



WADEM Oceania Newsletter December 2017

WADEM Congress Brisbane 2019

Update for Oceania Chapter

The Oceania Chapter of WADEM will be hosting the 2019 Congress in Brisbane, May 7-10, 2019. The Congress will be held at the Brisbane Convention and Exhibition Centre.

The WADEM Executive have determined to establish a small Congress Executive comprising the WADEM President Tony Redmond, VP for Congresses Erin Downey, Paul Farrell, Vivienne Tippett and Gerry FitzGerald. The Brisbane Congress Executive will report to the WADEM Executive and will act as a conduit between WADEM and the Oceania Chapter for this Congress. Four sub-committees have been confirmed including finance and administration, scientific program, sponsorship and social program.

During the conference there will be plenary sessions and multi-track themes. These tracks could include WADEM's Special Interest Groups, Chapters, the conference sub-themes, the proposed legacy products of the Congress, and others. Each of these tracks will need a Chair and members. It is aimed to connect people with common interests prior to the Congress so that these people may reach out to others, and if appropriate, undertake prior work which may reach culmination at the Congress.

WADEM is moving to engage a local Professional Conference Organiser to assist with planning and conduct. We also need to develop a sponsorship package and then begin the task of securing sponsors.

The Scientific Program will run from Tuesday 7 to Friday 10 May, 2019. Pre-conference workshops will be encouraged. The overall theme is the application of emerging technology to the prediction, evaluation and management of disasters. We also propose the following principal sub-themes to be the core themes of each one of the days. These include technology and disasters, education and training, climate change and emergency medical responses.

We proposed there be specific "Legacies of the Conference" in the form of Position Papers. The ones we had previously identified include research priorities, an education and training framework, a conceptual framework for understanding the health consequences of disasters and health system resilience.

Finally, we have proposed an accompanying social program including a welcome reception, opening ceremony, conference dinner and closing ceremony. There will be an accompanying persons program. We will endeavour to keep costs down to ensure maximum participation.

What can you do?

Put simply, get involved. We need your involvement and guidance. For each of these sub-committees we need a Local Co-Chair and members. We need your advice as to keynote speakers and the tracks that should be included and people to facilitate those tracks. We need your help in identifying sponsors. Finally, we have proposed field trips to be organised during the Congress, and workshops and regional visits to places such as north Queensland or Christchurch. Can you help identify other options?

If you can help please contact Gerry FitzGerald gj.fitzgerald@qut.edu.au or Vivienne Tippett vivienne.tippett@qut.edu.au

WADEM INTERNATIONAL

The WADEM Board has been meeting frequently since the Toronto Congress; eight task force groups chaired by board members have been initiated to examine and develop strategic directions for the organisation. These task forces are focussed on technology, the strategic plan, the by-laws, membership, evaluation, publications, collaborations, and finance. The work of these task force groups is to strengthen and develop the organisation and provide opportunities for members, special interest groups, Chapters and affiliates to engage further with WADEM and maximise membership opportunities.

WADEM PSYCHOSOCIAL SECTION

The latest newsletter.

<https://wadem.org/wp-content/uploads/2017/10/Psychosocial-October-Newsletter.pdf>

Thanks to Gordy Dodge for sharing this.

Committee Election**OCEANIA CHAPTER COMMITTEE ELECTION**

The following have been appointed to the Chapter Committee for 2018-2019, nominations did not exceed positions so no election was required.

Joe Cuthbertson (Chair)
Erin Smith (Deputy Chair)
Penny Burns
Caroline Spencer
Rowena Christiansen
Peter Aitken
Vivienne Tippett
Sonia Morshead;
Sandra Richardson
Graeme McColl

Co-opted members:

Thompson Telepo (PNG)
Lidia Mayner (Flinders)
Hendro Wartatmo (Indonesia)

Introducing our new members:

Sonia Morshead

Occupational background:

Oct 17 –current Senior Project Officer.

Drought, Disaster and Emergency Incidents Team
Mental Health, Alcohol and Other Drugs Branch,

Queensland Department of Health.

Initially becoming involved in disaster management after joining the Queensland State Emergency Services in 2004, I developed a passion for assisting those in need during times of stress and uncertainty. I have accrued a Masters in Public Health/Disaster Management and Social Work (focusing on mental health) and specialise in the sub-area of assisting survivors psychologically in the immediate and recovery phases of the response.

I have been involved in both state IMT and field psychosocial responses for many events around Queensland, the Northern Territory and Fiji. Currently I am assisting with the STC Debbie response with the Queensland Department of Health, along with State strategic plan and operational development. I also assist Red Cross Emergency Services through volunteering as a team convenor and trainer.

Sandra Richardson.

My current role involves working full time across two organisations, the Canterbury District Health Board (CDHB) and the University of Otago. Within the CDHB, I work as a Nurse Researcher in the Emergency Department, an area where I have undertaken the majority of my clinical practice over the past 30 years, prior to moving into an autonomous research role.

In addition, I work as a Senior Lecturer with the University of Otago, Centre for Post Graduate Nursing, where I convene the High Acuity Nursing paper. I have been involved with the RHISE (Research into the Health Impact of Seismic Events) group since its inception, and worked as a committee member on the establishment of the inaugural People in Disasters Conference, held in Christchurch, NZ.

Also WANTED!!!

An Editor/Collator for the Oceania Newsletter. Position requires collection of items from members and news media, drafting into a format that the incoming editor can develop and forwarding, if required, to our wordsmith for fine-tuning. Our wordsmith is Liz Noble, Professor Frank Archer's former Personal Assistant.

After 7 years of collating the newsletter, I feel that it is time to take a break and have some fresh face(s) develop it and take it forward, and perhaps even develop into an online information and chat site.

A big thank you to all who have contributed, particularly Liz Noble for her great editing and Auntie of course for her wisdom and advice, some of which I can't print.

I'm still staying involved with WADEM Oceania.

Regards,
Graeme.

Research and Appointments

The Torrens Resilience Institute, and its World Health Organisation Collaborating Centre for Mass Gatherings, and Global Health Security at Flinders University, have recently welcomed Dr Rebecca Hoile who is currently working as an expert consultant for the World Health Organisation (WHO) as part of their World Health Emergency Programme.

The Health Security Interface project will focus on the *technical and scientific level* responses related to a suspected or known biological incident, including those aspects relevant to alleged use investigations. Her role is to bridge the gap between health agencies and law enforcement (and other security agencies) in order to provide a common language approach to a sometimes technical topic, and assist agencies to consider the impact of 'deliberate' events on the way we do business, including communication pathways, investigative challenges and response plans.

As part of this project she will be working with an international group of experts to undertake a gap analysis and make recommendations for strengthening response capability within the health and security interface.

In addition, a Steering Committee will be established to undertake a review of a number of guidance and reference documents, including those related to the response to chemical, biological, radiological and nuclear (CBRN) incidents.

The project aims to unite key international and national partners to:

- Discuss existing guidelines for inter-agency health and security interface management;
- Define the main needs and existing gaps, as well as ways to streamline improvements within health and security interface actions;
- Establish a way forward for strengthening connectivity between health and security agencies during deliberate biological events.

Dr Hoile previously headed the Bioterrorism Prevention program within the Chemical, Biological and Radiological Sub-Directorate, which was part of the Counter Terrorism and Vulnerable Targets Directorate at INTERPOL based in Lyon, France. She is recognised as an international expert in the field of CBRNe response, advising law enforcement, military and public health practitioners. She has also previously been Operations Manager, Senior Forensic Scientist and Forensic Counter Terrorism Manager for NSW Police.



Emergency Management Websites

GP Clinics and Pharmacies

The group I work with have developed an emergency management website for medical clinics and pharmacies to assist with their emergency planning, and to provide up-to-date information on current emergencies and topics of interest such as reports on the influenza season.

Contact Graeme at gmccoll@wadem.org for further information and a link to the site.

From Penny Burns

An ED / academic colleague of mine, in association with a rural GP here, has put together what I think is a great resource that is freely available for all. They saw a need for a set of easy cognitive prompts for emergencies and so have compiled this for GPs also managing small EDs in rural areas, but essentially, they are useful for us all...I know my memory for these emergencies needs constant refreshing and is seldom used.

They are happy for it to be linked to from other sites and to be freely distributed. The aim is for it to be useful and used.

It is at: <http://emergencyprotocols.org.au>

The pdf download is at: <http://emergencyprotocols.org.au/wp-content/uploads/2017/05/EmergencyProtocols.pdf>

The following links were supplied by Deborah Callahan, a member of Canterbury Primary Response Group.

For a library of training videos and resources.

<http://www.drc-group.com/project/jitt.html#response-volunteermanagementoperations>

This portal was developed for Hurricanes Irma and Harvey and is sort of a dashboard. It's got SIT REPs, maps, etc.

<http://ppp.trustedops.com/>

Disaster Preparedness Toolkit

Disaster Preparedness to Promote Community Resilience: Information and Tools for Homeless Service Providers and Disaster Professionals

The Veterans Emergency Management Evaluation Center (VEMEC) within the U.S. Department of Veterans Affairs (VA) is pleased to announce the release of a new toolkit, the Disaster Preparedness to Promote Community Resilience: Information and Tools for Homeless Service Providers and Disaster Professionals.

To view the toolkit, please click on the following links

https://www.va.gov/HOMELESS/nchav/docs/VEMEC_Intro_20170713_Final_508.pdf

- A concise overview and introduction to the toolkit.

https://www.va.gov/HOMELESS/nchav/docs/VEMEC_Toolkit_20170713_Final_508.pdf

- A concise overview and introduction to the toolkit.

Background/Purpose: Individuals and families experiencing homelessness are among the most vulnerable members of our society. They become even more vulnerable during natural disasters or public health emergencies, particularly if homeless service organizations are damaged or unavailable. Enhancing preparedness and continuity planning for healthcare providers and homeless service providers can assist in reducing potential disruption of services.

Emergency management Web Sites

Cyclone Season

For many in Oceania the beginning of summer is associated with increased disaster risk for cyclones in the tropics, and the impacts of climate change have exacerbated the effects of these upon communities, particularly small island nations.

An outlook report has been published by relief web that forecasts between four and seven cyclones for the upcoming cyclone season in the Pacific, and can be found here:

<https://reliefweb.int/report/world/pacific-region-tropical-cyclone-outlook-summary-13-november-2017>

Diversity in Disaster Conference

Location: The MCG in Melbourne

Dates: April 17-18, 2018

The Conference was launched on the International Day of Disaster Reduction, 13th October, 2017

Every year people and communities across Australia experience emergencies and natural disasters, but not all members of communities are equally affected.

Many people from diverse, marginalised or under-represented communities experience disasters differently, facing unique challenges that influence their ability to respond and recover.

How do we empower communities of all backgrounds to be more resilient to an emergency or natural disaster? How can we support them to bounce back and thrive?

Designed to enhance resilience and raise awareness of the needs and strengths of all in the community, the Diversity in Disaster Conference will engage emergency management practitioners, policy-makers and community services leaders with the latest research on disaster resilience.

This unique National Conference is consistent with the Sendai Framework and supports the Focus of the 2017 UNISDR International Day of Disaster Reduction: "Reducing the number of people affected by disasters".

This Conference is an initiative of the Gender and Disaster Pod (Women's Health Goulburn North East, Women's Health in the North, and Monash University Disaster Resilience Initiative), Victorian Council of Social Services, and Resilient Melbourne. It is funded by the Australian Government, in

partnership with the Victorian Government, under the National Partnership Agreement for National Disaster Resilience.

Further information on the draft program and registration is available at <http://www.genderanddisaster.com.au/diversity-in-disaster/>

Influenza (Awaiting us ?)

Update: Increase in Human Infections with Novel Asian Lineage Avian Influenza A(H7N9) Viruses During the Fifth Epidemic — China, October 1, 2016–August 7, 2017

Weekly / September 8, 2017 / 66(35);928–932

<https://www.cdc.gov/mmwr/volumes/66/wr/mm6635a2.htm>

Summary

What is already known about this topic?

The current Asian lineage avian influenza A(H7N9) virus (Asian H7N9) epidemic in China is the fifth and largest epidemic on record.

What is added by this report?

Human infections with Asian H7N9 virus were reported from more provinces, regions, and municipalities in China during the fifth epidemic than in the previous four epidemics combined. Because of antigenic variation between the Yangtze River Delta lineage viruses, the newly emerged high pathogenic Asian H7N9 viruses, and 2013 candidate vaccine viruses, new candidate vaccine viruses have been produced.

Among all influenza viruses assessed using CDC's Influenza Risk Assessment Tool (IRAT), the Asian lineage avian influenza A(H7N9) virus (Asian H7N9), first reported in China in March 2013,* is ranked as the influenza virus with the highest potential pandemic risk (1).

The risk to the general public is very low and most human infections were, and continue to be, associated with poultry exposure, especially at live bird markets in mainland China. Throughout the first four epidemics of Asian H7N9 infections, only low pathogenic avian influenza (LPAI) viruses were detected among human, poultry, and environmental specimens and samples. During the fifth epidemic, mutations were detected among some Asian H7N9 viruses, identifying the emergence of high pathogenic avian influenza (HPAI) viruses as well as viruses with reduced susceptibility to influenza antiviral medications recommended for treatment.

Epidemiology

During March 31, 2013–August 7, 2017, a total of 1,557 human infections with Asian H7N9 viruses were reported; at least 605 (39%) of these infections resulted in death.

During the fifth epidemic, LPAI Asian H7N9 viruses acquired an HPAI mutation that causes increased morbidity and mortality in poultry.

Discussion

The fifth annual epidemic of Asian H7N9 in China is marked by extensive geographic spread in poultry and in humans. The number of human infections reported in the fifth epidemic is almost as many as were reported during the previous four epidemics combined. The consistent epidemiology, combined with a similar number of clusters, suggests that the increased number of human infections appears to be associated with wider geographic spread and higher prevalence of Asian H7N9 viruses among poultry rather than any increased incidence of poultry-to-human or

human-to-human spread. Furthermore, surveillance and testing have remained relatively unchanged from the fourth to fifth epidemic.

Although human infections with Asian H7N9 viruses from poultry are rare and no efficient or sustained human-to-human transmission has been detected, when human infections do occur, they are associated with severe illness and high mortality.

Lessons from Actual Events

What Hurricane Harvey is teaching about managing disasters.

Rather than “Think twice before closing smaller medical facilities” the message should be “Do not forget primary care in emergencies”

1. You cannot simply leave general practices open – many of them will be damaged or have lost staff – but you *can* reconcile them
2. Most health problems in the wake of a disaster are ordinary primary care problems (i.e. chronic disease and mother and child), or water and sanitary health– *not* trauma cf See especially slide 11 Olivier Hagan et al - attached

You should schedule time off for *all* staff, but that may require reconciliation of services at least in short-to-medium term

c) **Early evacuation** rather than dump trucks for complex cases is essential.

d) An emergency is not the time to “Establish clear and trusted sources of information” – these should **already be established**. e.g. The Mayor or the Medical Officer of Health

Executive Summary

The damage inflicted by Hurricane Harvey has posed enormous health challenges in Houston and neighboring areas hit hard by the storm. While the response is ongoing, there are early lessons that could help governments and health systems in dealing with the aftermath of Hurricane Irma and other major catastrophes down the road: Deploy existing resources creatively to address unforeseen challenges. Think twice before closing smaller medical facilities. Schedule medical staff and give them time off to avoid burnout. Establish clear and trusted sources of information. And don't underestimate the human spirit.

The damage inflicted by Hurricane Harvey has posed enormous health challenges in Houston and neighboring areas hit hard by the storm. As regional medical director of emergency medicine for the Houston Methodist Hospital System, one of us (Neil) has been on the front lines of the medical response. The other (Ranu) has been involved in responses to such public health disasters as the Ebola crisis in Africa, Hurricane Katrina in Louisiana, and the 2010 earthquake in Haiti. The response to Harvey is ongoing, but there are early lessons that could help governments and health systems in dealing with the aftermath of Hurricane Irma and other major catastrophes down the road.

Deploy existing resources creatively to address unforeseen challenges. All health systems have contingency plans and run drills for emergencies like a hurricane. However, the challenges wrought by a disaster can confound even the best-laid plans, and responding effectively requires using available resources in ways not previously considered.

Unlike storms that typically hit hard and then move on, Hurricane Harvey cycled around the region for several days, rendering many areas inaccessible for a prolonged period and nullifying preset plans to transfer patients from damaged areas to less-affected ones. Traditional ambulances were unable to reach patients in flooded areas, and the U.S. Coast Guard did not have the personnel to evacuate patients with complex medical conditions, who were on ventilators or were undergoing other life-support measures. When getting these patients out was not possible, mobile teams were sent to these areas to bolster their capacity to care for them in place. Baytown, Texas, solved this challenge by repurposing large dump trucks used for industrial projects to go out with paramedics and retrieve patients.

Think twice before closing smaller medical facilities. Communities rely on a wide array of medical facilities to stay healthy, including smaller hospitals, physician offices, dialysis centers, nursing homes, and pharmacies. Severe flooding and damaged infrastructure made roads impassable and, along with power outages and water supply contamination, caused many of these facilities to shut down. (About 40% of dialysis centers in the area closed.) When any one of these medical contact points closed, patients did not know where to go for their routine, ongoing health needs. Consequently, many people developed complications from uncontrolled diabetes, heart disease, and other chronic conditions.

With nowhere to get routine services, patients poured into hospital emergency rooms that were already overwhelmed by people suffering from near-drownings, waterborne infections, and injuries from debris floating in fast-moving floodwaters. While emergency rooms are equipped to handle most crisis scenarios, such a large influx of patients for several days can incapacitate even the best-run ER. To avoid inundating emergency rooms, medical facilities that have strategic importance in delivering routine care should be provided with the extra resources — whether staffing, clean water, power supply, or transportation — so they can keep their doors open.

Schedule medical staff and give them time off to avoid burnout. When facing a crisis, there is a tendency to go to an all-hands-on-deck mode from the outset. However, creating a schedule to ration capacity and energy is indispensable for sustaining response efforts over the days and weeks required. Making sure teams have adequate time to sleep, eat, and rest while caring for patients is often overlooked, but hospitals that did not enforce downtime for frontline staff saw a downturn in morale, energy, and cognitive awareness even within the first 24 hours.

With Harvey in particular, the prolonged rains caused many patients to wait to seek care until days later when floodwaters began to recede, causing a delayed influx of people in need. Patients will require help for weeks, if not months, after such an event, and it is paramount to keep this long-term time horizon in view and avoid early burnout.

Establish clear and trusted sources of information. Amid any crisis comes hysteria that can lead to rapid dissemination of unconfirmed hearsay. During Harvey, rumors abounded about impending road closures, water shutoffs, and worsening conditions that influenced people's decisions on when and where to seek care. When a disaster is imminent, public authorities should establish sources of accurate information that the public can be made aware of in advance. When rumors begin to spread, especially on social media, they need to be refuted so that people can make urgent decisions for themselves and their families with clarity.

Don't underestimate the human spirit. At a moment of heightened polarization nationally, one of the most remarkable things that occurred in the area struck by Hurricane Harvey was that people facing hardship and tragedy worked together to care for one another. The number of ordinary people who stepped up with extraordinary acts of kindness are too numerous to count but have

been the linchpin of the response so far.

A number of informal initiatives spontaneously came together to stem an impending health crisis. For example, physicians and nurses from around Houston trekked from their homes to expeditiously set up basic medical services at the George R. Brown Convention Center and NRG Center, the two largest shelters, which housed over 10,000 people. Emails were sent, online sign-up sheets created, and supplies donated such that, within hours of opening, both shelters were staffed and equipped to care for those displaced from their homes. Local pharmacies and mental health organizations also volunteered their efforts.

We need to sustain this compassion and solidarity as we transition from immediate response to long-term recovery in the months ahead. As these efforts continue in Texas, our thoughts are with the people of Florida and our colleagues caring for those affected by Hurricane Irma.

Neil A. Gandhi, MD, is the regional medical director of emergency medicine for the Houston Methodist Hospital System in Texas. He also serves as the chairman of the Department of Emergency Medicine at Houston Methodist San Jacinto Hospital in Baytown, Texas.

World Risk Report (Contributed by Diana Wong)

Bonn, November 7, 2017 – The vulnerability of countries worldwide to extreme natural events has declined. On average, people are better prepared for natural hazards such as cyclones or earthquakes than they were five years ago. This is the outcome of a five-year analysis of the WorldRiskIndex. Today, Bündnis Entwicklung Hilft presents its new WorldRiskReport at the COP 23 Climate Conference in Bonn.

The WorldRiskIndex states the risk of an extreme natural event leading to a disaster in 171 countries. The five-year-analysis shows that the disaster risk global hotspots are in Central America, West and Central Africa, Southeast Asia and Oceania. In a comparison of world regions, the disaster risk is at its highest in Oceania and at its lowest in Europe. “On a global scale, vulnerability to extreme natural hazards has declined. Many countries have learnt from previous disasters and are improving disaster preparedness,” says Peter Mucke, WorldRiskReport Project Director and Managing Director of Bündnis Entwicklung Hilft.

However, warning against false optimism, Mucke adds: “There has been a marked increase in extreme weather events such as storms and heavy rain. This has once again been demonstrated by both the hurricanes in the Caribbean and the severe storms in Germany. And extremes in climate such as prolonged drought are expected to occur more frequently in the future.” Less vulnerability could be offset by higher exposure to natural hazards. Binding commitments to mitigate the consequences of climate change as well as progress in development cooperation and disaster preparedness are therefore indispensable.

The report identifies that there are many options to lessen risk, particularly in the tropical, developing coastal nations that are the most at risk, including ecosystem-based options. “Mangroves can reduce flood risks to people and property by 25% every year” says Dr. Michael

Beck, Lead Marine Scientist for The Nature Conservancy.

Since 2011, the WorldRiskReport has been published annually by Bündnis Entwicklung Hilft, and the WorldRiskIndex it contains was developed together with the Institute for Environment and Human Security of the United Nations University (UNU-EHS).

The full report and other material will be available for downloading as of 07.11.2017, 09.00 a.m., at www.WorldRiskReport.org.

From Erin Smith, her E Book, now published.

"**After the towers fell: 9/11**, First responders and their families share their stories"

This has been published on Apple iBooks.

This is the link:

<https://itunes.apple.com/us/book/id1276139877>

The book is available for free download now!

You can also download a PDF version of the book from this link:

<http://www.ecu.edu.au/schools/medical-and-health-sciences/about/news-and-events/school-of-medical-and-health-sciences/2017/10/after-the-towers-fell-16-years-following-911-the-first-responders-share-their-stories-about-ongoing-impact>

Congratulations and Thanks Erin.

ASK AUNTIE

This section is an advice column where readers can submit their questions and 'Auntie' will draw on many years of experience to provide reasoned advice and counselling.

Dear Auntie,

I have been studying so many aspects of emergency management that I am now confused with much of the material presented. In particular, all the 'R' words, like reduction, readiness, response and recovery, and then others throw in words like mitigation and preparedness.

I am sure from your vast experience you can help me sort out what of these areas require the most effort and where I could concentrate my interest.

Sincerely

Stefanie

My Dear Stefanie,

What a lovely name you have, was it deliberate or your father not being able to spell when he registered your birth. Men are well known for creating new names that way.

Anyway, to your question, all those areas are important and some like mitigation and

reduction, preparedness and readiness have the same meaning. In a household situation like I used to rule, mitigation meant I would hide car keys, shoes and other items so my late husband had to stay home and tidy the house so I wouldn't strain myself doing those boring mundane tasks, thus preventing injury. It could be said that readiness involved knowing what to hide and where to hide it so this could happen. My favourite response was when he had to care for me after I had suffered an injury due to his failure to follow my rules. A cup of tea and a lie down worked well, leading to my recovery. (It is only partly true that my 'injuries' were sometimes faked).

In seriousness though, all mitigation/reduction and preparedness/readiness must be ongoing to make lives and property safer and to provide appropriate actions when events happen. Both these areas are often neglected through disinterest, thinking you know it all and the big bogey \$\$\$ as such work may involve large amounts of money.

However, I am learning from my lovely nephew, Graeme, that recovery can be a long and slow process, costly and frustrating for many affected. He has informed me that the main transport corridor for goods and people linking the top of New Zealand's South Island to his city of Christchurch is due to open mid-December after being closed for over 12 months due to earthquake damage. This closure has affected travel and goods delivery between the North Island and South, adding time and financial costs to transport providers and individuals. It has also affected families wanting to visit each other when they live on opposite sides of the road closures.

This disruption has added to the stress of those living in the area who are still trying to rebuild their homes and local economy, much of the latter from tourism, and the tourists can't get there. Similarly, in Christchurch many are still trying to settle with insurance claims contributing to their stress levels, this almost 7 years post-earthquake.

I should emphasize that the physical aspect of recovery as mentioned is only a small part of the recovery process. The well-being of people is the most important and resources need to be provided to care for those affected to ensure that they are in a position to be capable of handling the physical recovery. This can be through health and psychosocial support and assistance in dealing with the bureaucracy requirements.

My wonderful GP Penelope recommends orange juice, bacon and eggs and strong coffee to aid recovery; evidently, she has tested that many times. This advice was given after I consulted her after celebrating one of my many birthdays.

So, my dear, recovery after an event is more than just rolling over for the mandatory cigarette, although that is probably banned now. It was with my late husband, the hypochondriac who was run over by a bus, and whose name eludes me.

In Kindness.

Auntie

(I am grateful to Auntie for making a comeback for my last effort with the newsletter. Graeme)

REQUEST FOR MATERIAL

Material is required for any of the sections listed, or under a new category, if that is appropriate. Personal experiences, case and research reports are especially welcome and we ask that these are limited to no more than 1,000 words. The subject matter can be aspects of a disaster or response that is unusual because of its type, location or effects. Material is welcome from WADEM members and even non-members internationally.

Any suggestions regarding material for content, or to improve this Newsletter, are welcome.

Please forward contributions to gmccoll@wadem.org

DISCLAIMER

The comments, opinions and material in this newsletter are those of the respective authors and not necessarily those of WADEM or the WADEM Oceania Chapter.