LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

Inquiry into the supply and use of methamphetamines, particularly ice, in Victoria

Mildura — 5 December 2013

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Mr P. Guest, Mobile Intensive Care Ambulance Paramedic, Ambulance Victoria.

Mr S. Fumberger, Group Manager, Sunraysia Region, Ambulance Victoria.

Mr D. Richards, Clinical Support Officer, Loddon Mallee Region, Ambulance Victoria.

The CHAIR — I now reconvene the public hearing and ask the witnesses for this session, Steve Fumberger, who is group manager, Peter Guest and Dale Richards, to come forward. Steve, I know who you are; you are group manager of the mobile and intensive care ambulance, but we do not have a bio on either Dale or Peter. You might want to briefly and quickly introduce yourselves.

Mr RICHARDS — I am Dale Richards. I am the clinical support officer for the Northern Mallee district, which is part of the Loddon Mallee AV group. I am in charge of in-field education as well as intensive care assistance.

Mr GUEST — My name is Peter Guest. I am a MICA paramedic working on the roster in Mildura and Irymple, mostly Mildura.

The CHAIR — My name is Simon Ramsay. I am a state member for Western Victoria Region and Chair of this joint parliamentary Law Reform, Drugs and Crime Prevention Committee, which is conducting an inquiry into the supply and use of methamphetamines, particularly ice, in Victoria.

I will quickly read you the conditions under which you are presenting to this inquiry this afternoon. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and is further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation of other Australian states and territories. It is important that you note that any comments you make outside the hearing, including effective repetition of what you have said in evidence, may not be afforded such privilege. Have you received and read the guide for presenting evidence to parliamentary committees? I think you have; I am sure you were sent a copy.

Mr FUMBERGER — We have, thank you.

The CHAIR — It is also important to note that any action which seeks to impede or hinder a witness or threaten a witness for the evidence they would give or have given may constitute and be punishable as contempt of Parliament. We are recording the evidence, as you see, with Hansard here, and we will provide a proof version of the Hansard transcript at the earliest opportunity so that you can correct it as appropriate. Thank you again for attending this public hearing. We have the media, as you have noticed, in the gallery, and we are recording, as I said, through Hansard. We have time constraints in relation to this whole hearing, and we have asked for brief contributions from those witnesses attending at the table to allow some time for the committee to ask questions. I will leave it up to you to decide who starts first, and then we will finish with the questions.

Mr FUMBERGER — I think I will start, and I will get some input from the guys either side. We three have been in the job for over 30 years apiece, basically, so there is a lot of history with it. I suppose if I look at all the data and so forth that I get through to my table, we are probably doing about 15 overdose-related projects or cases a month. In that — and we are just sort of going back through our data, it is just the last 12 months, and Peter can probably help you with a bit of this as well — the ice-affected are now starting to sort of pop up. We are actually starting to notice that it is far more problematic for us when someone is affected by the ice, the methamphetamine.

So as an organisation we are really now finding it probably not difficult but we have had to actually change our tack and our management styles and our training styles in regard to what we deliver back to our ambulance paramedics. If we have an agitated patient, we have guidelines around 'agitated', and that is a very wholesome sort of terminology, but when it gets back down to an ice-agitated person it is a different sort of scenario for us. Peter has had firsthand experience with dealing with these people who come on in the back of an ambulance. Whilst we are putting all those training things into practice, on the practical side and in the practical sense of it I think our biggest problem with anyone who is affected by ice is that we do not know — we do not know that until it is probably too late or it is hearsay or it is anecdotal. People are calling in, and the person that we are treating who has been affected by it does not tell you that they have been on ice or methamphetamine. It works hand in hand with the person who might be a diabetic or may be on another form of drug, or it may be alcohol et cetera. For us it is hugely problematic. We are as an

organisation dealing with that, but I think it is very slow and sure. But again, it is in small, small numbers here in Victoria. I am probably happy for Peter to give you an incident, if you like.

Mr GUEST — My own experience — sorry, I was not very well prepared for today — is I have noticed over the last two to three years we have had lots of agitated people, usually alcohol-based, and now it seems that the de-escalation is not working. It seems to me that we have people who we think are alcohol affected, but they are different. De-escalation does not work. They are strong, just amazingly strong, and we do not know what is really going on until afterwards. So we deal with what we have to deal with — what we call psychotoxic patients now — where we do have medications that can quieten them down. Anyone in this room who had one dose of that medication would be compliant. These people can have up to three and four doses — which we can give — and we just do not know what is going on there. Then in hindsight we think back and we read literature and we think, 'Oh, that's what that probably was'. So we are going in blind and we are just dealing with what we have got at the time, and that is that.

A recent experience, in hindsight again, was with a nice young man from a nice home. His mother was worried, and it took two police and two male ambulance paramedics to control this skinny little 17-year-old. It was unbelievable, his strength. At the time we did not have a clue what was happening, but now — it is an assumption — I am pretty sure that it was not alcohol, it was some sort of drug; whether ice or not, we do not know. Follow-up of these patients is really hard because they do not admit anything to the A and E department once they have sobered up. We try to follow up and find out what it was. No-one knows. No-one is the wiser; they went home. So we deal with it again as we have to.

Mr SOUTHWICK — Do you find repeat customers, where you are going back again to homes?

Mr GUEST — There are some; not a lot, because there are 24 staff sort of thing and we share the load. But yes, there are some repeats. It is usually alcohol-induced violence that we go to, and the violence is finished and whatever, but with the psychotoxic patients, whether it be from ice or some other substance, we just cannot de-escalate. Just recently we had a really good de-escalation lecture out at Irymple. I cannot remember the man's name. He works with Victoria Police as well, Tony something. It was excellent. He said that that is good procedure for sober people; it may not work for intoxicated people. Then it comes down to numbers and people, strength against strength, until we can sedate them, say, or whatever.

The CHAIR — What do you do differently to a potentially methamphetamine-affected patient who is quite aggressive from someone else? Do you have to have police in attendance, do you use tasers, do you use cufflinks?

Mr GUEST — No. We have a drug called midazolam that we can come to. That is the sedative that I was talking about, for the psychotoxic patient. I could give you one dose, but if you are psychotoxic, you may need four to be compliant. That is where we end up if we have to, but it is an intramuscular injection and we still have to give them an injection, probably against their will.

The CHAIR — The point was: can you subdue them to a point where you can actually inject or do you require police assistance?

Mr GUEST — We generally need police assistance, yes.

The CHAIR — So I am getting to the resource issue.

Mr GUEST — We always want but we do not always get, because of whatever. Just recently at 10.30 in the morning I was wrestling on the ground with what we suspected was a psychotoxic patient. It took two of us to control him until the police arrived. We were just winning, I guess, and it was just a physical confrontation. In the end, that is what it came to and it got to us or him.

Mr FUMBERGER — Fight and flight. Our main concern as management is the health and wellbeing of our paramedics. If there was a scenario where a patient was very aggressive and

behaving violently, the point is we have to either get rid of the patient — and obviously we have other methods that we try to go through, but if it gets to the point where we are going to be harmed, the patient will have to get out of the car — or we will leave the car and get out and the police will be called. Where we have our radios we can hit a button and send out a signal, a duress alarm, back to the control room and we will come as a pack as well and the police will assist. All these things are probably more prevalent now than they were say 5 or 10 years ago, I would suggest.

Mr GUEST — About five, yes.

Mr FUMBERGER — Probably the last five.

Mr SOUTHWICK — Where would many of your call-outs be? Would they be to family homes or nightclubs? Where are you finding these types of patients?

Mr GUEST — Personally, it is completely unpredictable: out in the street at 9.30 in the morning. The other thing I want to say just quickly is that most of our patients do not want us. It is a mother, girlfriend or whatever who has called us. They are in complete denial and do not want to see us in the first place. That is if they are not intoxicated; they are just sort of hung over or whatever and they are malnourished and they need help. That could be just in the bedroom in the morning, 9.30 in the street, in a nightclub. I have had only alcohol at nightclubs that I am aware of, but you do not know, really. It is very unpredictable. When someone has got to a situation like this, I do not think it matters whether it is Sunday night or Friday night. It is the same.

Mr RICHARDS — Just to add to that, this morning I was doing some research and saw that most cases that we have attended this year were in private homes, so they were not even in public places as such. They might have been out the front, but they were not at entertainment areas. It was something that might have been done in more of a private situation rather than at a gathering.

Mr SOUTHWICK — It is probably hard for you to answer this question, but in many of those instances would you think that that person has come home from something else or that the drugs had been consumed at the place where you have attended?

Mr RICHARDS — I am sorry, I am not sure of that. As Peter suggested, a third party has contacted us for an ambulance to attend. I am not too sure whether they had ingested the drugs on the premises or returned home after ingesting drugs. Also, as Peter said, the patient is almost never forthcoming in admissions. It is going on behaviour, style or evidence that we can see surrounding — whether there is any drug paraphernalia, any empty alcohol containers or things like that — which may give us a bit of an indication of where the problem is coming from.

Mr FUMBERGER — The third party is probably letting you know that there is a problem with it. Again, the catalyst is usually the third party who creates that phone call. It is not being initiated by the person who is not in control.

Mr GUEST — Just quickly, again when you think back, it is not all agitation or violence or whatever. A lot of these people are just sick, the morning after-type sick. It is not from one instance of abuse; it has been months or whatever. You can see people, friends even, change in the space of three months of constant abuse. A lot of these people are not being violent or whatever. They still do not want our help. They are malnourished, they are dirty, they are on skid row, so to speak.

Mr McCURDY — If a third party has called you and you know you are going to an incident that involves ice use, do you take any other precautions or do you do anything different? Do you take the police with you or do you always go and assess first?

Mr GUEST — We never know. Very rarely would you know it was — —

Mr McCURDY — Even a third party would not tell you that it is because of ice use?

Mr GUEST — No, and a lot of third parties do not know that it is because of ice use. Their offspring or their partner or whatever is unwell and they do not know why.

Mr FUMBERGER — There may be an assumption, as well.

The CHAIR — What is the typical demographic of the ice user that you attend?

Mr GUEST — A down-the-bottom-of-the-staircase ice user? Terribly poor hygiene. They talk about teeth, but I think that is a hygiene thing. They are pale, they look diaphoretic or sweaty, they are emaciated and they are in denial.

Mr FUMBERGER — Just to add to that, our age group is between 17 and 43 and they are mainly Caucasian.

Mr SOUTHWICK — You said before that it is hard to determine whether they are on drugs. Is there any testing that you can possibly do in that situation?

Mr GUEST — Not that we are aware of. The only way we can find out is by people being honest.

Mr SOUTHWICK — So you could not administer a drug test to get more definite information as to what you are dealing with?

Mr RICHARDS — Not in the field, no.

Mr FUMBERGER — There are certain types of other drugs that you can tell have been used, maybe by pupils and so forth. There is Narcan and so forth you can give them to counteract the effects, but with the ice or methamphetamines there are none.

Mr GUEST — We can only go by physical signs and symptoms, and then it is not definitely specific. A narcotic may be specific, with pupils or whatever, whereas an amphetamine does the opposite to pupils. But there are lots of things that do the opposite to pupils, whereas there are not a lot of things that make pupils appear a narcotic, if you know what I mean.

Mr FUMBERGER — And just 30 years experience probably helps, too.

Mr CARROLL — Thanks for your presentation. My question is back on admissions. Is it basically that when you have gone out there people will not admit that they have taken ice purely for fear that the police will be informed?

Mr GUEST — Probably. We all would say — with respect to the police; I'm not saying that they are mean or anything — 'I'm not a policeman; I'm not judging you. I'm just trying to figure out what's going on'. Some people, probably 2 out of 10, may come forth then, but people are still in denial. They are obviously intoxicated and you ask, 'How much have you had to drink?', and they will say, 'Only had a stubby'. It drives you mad.

Mr CARROLL — As paramedics, what are you obliged to do if someone does admit, 'Yes, I've been on ice; I've been on it all day. I'm worried'? You rehabilitate them and take them to hospital. Are you obliged to then also contact the police?

Mr GUEST — No.

Mr CARROLL — That is at your discretion?

Mr RICHARDS — We will pass on that information to the receiving hospital.

Mr FUMBERGER — I was going to add quickly that the only thing that we are probably advised to be worried about would be if there was a young child or someone similar, an under-age child, and therefore there were other people and a drug may have been supplied by the parents and/or the carers et cetera. We have an obligation, and that would be something that we would report.

The CHAIR — Do you talk in your association in relation to whether Mildura particularly has more prevalent ice activity than other regions? Is there anything special about Mildura in relation to the amount of work you have to do in ice-related cases?

Mr RICHARDS — I do not believe so. The group managers we will speak with on a monthly basis, or there are education releases on topics that may be of importance throughout the state, and there is information shared on ice too, I should say, but there is not a — —

Mr FUMBERGER — Databank or something.

Mr RICHARDS — Yes, or a significant identification of Mildura alone. It seems to be a fairly widespread problem. Shepparton might argue the same — that they have an increasing problem there — and there may be other centres near Geelong or whatever that will say something similar or 'Yes, our problem's escalating', but I do not think it stands out that anywhere is worse than the next place, I do not believe.

The CHAIR — Any closing remarks you would like to make?

Mr FUMBERGER — The only closing remark is that I think probably over the last six months, I suppose, would be a very good time line where there has been a lot more awareness, and therefore as an organisation AV is actually attending a lot more meetings and cooperating also with the police and mental health and other people. So it is becoming more of a concern to us. Basically, I suppose, as an organisation, with others, we are actually pulling together and probably looking at a way forward. In the background there is plenty of work going on, I suspect — that is really what I am try to add — as well, so it has been very good.

Mr RICHARDS — Good public awareness. The drug and alcohol counsellors have been quite strong behind all this to make public forums available for parents, schools, ambulance et cetera. It has been a good public response so far, but we probably do not have any great answers on where to go from here.

Mr GUEST — This is a good start.

Mr FUMBERGER — This is excellent. We are very happy.

The CHAIR — Thank you. We have interviewed many of your colleagues in other parts of Victoria, and we appreciate the response we are getting from the paramedics. Thank you very much for your time.

Witnesses withdrew.