foreword

The complexity and scale of incidents addressed by the Western Australia (WA) health system demonstrates the need for a robust and integrated framework for preventing, preparing for, responding to, and recovering from, emergencies and disasters within the jurisdiction of Western Australia and beyond.

These arrangements have been developed to outline the WA health system's strategic approach to emergency management and to establish uniformity in structure, nomenclature, and approach to emergency management governance and planning.

The arrangements support the *all agencies, all hazards* State Emergency Management Plan, policies and procedures, and links to the National Health Emergency Response Arrangements (NatHealth Arrangements), and other National EM frameworks.

These arrangements reflect the WA health system's statutory requirements under the *Emergency Management Act 2005*, and assists Health Service Providers in achieving compliance with National Safety and Quality Health Service Standards.

Dr Andrew Robertson CSC PSM
DIRECTOR DISASTER MANAGEMENT
DEPARTMENT OF HEALTH

Authorisation

This arrangements outlined in this document have been endorsed as the common framework that ensures a clear, consistent and comprehensive approach to emergency management is undertaken across the WA health system.

Approved

Dr Andrew Robertson
DIRECTOR DISASTER MANAGEMENT
DEPARTMENT OF HEALTH

Date *2nd October 2014*

Contents

1. Introduction

The number, scale, and complexity of emergencies demonstrates the need for the WA health system to have robust and integrated emergency management arrangements in place to prevent, prepare for, respond to, and recover from, emergencies, disasters and other disruptive events.

1.1 Aim and objectives

These arrangements provide a common framework that ensures a clear, consistent and comprehensive approach to emergency management is undertaken across the WA health system. The objectives of these arrangements are to:

- assist Health Service Providers (HSPs) in achieving compliance with the emergency management policy;
- outline the command and control arrangements;
- identify key stakeholders: their roles, responsibilities and delegations; and
- provide a framework for the development of emergency management plans and procedures.

1.2 Principles

The WA health system applies the following principles in its approach to emergency management:

- the *comprehensive approach* to emergency management, which considers the elements of prevention, preparedness, response and recovery (PPRR);
- the *all hazards approach,* which recognises the WA health system's role, function and activities in an emergency are applicable across a range of hazards and circumstances;
- the *all agencies coordinated and integrated approach*, which recognises all relevant organisations, agencies and governments have specific roles in any incident that require coordination and inter-operability;
- the *graduated approach,* to ensure a proportional, practical, and scalable approach to emergencies, for the appropriate use of resources, and the empowerment of decision-making at the lowest appropriate level;
- *continuous improvement* through monitoring and review of arrangements, plans, and lessons identified to improve emergency management across the WA health system;
- clear *governance structures* that delineate roles and responsibilities; and
- *developing capability* through education, training and exercising.

2. Governance

2.1 Legislative framework

The *Emergency Management Act 2005* and subsidiary *Emergency Management Regulations 2006* establish the legislative framework for emergency management in Western Australia.

2.1.1 Combat agency

A combat agency is defined, in subsection (1) of the *Emergency Management Act 2005, as* a public authority, which, because of its specialised knowledge, expertise and resources, is responsible for performing an emergency management activity prescribed by the regulations.

Due to its specialised knowledge, expertise, and resources, the Department of Health is prescribed as a combat agency under section 26 of the *Emergency Management Regulations 2006,* with responsibility for the emergency management activity of providing health services. The combat agency responsibility is applied across the spectrum of the 27 prescribed hazards, in line with the *all hazards* approach.

2.1.2 Hazard management agency

A Hazard Management Agency (HMA) is a public authority or other person, prescribed by regulations because of that agency's functions under any written law or because of its specialised knowledge, expertise and resources, to be responsible for the emergency management, or an aspect of emergency management, of a hazard for a part or the whole of the State.

2.1.2.1 State Health Coordinator

The State Health Coordinator (SHC) is the nominated HMA position with responsibilities under section 22 of the *Emergency Management Regulations 2006*. The SHC is the HMA for the following hazards:

- actual or impending spillage, release or escape of a biological substance
- heatwave

In a heatwave or biological hazard incident, the SHC is responsible for appointing an Incident Controller, an officer with responsibility for all incident control activities across a whole incident.

2.1.2.2 State Human Epidemic Controller

The State Human Epidemic Controller (SHEC), Department of Health, is the nominated HMA position under section18 of the *Emergency Management Regulations 2006*. The SHEC is the prescribed HMA for the hazard of human epidemic.

The SHEC is the Chief Health Officer of WA. The multi-agency response arrangements for Human Epidemic are outlined in [Westplan – Human Epidemic](), whereas the internal health system arrangements for infectious disease emergencies are detailed in the Infectious Disease Emergency Management Plan (IDEMP).

2.1.2.3   WA Health System Coordination

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

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

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

2.2 Committee structure

2.2.1 State Emergency Management Committee

The State Emergency Management Committee (SEMC) is the peak statutory body for emergency management in Western Australia, which is established under section 13 of the *Emergency Management Act 2005*, and reports to the Minister for Emergency Services. WA Health is represented at the SEMC by the Director General.

The SEMC has reporting lines from District Emergency Management Committees (DEMCs) and four SEMC subcommittees. WA Health has representation at each of the four SEMC subcommittees:

- Community engagement subcommittee
- Risk subcommittee
- Response and capability subcommittee
- Recovery subcommittee

2.2.2 WA Health Emergency Management Committee

WA Health Emergency Management Committee (WA HEMC) is the peak emergency management body for the WA health system. It is chaired by the delegated SHC, and has responsibility for strategic direction for emergency management across WA Health.

WA HEMC has two subcommittees:

- Prevention and preparedness subcommittee
- Response and capability subcommittee

WA HEMC has representation from HSPs, Public Health, St John Ambulance, Australian Red Cross Blood Service, and the Private Hospitals Association.

2.2.3 Health Service Provider committees

HSPs are required by policy to have adequate governance and policy arrangements in place to ensure emergency management is implemented appropriately.

2.2.4 Local and district emergency management committees

HSPs have significant roles to play in an emergency or disaster and are key stakeholders in their community's emergency management planning process. HSPs are required by policy to provide representation to local and district emergency management committees. A summary of the local, district, state, and national emergency management governance structures can be found at Appendix A.

Committee representatives may be requested to provide health advice on preparedness and response arrangements for the WA health system's prescribed hazards (human epidemic and heatwave) under the *Emergency Management Regulations 2006*, as well as the local health service's role in the provision of health care relating to an emergency or disaster. Representation may include provision of advice, involvement in multi-agency exercises, and input into local or district emergency management arrangements and emergency risk management plan.

HSPs provide representation to the following DEMC(s):

Health Service Provider	District Emergency Management Committee(s)
South Metropolitan Health Service	South Metropolitan DEMC
North Metropolitan Health Service	North Metropolitan DEMC
East Metropolitan Health Service	East Metropolitan DEMC and Central Metropolitan DEMC
WACHS – Goldfields	Goldfields – Esperance DEMC
WACHS – Great Southern	Great Southern DEMC
WACHS – Kimberley	Kimberley DEMC
WACHS – Midwest	Midwest – Gascoyne DEMC
WACHS – Pilbara	Pilbara DEMC
WACHS – South West	South West DEMC
WACHS – Wheatbelt	Wheatbelt DEMC

A map of HSP and regional boundaries with emergency management districts overlaid can be found in Appendix B.

More information on LEMCs, DEMCs and the SEMC can be found at
https://www.oem.wa.gov.au/

2.3 Key roles and responsibilities

2.3.1 Department of Health

Director General: has overarching authority and accountability for emergency management for WA Health.

Key responsibilities include:

- providing strategic oversight and governance, including supervision of the WA HEMC; and
- representing the WA health system at the SEMC.

This position is responsible for ensuring appropriate emergency management policies, frameworks and planning are in place to minimise the impacts on the WA health system from emergencies and adverse events

Key responsibilities include:

- chairing the WA HEMC;
- acting as the official deputy and proxy to the Director General at the SEMC;
- briefing and advising the Director General and Minister for Health on emergency management matters affecting the WA health system;
- ensuring the WA health system can fulfil its roles and responsibilities under various plans and arrangements by providing oversight on the development and approval of strategic emergency management plans and policies;
- liaising, engaging, and consulting with key stakeholders about emergency management within the WA health system;
-

Chief Health Officer: oversees all emergency management elements relating to public health. The Chief Health Officer is a statutory position under the *Public Health Act 2016.*

Key responsibilities include:

- fulfilling the role of SHEC during human epidemic emergencies;
- representing the WA Health System at the Australian Health Protection Principal Committee (AHPPC) and other national bodies;
- fulfilling various statutory obligations under various legal instruments; and providing leadership and oversight on public health aspects of any emergency or disaster

The Director General's delegate (as described in 2.1.2.3) will be delegated to direct a health entity within the WA Health system. Key responsibilities include:
- commanding, controlling and coordinating the WA health system during an emergency, via the State Health Incident Coordination Centre (SHICC);
- acting as the Department of Health media spokesperson during emergencies;
- allocating the role of Health Commander for any Health Response Team (HRT) deploying within the metropolitan area;
- acting as the Department of Health representative at the State Emergency Coordination Group (SECG); and
- providing advice to the State Recovery Coordinator on Health recovery efforts.

Disaster Preparedness and Management Unit: provides the policy framework, logistical support and operational emergency management capability to the WA health system.

Key roles include:

- developing plans, policies and arrangements affecting emergency management within the WA health system;
- staffing a 24 hour On Call Duty Officer for notification, monitoring and escalation of all emergencies and adverse events;
- managing the AUSMAT and WAMAT capability;
- communicating with internal and external stakeholders;
- coordinating logistical support to incidents;
- providing leadership and coordination across the WA health system through the mobilisation of the SHICC; and
- providing a range of risk management, training, and exercising support services

Environmental Health Directorate: is the principal environmental health body for the WA health system.

Key roles include:

- providing advice and assistance in relation to water quality, food safety, human waste, hazardous materials, site contamination, radiation and vermin/vector control;
- providing guidance and assistance to local government environmental health officers to manage local response; and
- providing a 24 hour on-call service for environmental health

Communicable Disease Control Directorate: is the principal body for managing communicable diseases.

Key roles include:

- conducting infectious disease surveillance and monitoring trends;
- investigating outbreaks of communicable diseases;
- following up of sporadic cases of certain diseases where there is immediate risk to the public;
- providing advice and information about communicable diseases and immunisation; and
- providing a 24 hour on call service for communicable disease advice and response.

Director, Communicable Disease Control Directorate: assumes the role of Chief Human Biosecurity Officer for Western Australia under the *Biosecurity Act 2015* (Australian Government)

Key roles include:

- liaising with the Communicable Disease Network Australia (CDNA), Australian Government Department of Health's Director of Human Biosecurity, the Chief Health Officer for WA, and the National Incident Room (Australian Government Department of Health) in relation to any threatened or actual infectious disease emergency; and
- coordinating the operations of the Public Health Emergency Operations Centre (PHEOC) during infectious disease emergencies

2.3.2 Health Service Providers

Chief Executives: provide oversight to emergency management within their respective Health Services.

Key roles include:
- ensuring the emergency management arrangements are in place and adequately resourced to minimise the negative impacts from emergencies;
- providing the system manager with assurance the Health Service is adequately prepared for emergencies affecting its health service;
- ensuring all entities within the health service are compliant with the requirements of this policy;
- ensuring health service representation to WA HEMC and respective DEMCs (see policy statement 2);
- providing support, media assistance and resourcing to hospitals; and
- providing additional resources at the request of the SHC.

Regional Directors and Regional Health Disaster Coordinators (WACHS Regions):

The roles and responsibilities of Regional Directors and Regional Health Disaster Coordinators (RHDCs) are detailed in the WACHS Disaster (Emergency) Management Policy.

Population Health Units: manage communicable diseases outbreaks within the boundaries of the Health Service or region, in conjunction with the Communicable Disease Control Directorate (CDCD).

Key roles include:
- performing disease surveillance;
- investigating of disease outbreaks;
- following up of sporadic cases of certain diseases affecting the Health Service or region; and
- Establishing and maintaining a metropolitan or regional Human Epidemic Coordination Centres (HECC) (see IDEMP for more information).

2.3.3 Local health services

Executives: govern and resource the hospital emergency management arrangements, and undertaking a leadership role during emergencies.

Key roles include
- Overseeing the development and maintenance and approval of local health service emergency management plans;
- providing resources to ensure emergency management activities are undertaken, in compliance with relevant policies and procedures;
- ensuring appropriate representation to LEMCs
- ensuring appropriate representation to Health Service (metropolitan) or Regional (WACHS) emergency management committees; and
- appointing a Hospital Incident Commander (HIC) (metropolitan hospitals) to oversee emergency response coordination.

Local Health Disaster Coordinator (WACHS): coordinate the emergency management activities at local hospitals / health service entities.

Key roles include:
- developing, maintaining and testing of emergency management plans;
- leading the local Health response to emergency;
- notifying and liaising with the RHDC;
- where requested, participating in a local multi-agency Incident Support Groups (ISG); and
- leading internal recovery efforts

Hospital Incident Commander (metropolitan hospitals): coordinate the emergency response and recovery activities undertaken by a hospital or health service entity in response to an emergency.

Key roles include:
- activating and de-activating hospital emergency management plans;
- notifying and escalating issues to the SHICC;
- leading the hospital response to an emergency;
- where requested by the Director General or delegate, deploying assets and personnel in response to an emergency; and
- leading internal recovery efforts.

3. Prevention (including mitigation)

Prevention includes strategies, measures and interventions taken in advance of an emergency occurring, which aim to reduce or eliminate the negative consequences of the emergency on our society, the environment, the economy, human health, and critical infrastructure. Preventative measures can include physical or engineered solutions, legislative instruments and public health initiatives, such as immunisation programs.

3.1   Risk management

HSPs have a statutory requirement to practice risk management, in accordance with *Treasurers Instruction 825 – Security and Risk Management* and Public Sector Commissioners Circular 2015-03 Risk Management and Business Continuity Planning. The risk management requirements are articulated the Risk Management Policy.

In the emergency management context, prevention and mitigation is heavily associated with risk management: a systematic process which deals with the effect of uncertainty on the objectives of an organisation. Emergency risk management involves identifying, assessing, and treating risks to minimise the likelihood of an adverse event occurring and/or mitigating the impacts of events when they occur. Some risks, such as heatwaves and cyclones, cannot be prevented, so the focus shifts to mitigating the impacts.

3.1.1 Risk-based approach to emergency management

Emergency management arrangements should adopt a risk-based approach. The risk-based approach includes assessing the likelihood and consequence of all foreseeable risks and hazards, and the development of appropriate control strategies. Control strategies should focus upon reducing the likelihood of an event occurring and/or mitigating (reducing or constraining) the consequences. Control strategies should be developed for all foreseeable risks and additional treatment strategies initiated to improve controls to comply with the identified risk tolerance for the HSP.

For example:

A hospital in the northwest of Western Australia undertakes a risk assessment on its exposure to tropical cyclones. As part of its risk assessment, the hospital seeks advice from the Bureau of Meteorology, Department of Fire and Emergency Services and local government. The hospital determines a cyclone would likely affect its facility at least once every one to three years, ranking the likelihood as 'Likely' (4). The hospital assesses a cyclone would likely lead to a potential medium term suspension of work, ranking the impact as moderate (3). The overall risk of cyclones on the facility is ranked as 12 (3 x 4) = High.

As cyclones cannot be prevented, the risk treatment focuses upon mitigating the impact of a cyclone. The hospital implements a number of control strategies including:

- ensuring the facility complies with the relevant building codes and regulations to withstand the predicted severity of cyclones;
- ensuring it has a back-up power and water supply and sufficient portable medical gases;
- developing procedures and strategies to ensure there are enough supplies, linen and critical consumables on hand during the season; and
- developing procedures for rapidly preparing the building before a cyclone is expected to impact.

- establishing a business continuity plan for the prioritised resumption of critical services in the event of a disruption.

4. Preparedness

Preparedness refers to the activities that are undertaken in preparation for an emergency. Activities include:

- planning;
- stakeholder engagement;
- education;
- training and exercising; and
- resource management.

4.1 Planning

To ensure the WA health system can provide a coordinated and integrated response to an emergency, it must ensure planning has been afforded. Planning should be risk-based and align with appropriate local, district, State and Australian requirements. Planning should be based upon:

- best practice principles;
- technical and scientific knowledge;
- an evidence-based approach; and
- local knowledge and experience.

Health service planning requirements are reinforced by National Safety and Quality Health Service Standards and Australian Standards, including:

- AS/NZS ISO 31000:2009 – Risk Management – Principles and Guidelines
- AS 4083:2010 – Planning for emergencies – Health care facilities
- AS 3745:2010 – Planning for emergencies in facilities
- ISO 22301:2012 – Societal Security – Business Continuity Management Systems – Requirements

4.1.1 WA Health system emergency planning framework

WA Health system's emergency planning framework aligns with Australian and State requirements, and is based on a graduated, all hazards approach. Accordingly, HSPs should align plans and procedures to this planning framework to ensure a consistent and coordinated approach as indicated below.

		WA Health Emergency Planning Framework	
		Enablers	**Plans**
National	Health-specific	Australian Health Protection Principal Committee (AHPPC) National Health Emergency Management Standing Committee National Critical Care Trauma Response Centre (NCCTRC)	• National Health Emergency Response Arrangements (NatHealth Arrangements) 2011 • Domestic Response Plan for Mass Casualty Incidents of National Consequence (AUSTRAUMAPLAN) 2011 • Domestic Health Response Plan for Chemical, Biological, Radiological or Nuclear Incidents of National Consequence (Health CBRNINC Plan) • Emergency Response Plan for Communicable Diseases and Environmental Health Threats of National Significance (CDEHPLAN) • Emerging Issues of National Significance (includes the Australian Health Management Plan for Pandemic Influenza (AHMPPI)
	All agencies	Emergency Management Australia	• Australian Government Disaster Response Plan (COMDISPLAN) • National Response Plan for Mass Casualty Incidents Involving Australians Overseas (OSMASCASPLAN) • Australian Government Overseas Disaster Assistance Plan (AUSASSISTPLAN) Australian Government Plan for the Reception of Australian Citizens and Approved Foreign Nationals Evacuated from Overseas (COMRECEPLAN)
State	Health-specific	WA Health Emergency Management Committee (WA HEMC)	○ WA health system emergency management arrangements (this document) ○ State Health Emergency Response Plan (SHERP) • Infectious Disease Emergency Management Plan (IDEMP)
	All agencies	State Emergency Management Committee (SEMC)	○ State EM Plan • Hazard management plans (Westplans)
Regional (District)	Health-specific	Health Service Emergency Management Committee	• Regional Health Emergency Response Plan (WACHS only) • Business Continuity Plan • Infectious Disease Emergency Management Plan (WACHS only)
	All agencies	District Emergency Management Committee (DEMC)	• District Emergency Management Arrangements
Local	Health-specific	Health service entity emergency management committee	• Emergency Management Plan ○ Infectious Disease Emergency Management Plan • Business Continuity Plan • Other plans (as based on local risk assessment)
	All agencies	Local Emergency Management Committee (LEMC)	○ Local Emergency Management Arrangements

4.1.2 State Plans

4.1.2.1   State Emergency Management Plan

The State Emergency Management (EM) Plan is the over-arching, multi-agency plan that outlines the arrangements for preventing, preparing for, responding to, and recovering from, prescribed hazards within Western Australia. The State EM Plan is supported by hazard-specific plans (Westplans).

4.1.3 State Health plans

4.1.3.1   State Health Emergency Response Plan

The State Health Emergency Response Plan (SHERP) is an *all hazards* response plan that outlines how WA Health responds to an emergency or disaster. All HSPs should ensure their emergency management plans and arrangements align with the strategies outlined in the SHERP.

The SHERP remains in a default standby phase, and when an emergency occurs, it can be escalated to the response phase by the Director General or delegate. The SHERP provides a single response mechanism that is supported by a number of functional annexes, each outlining a specific response capability. Annexes include:

A. Pre-hospital and remote incident site coordination
B. Liaison Officers
C. Health Response Teams
D. Mass casualty aeromedical transport
E. AUSMAT response
F. Surge management
G. Trauma Response
H. Burn Response
I. Terrorist or criminal act
J. CBRN / HAZMAT hospital response
K. Environmental Health response
L. Management of the deceased
M. Mental Health
N. Media and public information
O. Other Health response considerations
P. Glossary of terms / acronyms

4.1.3.2   Infectious Disease Emergency Management Plan

The Infectious Disease Emergency Management Plan (IDEMP) outlines how the WA health system will prepare for and respond to any declared infectious disease emergency. The plan is an agency-specific emergency management plan that can be applied to any pathogen whereby a coordinated Health response is required. The IDEMP is an agency-specific plan, and is activated in conjunction with Westplan Human Epidemic. All HSPs should ensure their infectious disease emergency management plans align with the strategies detailed in the IDEMP.

4.1.4 Regional Plans

4.1.4.1   Regional Health Emergency Management Plan

The WA Country Health Service (WACHS) has articulated roles and responsibilities for developing, documenting and maintaining plans and procedures for emergency management in the WACHS Disaster Management Policy.

4.1.5 Hospital / health service plans

All hospitals and health services entities are required by policy and accreditation bodies, to develop a suite of site-specific plans that outline how the entity manages emergencies. These plans should include:

- emergency management plan (as based on the appropriate national standards and accreditation guidelines);
- infectious disease emergency management plan (clinical settings only);
- business continuity plan; and
- other plans, based on local risk assessment

4.1.5.1   Emergency management plans

Emergency management plans should be developed, documented and tested based on an all-hazards approach. The plan should outline how the hospital responds to, and recovers from, any emergency.

Hospitals and health care facilities utilise a nationally recognised set of codes to respond to emergencies. These codes are based upon *AS/NZS 4083 - 2010 - Planning for emergencies – Health care facilities* and *AS/NZS 3745 – 2010 Planning for emergencies in facilities.*

In addition to the requirements set out in AS/NZS 4083:2010, hospitals and health care facilities are required by the Emergency Management Policy to have procedures in place to address infant /child abductions (code black alpha) and active shooters (code black bravo).

4.1.5.2   Business Continuity Plans

HSPs are required by the business continuity management (BCM) policy to practice BCM, and establish a business continuity plan (BCP) to ensure the continuity of critical business activities in the event of a disruption.

This should include identification of critical business activities through a business impact assessment (BIA), identification of continuity strategies and resources, development of the BCP, and on-going training, exercising and maintenance of the BCP.

The BCP is to be tested and reviewed annually. The BIA for each business area should be reviewed every three years, or after any substantial organisational change or restructure.

The requirements can be found in the BCM policy.

4.1.5.3   Infectious Disease Emergency Management Plans

HSPs are required by policy to ensure infectious disease emergency management plans are developed, documented and tested. The plans should align with the IDEMP and focus on the operational aspects of maintaining essential services, in preventing Hospital Acquired Infection transmission(s), and, if applicable, in responding to a potential surge in demand for services.

4.1.5.4   Other hazard-specific plans

Using a risk-based approach, HSPs should develop hazard-specific emergency management plans to prevent or mitigate against foreseen risks. For example: hospitals in cyclone-prone areas should develop cyclone-specific emergency management plans and health service facilities in bushfire-prone areas should develop bushfire-specific emergency management plans.

4.2   Stakeholder engagement

The WA health system recognises that its partnering agencies all play an integral role in an emergency. Our stakeholders influence our plans, policies and procedures, and should be engaged across the response continuum to ensure the WA health system can better prevent, prepare for, respond to, and recover from, and emergency or disaster.

4.3   Education and training

A targeted and comprehensive emergency management education and training program can provide health staff (and allied emergency services) in country and metropolitan areas with the skills and knowledge to better prepare for, and respond to, the health consequences of a disaster.

The provision of a state-wide education and training program is a shared responsibility between individual health services and the Disaster Preparedness and Management Unit (DPMU).

4.3.1 Hospitals and health service entities

Individual health services should develop training programs that:
- identify local training needs based on identified risks in the area of emergency management;
- facilitate induction and general awareness training to staff;
- validate and practice local emergency response plans on an annual basis; and
- train members of the Incident Management Team and other relevant positions.

4.3.2 Disaster Preparedness and Management Unit

The DPMU provides the following training and educational services:

- identifies State-level health training needs based on identified risks in the area of emergency management;
- conducts State-level exercises; and
- delivers of a range of consistent emergency management training for all-of-health that cannot be suitably implemented at an individual health service; these may include:
  - general emergency management awareness training – available to all staff
  - Major Incident Medical Management and Support (MIMMS) training in the Pre-Hospital environment - for HRTs (both Health Commanders and Team Members)
  - Hospital MIMMS (HMIMMS) training in the Hospital environment – for Hospital management teams
  - Regional executive training
  - Emergo-Train System Instructor Training – useful for staff responsible for facilitating collective training
  - Australian Medical Assistance Team (AUSMAT) training
  - facilitating specialised 'one-off' training courses.

More information can be found at the DPMU website

For the mobilisation of HRTs A, B and C (as per Annex C of the SHERP), the following training requirements are suggested:

- Health Commanders of HRT
  - a current MIMMS Advanced Qualification

- Senior Doctors and Senior Nurses
  - minimum: a current MIMMS Team Qualification
  - preferable: a MIMMS Advanced Qualification

4.4 Disaster equipment and maintenance requirements

Hospitals and health services may be issued with items of specialised equipment to fulfil its combat agency obligations. This may include, but is not limited to:

- disaster response kits;
- communication equipment, including radios and satellite telephones;
- personal protective equipment, including HRT uniforms and CBRN/HAZMAT protective suits and respirators;
- disaster surge equipment, medical consumables and pharmaceuticals; and
- Parry packs (WACHS facilities).
- Hospitals and health services are required by policy to ensure all disaster response equipment is maintained in a functional state of readiness at all times.

4.5 Exercising

The testing and/or exercising of emergency management plans is critical to ensure the plans are valid, fit-for-purpose, and integrate with the WA health system emergency management arrangements. Exercising of plans is also a training opportunity for key stakeholders. The annual testing of emergency management plans is required under State Emergency Management Policy, which is issued under the auspices of the *Emergency Management Act 2005*. HSPs are required by policy to regularly exercise their EM arrangements.

Exercises are a critical component of preparedness and assist in a number of facets, including:

- validation of emergency plans and procedures
- exploring issues
- building, enhancing and demonstrating capability
- testing assumptions
- continuous improvement
- promoting awareness
- assessing competence
- identifying gaps
- evaluating equipment, techniques and processes.

4.5.1 Types of exercise

Exercises should be conducted on a regular basis, determined on a risk-based approach. There are three main exercise styles:

- **Discussion exercise** – A discussion exercise (discex) is a cost effective and efficient exercise method that uses a discussion among participants to actively explore issues, assess ideas and build confidence in the use of plans and procedures

- **Emergency operations centre exercise** – An emergency operations centre (EOC) exercise involves testing the governance structure, communication and decision-making of the Incident Management Team that has overall responsibility for managing an incident at a health care facility.
- **Field Exercise** – A field exercise involves the deployment of resources and personnel to a simulated incident or emergency. Teams involved in a field exercise may be required to respond to a pre-determined sequence of events that occur in real time, in collaboration with other partner agencies. Field exercises are resource-intensive and require extensive planning and resources.
- **Drill or simulation** – A drill or simulation involves participants performing their duties using a realistic, hypothetical scenario or simulation, such as an Emergo-Train System exercise.
- **Real event** – Where emergency management plan is activated, and EOC is mobilised due to an actual emergency.

4.5.2 Post-exercise debriefing and reporting

Following an exercise, debriefing helps to capture lessons learned and to identify any opportunities and changes required to plans, procedures and structures. For more information on debriefing, please refer to section 6.1.

A post exercise report provides a synopsis of a hospital or health service's response to an exercise and should be developed using the outputs from the debrief. It is a policy requirement for post-exercise reports to be tabled at the appropriate emergency management committee.

5. Response

As a provider of an essential service, the WA health system is required to provide a capability to respond to any event that causes, or threatens to cause, destruction or damage to property, death and injury, or disruption to critical services.

All staff should understand the process for notifying the appropriate authorities of an actual or potential emergency, and their roles and responsibilities when responding to an emergency.

5.1 Activation and escalation

Emergency response plans should clearly identify who has the responsibility and authority for activating the suite of plans, how and when to activate them, and escalation procedures where appropriate.

Escalation should occur:

- from the LHDC to the RHDC, when an incident affecting a single WACHS health service or facility is beyond the capacity of that facility and requires assistance and coordination across the region;
- from the HIC to the Director General or delegate, when an incident affecting a metropolitan hospital or health service entity is beyond the capacity of that facility and requires assistance and coordination across all metropolitan health services; and
- to the Director General or delegate, when an incident affecting a WACHS region or Health Support Services (HSS) and other State-wide shared services, is beyond the capacity of the region or entity and requires assistance and coordination across all of WA Health

In a large scale disaster, where the capacity of the entire WA health system is exhausted or overwhelmed, the Director General or delegate may (through the appropriate channels) request Australian Government assistance.

5.2 Notification

In an emergency, telephone is the primary notification method. Once notification has been established, ongoing communication may be established through alternative means including WebEOC, email and other Information and Communication Technology (ICT) platforms.

The WA health system is often notified of an incident by an external agency, such as St John Ambulance. In these circumstances, the person receiving notification should assess the incident and escalate the issue as necessary using the above mentioned escalation processes.

5.2.1 Hospital and health service entities

5.2.1.1 Internal notification

Hospitals and health services entities should have internal notification processes in place to notify key personnel of an emergency.

5.2.1.2 External notification

All hospitals are required to have a principal telephone number that can be utilised by the SHICC or RHDC (WACHS only) for urgent notification during an incident or disaster. The principal number should:

- be staffed at all times by people trained to respond to incident notification calls; and

- not be changed once the hospital's Emergency Operations Centre (EOC) is activated. Metropolitan hospitals with emergency departments should provide Emergency Department priority numbers to the SHICC. This number is used to rapidly request the preparation for deployment of HRT to an incident site.

5.2.2 WACHS regions

WACHS regions are encouraged to have a centralised emergency notification system in place for urgent notification during an incident or disaster. The number should be staffed at all hours.

5.2.3 State Health Incident Coordination Centre

The Director General or delegate is be notified on **(08) 9222 4444** (24 hours).

5.2.4 Maintenance

Any changes to emergency notification numbers are to be immediately conveyed to DPMU.

5.3 Incident communication

Rapid notification and efficient communication systems within the WA health system are vital to a successful and timely incident response.

5.3.1 Broadcast messaging system

A broadcast message may be sent via email, SMS and/or telephone to pre-designated stakeholders to provide urgent notification of an event. The broadcast message will contain a brief message about the incident, and a request to join a teleconference for further information. Hospitals and health services are responsible for maintaining the currency of the broadcast contacts list.

5.3.2 Notification of the nearest hospital to the incident site

If an incident occurs near a hospital, SHICC may contact the hospital/region directly so that incident details can be relayed immediately. This call may precede, but not necessarily replace, the initial broadcast notification.

5.3.3 Requesting a Health Response Team

The SHICC may directly contact a metropolitan hospital emergency department and request they undertake preparation for deployment of a HRT to an incident site. This request may precede, but not necessarily replace, the initial broadcast notification.

5.3.4 WebEOC

WebEOC is the WA health system's Crisis Information Management System (CIMS). WebEOC provides secure real-time information sharing during an incident, enabling staff within an emergency operations centre to improve coordination of a response.

All incident-related information is to be entered into WebEOC, and shared as appropriate.

5.3.5 Situation reports

The Director General or delegate or RHDC may disseminate Situation Reports (sitreps) via email to relevant stakeholders to apprise them of an internal or external incident.

Sitreps contain a précis of the incident with appropriate updates and actions required. Hospital staff requesting to be added to sitrep distribution lists will be directed to the appropriate hospital or regional distribution list owners.

Guidance on drafting a sitrep and a sitrep template are available in Appendix C.

5.4 Incident management

Incident management is the process of commanding and controlling the incident, and coordinating resources. The concepts of command, control, and coordination are essential in managing emergencies.

5.4.1 Command

Command refers to the vertical line of authority within each agency or organisation. It is exercised by a commander who has complete authority over resources.

The WA Health System's command structure is scalable and proportionate, and varies depending upon whether the incident is affecting a local area, regional or metropolitan area, or the entire state.

At the local (hospital) level, an appointed HIC (metropolitan area) or Local Health Disaster Coordinator (LHDC) (WACHS Regions) has overall command of Health resources for the hospital(s) they command.

In WACHS regions, the RHDC has overall command of Health resources within their respective region. All LHDCs report directly to the RHDC. Within the metropolitan area, hospitals report directly to the Director General or delegate.

Deployment of resources, including HRTs, is authorised by the RHDCs in regional areas, whereas metropolitan HRTs can only be authorised by the Director General or delegate.

The Director General or delegate provides the state-level command of all WA Health System resources.
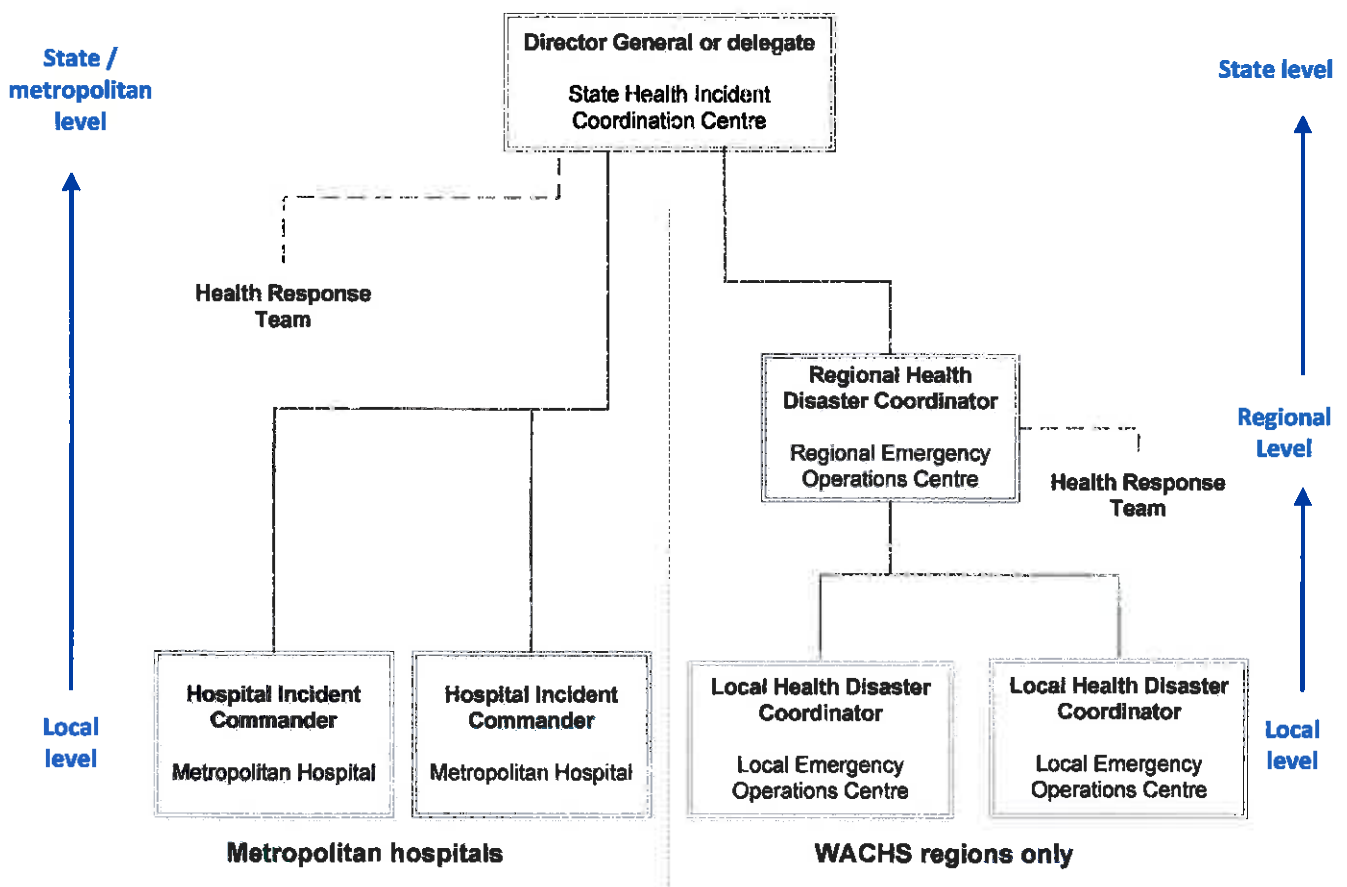
5.4.2 Control

Control refers to the overall direction of emergency management activities during an emergency. Control operates horizontally across agencies to ensure the overall activities of responding agencies are appropriate to the needs of the incident. In Western Australia, control is 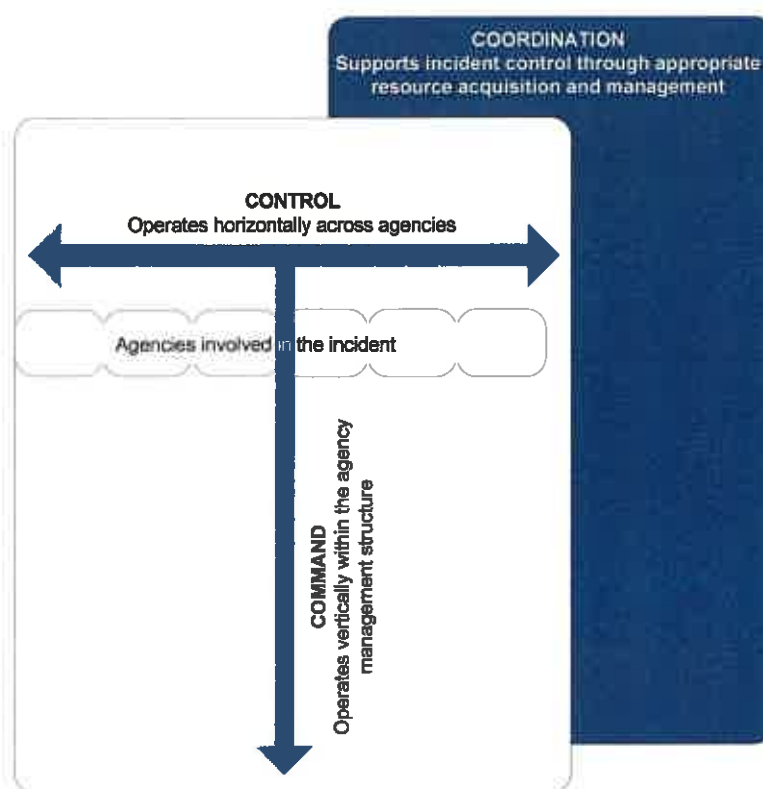supported by legislation where the nature of the hazard dictates which agency has overall control of the incident. This agency is referred to as the Controlling Agency, and an Incident Controller may be appointed to manage and assume overall control of the incident.

5.4.3 Coordination

Coordination refers to bringing together of responding agencies to ensure the systematic acquisition and application of resources is achieved.

COORDINATION
Supports incident control through appropriate resource acquisition and management

CONTROL
Operates horizontally across agencies

Agencies involved in the incident

COMMAND
Operates vertically within the agency management structure

(sourced from Australasian Inter-Service Incident Management System 4th Edition, Australasian Fire and Emergency Services Council 2013).

5.5   Incident management system

When responding to an emergency, a scalable, incident management system is to be used to provide coordination and control to manage and respond to any emergency. The Incident Management Team (IMT) is the organisation that is mobilised by the Hospital Incident Commander, in response to an incident that takes responsibility for resolving the incident.

An incident management structure is based on the following principles:

- flexibility
- unity of command
- span of control
- management by objectives

- functional management

5.5.1 Flexibility

Flexibility refers to the ability of an IMT to be applicable to a range of hazards and respond to changes that evolve during an incident, including the ability to scale up and down.

5.5.2 Unity of command

Unity of command refers to the need to have clearly defined set of common objectives and clear lines of command. It recognises that each subordinate should have only one reporting line.

5.5.3 Span of control

Span of control recognises the size and structure of the IMT should be reflective of the size and complexity of the incident. It also takes into consideration the number of people that can be successfully supervised by one person.

5.5.4 Management by objectives

Management by objectives recognises the Hospital Incident Commander, consulting with the IMT, determines the desired outcomes of the incident.

5.5.5 Functional management

Functional management is the recognition that a combination of tasks can be grouped together as functions under one cell which can be scaled up or down, depending upon the nature and size of the incident. In small scale incidents, one staff member may be able to perform several functional roles, or some activities may be shared across several cells. Additional IMT functions can be established where there is a requirement to provide a dedicated function for the effective management of the incident.

The IMT structure includes a number of mandatory, core and additional cellular functions.

Mandatory functions
- Command

Core functions

- Operations

- Planning

- Logistics

Additional functions

- Safety

- Intelligence

- Public Information

- Investigation

- Finance

- Liaison Officers

Mandatory Incident Function

Command

Role: has overall responsibility for managing the health service entity and its resources during an incident

Responsible for:
- taking charge and exercising leadership
- setting the incident objectives
- approving the incident action plan.

Core Incident Functions

Planning

Role: develops the objectives, strategies and plans for resolution of the incident.

Responsible for:
- preparing incident action plans and strategies
- maintaining awareness of all the resources that have been impacted or deployed to the incident
- managing intelligence and public information functions, (unless established as their own separate functional cells)

Operations

Role: implements the incident action plan and managing the operational response at the health site

Responsible for:
- reducing the immediate hazard
- saving lives and property
- establishing situational command
- restoring normal business processes

Logistics

Role: provide and acquire the human and physical resources required to achieve the incident objectives

Responsible for:
- managing activities and resources necessary to provide local support to the incident

Additional Incident Functions

Intelligence

Role collects and analyses information or data which is disseminated to support decision-making

Safety

Role: supports the incident commander with advice on safety and operational risks

Finance

Role: consolidating and tracking costs and expenditure on supplies, equipment and resources that have been utilised for responding to the incident. This role may also include administrative functions

Public Information

Role: provides oversight for the development and distribution of public and media information

Responsible for:
- responding to media requests
- social media monitoring and response
- engaging with affected stakeholders
- internal communications to staff

Investigation

Role: determines the cause of the incident and/or factors that led/contributed to the impact of the incident

Liaison

Role: provide expert advice, commit resources and enhance communications between services and organisations

5.6 Emergency Operations Centre

The Emergency Operations Centre (EOC) is the coordinating hub where the IMT assembles to undertake management of the incident. The EOC should be configured to support the gathering of incident and health-related intelligence, command of staff and resources, facilitation of multi-agency cooperation and liaison with higher levels of Health command.

The EOC is to have a direct line of communication with higher and lower levels of command. In regional areas, a Regional Emergency Operations Centre (REOC) may be established to provide regional coordination. Where metropolitan or State-level coordination is required, the SHICC is activated. All hospitals, health care facilities, and regions should have a nominated EOC.

5.7 Incident documentation

5.7.1 Incident Action Plan

An Incident Action Plan (IAP) should be developed for every emergency. Where an IMT is mobilised, a formal IAP should be documented, developed and communicated to all IMT members and relevant stakeholders. The IAP is iterative, and may be revised during an incident to reflect developments and changes in circumstances.

The SMEAC model can be used when developing an IAP.

S	**Situation** – what is the general situation / nature of incident?
M	**Mission** – what are our objectives?
E	**Execution** – how will we achieve our objectives?
A	**Admin and Logistics** – what logistical and administrative support is required?
C	**Command, Control and Communication** – who's in charge? who reports to who? How and who do we communicate to? when do we escalate?

5.7.2 Incident Log

An incident log should be established at the earliest opportunity. The log is a record of all decisions made, actions taken and communication with appropriate stakeholders when responding to an emergency. The incident log provides a running commentary of the incident and helps to maintain continuity of situational awareness and decision-making. The incident log should be appropriately filed in compliance with the *State Records Act 2000*.

Each log should contain:

- time / date of activity or communication
- person(s) involved
- method of communication (in person, telephone, email)
- detail of decision, action or communication

In complex emergencies, a WebEOC incident may be created by the SHICC. Upon creation of a WebEOC incident, all subsequent commentary should be entered and shared appropriately in the Activity Communications Log.

5.8 Financial management

All HSPs are to track expenditure and costs incurred relating to an incident. Expenditure should include expenses such as overtime payments, consumables and contractor expenses that are not covered under normal operating budgets.

In large-scale emergencies, the Director General or delegate may approve the activation of a dedicated cost centre. Detailed information on expenditure directly relating to the incident can then be forwarded to the SHICC for assessment and processing.

5.9 Safety and welfare

The HIC has responsibility for the safety and welfare of all personnel involved in the incident. Many incidents have the potential for prolonged activations, and the HIC should consider the fatigue management issues, shift length, access to amenities, suitable and safe work environment, and catering.

5.10 Media and public information

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

Media coordination during State-level incidents is undertaken by the Department of Health Communications Directorate. Less complex incidents may be managed by hospital media coordinators (metropolitan area only) or WACHS Media (regional areas).

5.10.1 Responsibility

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

- providing up-to-date information to media outlets;
- responding to media enquiries;
- coordinating social media messages;
- 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 WA health system;
- liaising with the Minister of Health and Department of Premier and Cabinet Media Offices;
- liaising with media and public relations staff from other government and non-government agencies involved in any emergency event (eg WA Police, Department of Fire and Emergency Services, St John Ambulance, Royal Flying Doctor Service, etc); and
- ensuring close communication is maintained with key stakeholders throughout the emergency, including via the Public Information Reference Group.

5.10.2 Media process during an emergency

- All Hospital Incident Commanders must advise Department of Health Communications Directorate (**9222 4333** - 24 hours) as soon as they become aware of a significant emergency or disaster.
- The Director General or delegate has ultimate responsible for the provision of emergency public information for the WA health system.

- Preparation of media statements, including social media, and coordination of media inquiries during an emergency lies with the Department of Health's Media Manager or nominated delegate.
- All media responses and spokespeople must be approved by the Director General or delegate.

5.10.3 Hospital, health service and regional public relations

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

5.10.4 State Emergency Public Information Management

The Director General or delegate, with advice from the Media Manager, may request assistance from the State Emergency Public Information Coordinator (SEPIC) to provide additional media relations support for the health emergency management functions, if required.

6. Recovery

The focus of recovery is to return to normal state of operations as soon as possible whilst taking into consideration, lessons learned from the incident, and opportunities to improve plans, procedures and structures.

Following the abatement of the incident, the following recovery activities should be undertaken:

- debriefing and post-incident reporting;
- post-incident support;
- recovery of deployed staff and assets;
- replenishment of stock and consumables; and
- financial reconciliation and accountability.

6.1 Debriefing and post incident reporting

6.1.1 Debriefing

Debriefing involves analysing the health service's response to an incident to capture lessons learned and to identify any opportunities and changes required to plans, procedures and structures. The lessons identified should be shared widely with other hospitals and health services as a means of best practice.

There are two main types of debriefs:

1. **Hot debrief** – A short informal debrief immediately following the incident to capture any feedback, outcomes and actions requiring urgent action.

2. **Operational debrief** – A formal process that is scheduled no more than three weeks following an incident. The operational debrief should be facilitated by the HIC, and involve all those involved in the incident plus any other appropriate stakeholder. Where an incident affects more than one health service, the Director General or delegate may facilitate the debrief.

   All significant and complex incidents should have an operational debrief conducted. The operational debrief should include the following items:

   - overview of incident
   - timelines of events
   - analysis of what activities worked well, and those that didn't work well. The analysis should address the following elements of capability:
     - people – roles, responsibilities, accountabilities, skills
     - processes – plans, policies, procedures, processes
     - organisation – IMT structure
     - support – infrastructure, facilities, maintenance
     - technology – equipment, systems, standards, security, inter-operability
     - training – capability, qualifications/skill levels, training requirements
   - identification of lessons learned. Lessons may need to be risk-assessed to determine the priority for action
   - identification of actions required

The outputs from the operational debrief should be incorporated into a post-incident report.

6.1.2 Post-incident reporting

The post-incident report provides a synopsis of a hospital or health service's response to an emergency and should be developed using the outputs from the operational debrief. The post-incident report should be tabled at the emergency management committee (however titled) for the hospital or health service.

6.2 Post-incident support

It is recognised that following during incident or disaster, employees may encounter extraordinary situations which can have an adverse effect on their wellbeing.

HSPs offer Employee Assistance Programs (EAPs) that allow free access to independent and confidential counselling services.

More information on EAPs can be obtained from the appropriate human resources department and from:

> https://healthpoint.hdwa.health.wa.gov.au/workingathealth/staffsupport/Pages/employee-assistance-program.aspx

6.3 Financial reconciliation and accountability

Depending upon the nature of the incident, some expenses incurred from responding to an incident (not including normal operational costs) may qualify for disaster relief and recovery funding. To qualify for funding, detailed records of expenditure must be maintained.

HSPs should not assume that all costs will be reimbursed.

Appendix A: Local, district, state, and national emergency management governance structures
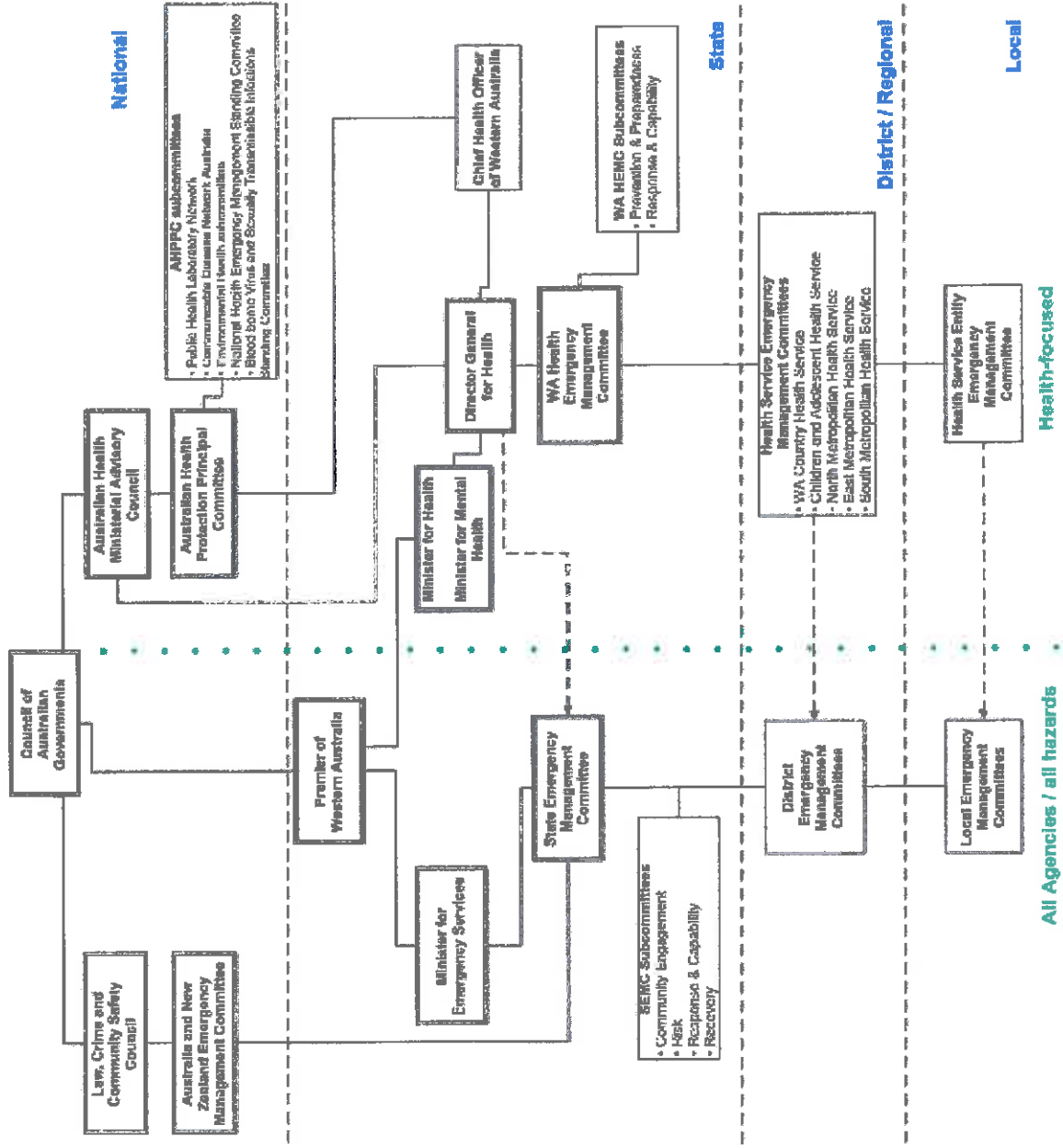
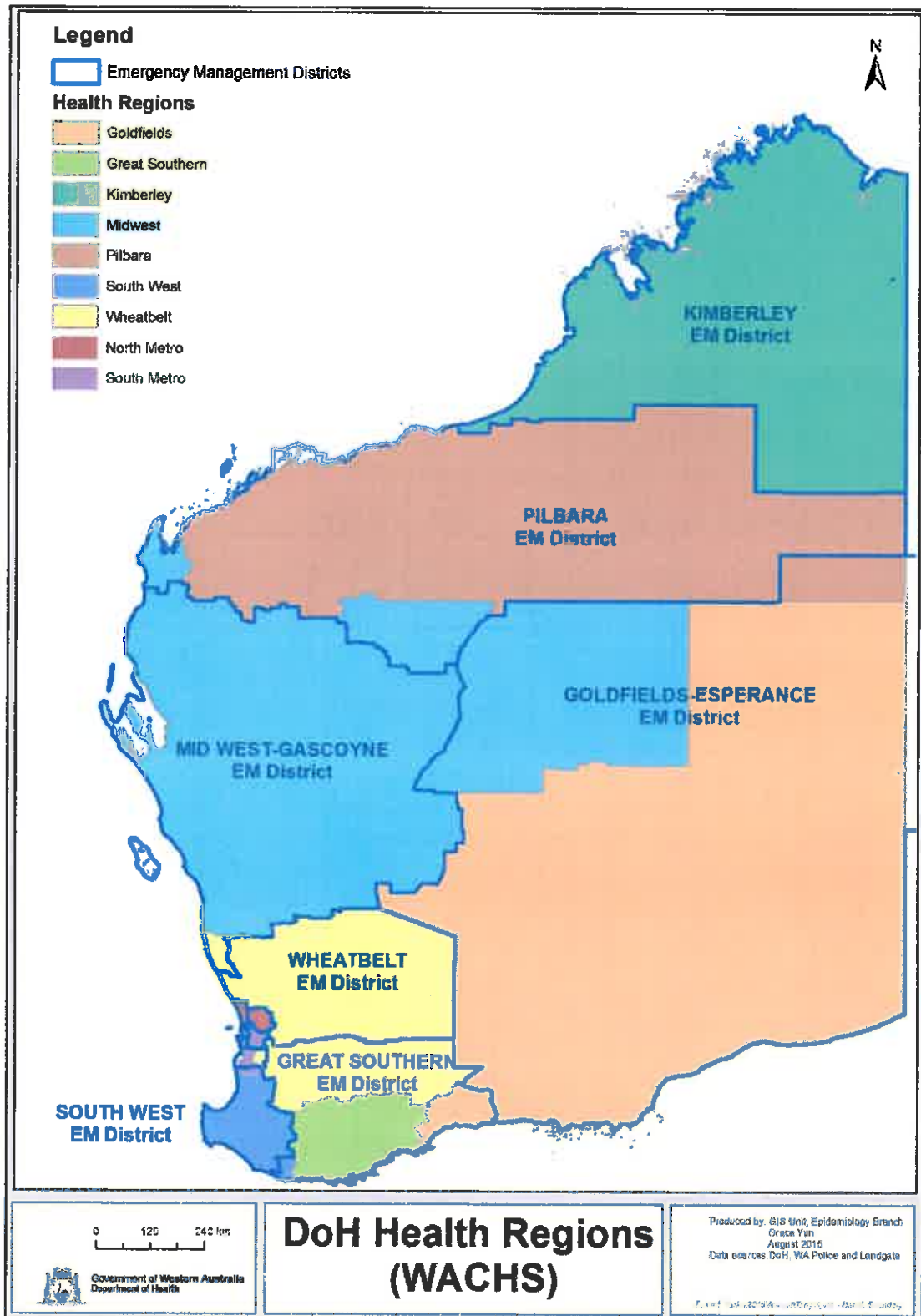# Appendix B: DEMC boundaries and representation

WACHS health regions with district emergency management boundaries overlaid

Legend

Emergency Management Districts

Health Regions
- Goldfields
- Great Southern
- Kimberley
- Midwest
- Pilbara
- South West
- Wheatbelt
- North Metro
- South Metro

KIMBERLEY EM District

PILBARA EM District

GOLDFIELDS-ESPERANCE EM District

MID WEST-GASCOYNE EM District

WHEATBELT EM District

GREAT SOUTHERN EM District

SOUTH WEST EM District

0   120   240 km

Government of Western Australia
Department of Health

DoH Health Regions (WACHS)

Produced by: GIS Unit, Epidemiology Branch
Grace Yun
August 2015
Data sources: DoH, WA Police and Landgate

Metropolitan health regions with district emergency management boundaries overlaid

DoH Health Regions (Metropolitan)

Legend
Emergency Management Districts

Health Regions
Wheatbelt
North Metropolitan
East Metropolitan
South Metropolitan

0 5 10 km

Government of Western Australia
Department of Health

Produced by: GIS Unit, Epidemiology Branch
Shannon Carter
Feb 2016
Data sources:DoH, WA Police and Landgate
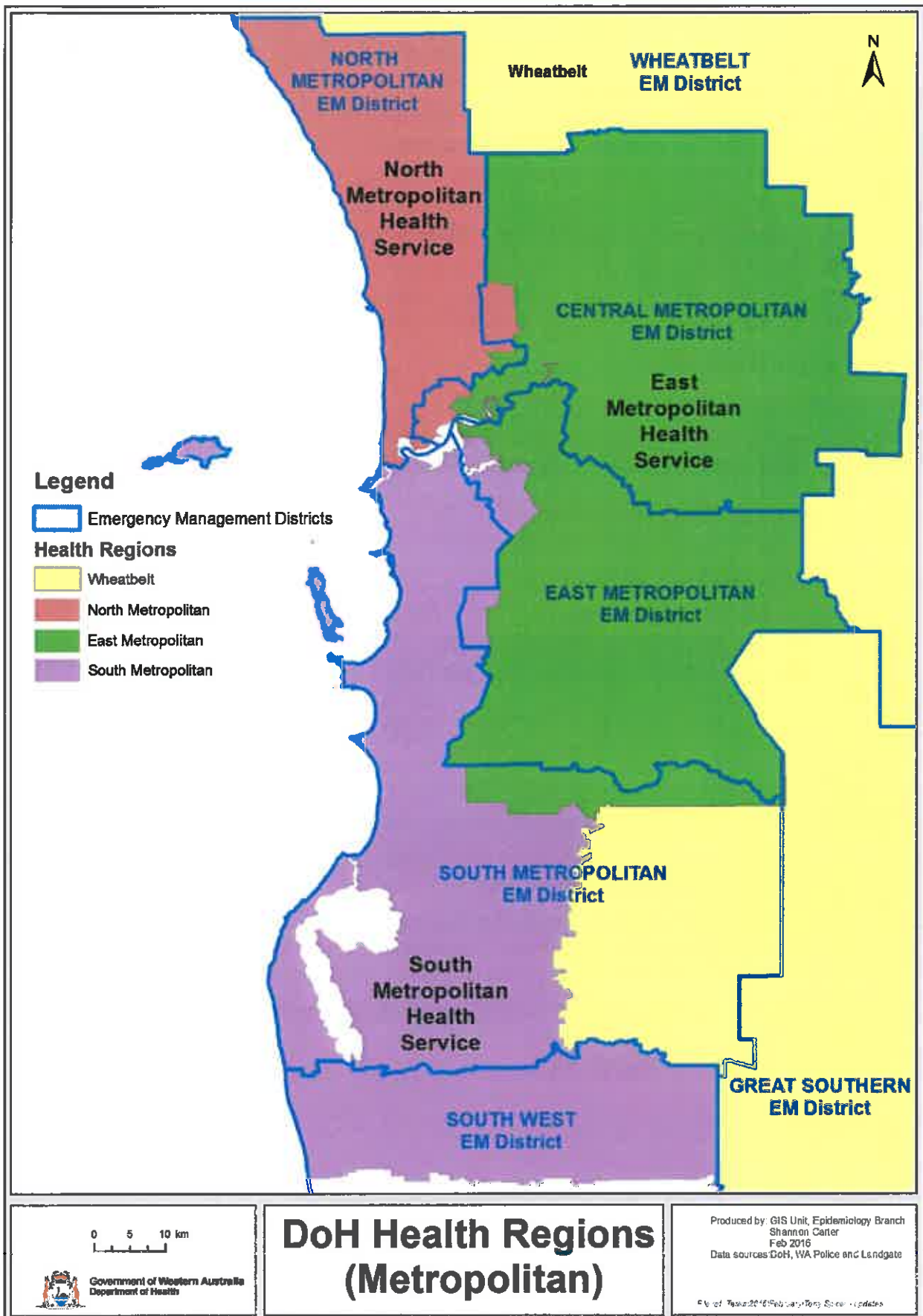
Appendix C: Situation Report Template

Introduction

A situation report (sitrep) is a document used to advise stakeholders:

- of the occurrence of an incident,
- information about the incident,
- what is being done in response to the incident, and
- the associated requirements of stakeholders.

Sitreps are prepared and distributed by organisations with whole or part responsibility for responding to the incident, and distributed as needed until the incident is resolved or the coordinating centre's responsibilities have ended.

Note: the publishing and distribution of a sitrep is not contingent on there being new information; on occasions, a sitrep may advise that the situation has not changed.

When to write a sitrep

Sitreps are to be prepared and distributed whenever:

- there is any incident that may conceivably affect the operations or interests of a stakeholder
- there is need to clarify details for stakeholders who may have heard inaccurate reports on an incident
- requested by the delegated authority.

Example incidents warranting a sitrep include:

- An incident with multiple casualties
- An incident affecting hospital service continuity
- An interstate or international incident that may have a bearing on WA

Writing a sitrep

A good sitrep is "A B C" – Accurate, Brief, and Clear.

Accurate   Information should be current with all details checked.

Brief   Information should be brief and concise.

Clear   Information should be conveyed in short clear sentences, and in plain English. It should not contain abbreviations, jargon or misleading words.

The sitrep should not contain information that lies beyond WA Health's functions under law or specialised knowledge, expertise or resources.   For example, DFES is the Hazard Management Agency for Bushfire, and it is their responsibility to report on the fire. A sitrep can, however:

- summarise other agency information for the purposes of clarifying the details of the incident,
- refer to it, or
- link to it (if available on the internet).

State Health Incident Coordination Centre
Department of Health (WA)

Delivering a Healthy WA

Situation Report

Security	No restrictions, restricted, In Confidence
Distribution	General distribution, metropolitan, regional,
Target audience	Executives, Emergency Departments,

Sitrep XX Insert Incident Name (new information in bold blue)

Day, DD Month YYYY HH:MM hours

This sitrep has been authorised by the Insert position, Title Insert Name

Background

- Brief synopsis of the incident, including contributing factors or direct causes.
- The background should be objective, avoid speculation and be politically neutral.
- Be concise, use plain English, avoid jargon and technical words

Current situation

- Impact of the incident (clinical, business, etc)
- Actions taken, preparations underway, workarounds insitu
- Plan activation status (if any)

Actions required

- General requests to or actions required of stakeholders
- (note: formal tasking shall be performed in WebEOC where the stakeholder has access through other appropriate channels where the stakeholder does not have WebEOC access)
- Next teleconference (if applicable)
- "Stakeholders are asked to monitor the situation and report any issues or clinical impact to SHICC by way of responding to this email"
- Any other relevant directions or information

Further situation reports

Next sitrep (estimate) or if further information comes to hand

Sitrep prepared by: Insert Name   Insert Position

Insert contact details or signature block

Appendix D: Glossary

The following table provides a list of terminology, acronyms, abbreviations and definitions.

Name	Abbreviation	Definition
Australian Medical Assistance Teams	AUSMAT	A state or territory-based medical assistance team, with self-sustaining field capability, that can be deployed in response to domestic or international incidents.
Business Continuity Plan	BCP	A plan that outlines the actions to be taken and resources to be used before, during and after a disruptive event to ensure the timely resumption of critical business activities and long term recovery of the organisation.
Crisis Information Management System	CIMS	An ICT platform that facilitates the secure, real-time information sharing to help stakeholders make sound decisions quickly. The WA Health system currently uses WebEOC® as its CIMS platform.
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
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.
Emergency Operations Centre	EOC	A facility established to control and coordinate the response and support to an incident or emergency. Also see Local Emergency Operations Centre (LEOC)
Emergency Response Team	ERT	A team deployed in the initial stages of an incident to assess, coordinate, and where necessary, escalate the incident to the Incident Management Team.
Health Response Team	HRT	A deployable team that can be sent to an incident site to augment the pre-hospital response or to provide specialist procedures and advice.
Hospital Incident Commander	HIC	A senior staff member that has authority for the coordination of all hospital staff and resources during an incident or emergency.
Health Service Provider	HSP	A statutory body, as defined under section 32 of the *Health Services Act 2016*.
Incident Action Plan	IAP	A statement of objectives and strategies to be taken to control an incident, and approved by the Hospital Incident Commander.

Name	Abbreviation	Definition
Incident Management		The process of controlling the incident and coordinating resources.
Incident Management Team	IMT	A scalable and flexible team of personnel, commanded by the Hospital Incident Commander that makes decisions and coordinates actions to resolve an emergency or incident.
Local Emergency Operations Centre	LEOC	A local facility established to provide local coordination across a WA Country Health Service hospital or health service during an incident or emergency.
Local Health Disaster Coordinator	LHDC	A designated senior staff member within a WACHS hospital or Health Service who has the authority to command and coordinate the use of all locally available Health resources during an incident.
Operational Area Support Group	OASG	A group of agency / organisation liaison officers convened to provide agency specific expert advice and support in relation to strategic management of the emergency.
Public Health Emergency Operations Centre	PHEOC	The State-level operations centre that coordinates the public health response to an infectious disease emergency.
Regional Emergency Operations Centre	REOC	A regional level facility established to provide coordination across a WA Country Health Service region during an incident or emergency.
Regional Health Disaster Coordinator	RHDC	A designated senior staff member who has the authority to command and coordinate the use of all resources with a WA Country Health Service region during an incident.
State Emergency Coordinator	SEC	A statutory position under section 10 of the *Emergency Management Act 2005*. The Commissioner of Police is the State Emergency Coordinator and is responsible for coordinating the response to an emergency during a state of emergency.
State Emergency Coordination Group	SECG	A strategic multi-agency group chaired by the State Emergency Coordinator that provides strategic advice and direction on emergency management to the public, emergency management agencies and the Minister for Emergency Services.
State Emergency Management Committee	SEMC	The peak multi-agency emergency management committee in Western Australia, established under section 13 of the *Emergency Management Act 2005*
State Emergency Management Plan	State EM Plan	An overarching multi-agency plan prepared under Section 18 of the *Emergency Management Act 2005* to outline the State arrangements for the emergency management of hazards and support functions.

Name	Abbreviation	Definition
State Health Emergency Response Plan	SHERP	The State-level plan that outlines how the WA health system provides a scalable, proportionate whole-of-agency response, with appropriate and timely interventions and allocation of resources, to minimise the health consequences of a disaster or emergency.
State Health Coordinator	SHC	A senior public servant with the delegated authority to command and coordinate the WA Health system during an emergency or disaster. The SHC is the regulated Hazard Management Agency for the prescribed hazards of: ■ heatwave, and ■ an actual or impending spillage, release or escape of a biological substance.
State Human Epidemic Controller	SHEC	The SHEC is the Chief Health Officer for Western Australia who is the regulated Hazard Management Agency for the prescribed hazard of human epidemic.
State Health Incident Coordination Centre	SHICC	The State-level facility that is established to provide coordination across the entire WA health system during an incident or emergency.
Situation Report	Sitrep	A brief report that is published and updated periodically during an emergency which outlines the details of the emergency, the needs generated, and the responses undertaken as they become known.
WA Health Emergency Management Committee	WA HEMC	The peak emergency management body for the WA Health System, which is chaired by the SHC.

Further definitions are available in the State Emergency Management Glossary