

DOWN AND BACK AGAIN – REFLECTIONS ON THE BEACONSFIELD MINING DISASTER

UNPUBLISHED PAPER PRESENTED TO THE 2007 AUSTRALIAN FAMILY THERAPY CONFERENCE – HOBART .

WORK IN PROGRESS.

Synopsis

This paper documents

1. An overview of part of our involvement with the disaster.
2. mental health planning and practice
3. family interventions (and systemic thinking)
4. Learning outcomes

Our intention is to provide information in relation to counselling and support efforts during and after the rescue of the trapped miners at the Beaconsfield mine collapse, April 2006. This paper reflects a broad brush, and invites discussion and comment at the Family Therapy Conference.

Overview

The answer to the question “do you want us there... now?” began a month of a challenge that proved rare and consuming for David and Deb on the morning of the Beaconsfield mining disaster 27 April 2006. The collapse that – at that time – signified that the men may still all be alive had occurred on the night before at 9 pm. Due to some technical difficulties we were not to know until soon after 8 am the next day. The simple message we responded to was –“There are three men trapped below.”

Journeying the forty minutes or so to the mine-site from differing geographic directions, we really had no idea what to expect. We began thinking about kinds of structures that may be needed to assist the miners to keep calm, focused and psychologically healthy for the ensuing period. All of the psychological first aid and critical incident training, and five years of experience working with this mine’s personnel (Employee Assistance Program counselling) ruminated through our minds, during the 40 minutes of travel. Our critical incident training had been influenced by two models we had been trained to use in prior years: the Mitchell and Louvre model. Deb had also recently attended training in community based recovery management with Emergency Management Australia.

On arrival the energy was palpable. It seemed like a bees nest that had been accidentally disturbed: a heightened buzzy activity tinged with wariness. The mine management group was bunkered down, poring over technical data and weighing likely strategies. In contrast, equipment and people were moving and shaking everywhere.

We were informed by one of the senior managers that our liaison person would be the mine rescue coordinator/Occupational Health and Safety manager. We knew him well. We cannot begin to express how grateful we were for the professional orientation to the mine site we had received six months earlier, as part of Occupational Health and Safety procedures. We had been down to the near end of the mine, one km below, in October. We knew that there was only the one main entry and exit: one shaft; all equipment and personnel had to share that one space. The first journey is a vertical drop of a third of a kilometer, taking quite some time. It is like a general confinement in a lift. Everyone keeps quiet and looks in the direction of the loft opening. Leaving the shaft-lift and mounting the rear of the transport 4WD, we had traveled the ever downward corkscrew journey past the various off-shoot tunnels until we reached the lower levels. This prior

experience helped us to visualize the rock fall, feel reasonably comfortable in a rather foreign setting and connect with the miners during the days to come.

Much could be written about the unfolding events from the counselor's point of view. This disaster event was unusual in that contradictory claims of causation were being explored by the media, worker's union and other professional sources. The politics of blame flowed through the unfolding events like an undercurrent of implied guilt and sometimes fear, putting pressure on management and workers during a very vulnerable period.

Several topics for discussion in this paper suggest themselves: working with industry -centered natural disasters, as opposed to community disasters, the role of an Employee Assistance Program (EAP) in the management of disasters, the politics of coordinating and working with other rescue orientated groups (ambulance and police services, paramedic groups both local and from interstate, other EAP groups, an independent group of psychologists assigned to working with the trapped miners, the rescue operation center and the community recovery group), and dealing with extraneous and difficult people who may not wish to respect professional and authorized boundaries.

Such were the circumstances that took us through an emotional labyrinth that in large part dictated our involvement: the shock and disequilibrium of the initial rock fall, the dreadful, largely unspoken thoughts that the three men may all be dead, the peculiarity of what seemed a media circus crushing the road to the mine site, the intensity of world scrutiny, the sadness of the recovery of a body, the exquisite euphoria of the discovery of the other two being alive, the sheer mental grind of careful recovery work, the dogged tiredness of many of the miners, the spikes of semi-euphoric elation and let downs when it looked like the rescuers may nearly be there, the tension of anticipation in the last few hours as the final rescue effort was controlled for last minute variables of rock containment and stage managed for transition from mine to surface, the explosive elation and relief with the movement of the now rescued miners to the surface and then on to hospital, re-entry into the palpable sadness of the burial of a deceased comrade, the largely unwritten post-rescue quietness of an exhausted and disheveled mine site (read bomb crater) and post-event dysphoria of an exhausted mine personnel, and not least the troubling safety investigations that commenced during the rescue and escalated almost immediately after the events.

Research has demonstrated that **communication should be accurate, factual and regular**. There is good basis for this. It reduces emotional and psychological over reactions. It reduces community emotional contagion. For many reasons practice has consistently found this difficult to achieve.

In situations of corporate incidents, where legal, safety and operational issues are concerned, organizations are naturally very careful about information sharing and worry about unauthorized leaks. Parts of this rescue included techniques that were untried in these work combinations. The situation underground changed hourly and the mine site was full of outside workers, including us! Our liaison person was also involved in the rescue itself. It was difficult to have consistent, up to date, accurate information with which to work against emergent fears and rumours, and to provide psychological services.

Miners work 12 hour shifts. We did this too, within reason, but including some night shift and sometimes double shifts. On occasion we slept on site. This enabled us to keep up with some of the communication rhythms and interpret prevailing moods.

Most research and training in critical incident responses focuses on community responses. When contracted by a corporation there is reliance on their communication processes, management structures, media management processes, legal requirements and working culture. Management knows that having a counseling component to a critical incident is necessary but may have limited and confused understandings of what we do, our working requirements and processes.

Models

We believe that matching theory to practice matters. Social Workers come into the field with some training in basic solution focused interventions and general counseling skills imbedded in strengths perspectives. What we then learn or have learnt as part of prior training/experience is often subject to what area of work we end up in or are moving towards.

In our case, what emerged first were the more obvious structured mental health perspectives and paradigms. The principle theoretical influences in regard to structured positive mental health outcomes included critical incident interventions. We are aware that the concepts of “critical incident debriefings” are under serious challenge. There is emerging evidence that CISD type interventions may be at best non-productive and at worst destructive. Mark Whattaker (The Australian, June 28 2008) sums up some of the current scientific thinking and comments that “CIS debriefings” seem to have changed into “CIS management” and has come to include distinctions between defusing and debriefings. Despite these critical perspectives we still, as a matter of fact, include the theoretical types that influenced our initial thinking.

1. The Lovre Model of Critical Incident Management which is a systems based approach to crisis management and relies heavily on intensive team training within organizations prior to an event. The parts of this model that were relevant to us at this point included the biochemistry, physiology, and psychology of trauma and suggested techniques for intervention including individual and small group work. Details of the model can be found by contacting the crisis management institute www.cmionline.org.

2. The Mitchell model of critical incident stress debriefing which is a widely used process to “reduce the impact of a critical event” and “accelerate the normal recovery of people who are suffering through normal but painful reactions to abnormal events” It relies heavily on two processes:

1. Debriefing
2. Defusing

in group meetings with strict guidelines for working with facts of the incident, thought processes, reactions, symptoms of stress, education about stress reactions and re entry into usual life patterns.

Lovre and Mitchell - limitations

Even with some of the uncertainties in regard to CISD interventions, there were immediate difficulties with implementing either of these theoretical models. Both were clear in stating that for best outcomes the model was to be used exactly as outlined. This would not have been possible. Facts and circumstances kept changing by the hour. Logistically, there were no rooms large enough on site to provide for group meetings. The presence of the media made off- site meetings nearly impossible (except for one rare and valuable occasion. See below.) The rescue always remained more important than debriefings, so phones could not be turned off for purposes of quiet and interrupted interventions. There were also work - cultural and other obstacles to psychological and emotional work.

For all of these reasons, we developed a more informal approach.

Psychological First aid, stress symptomologies and PTSD

Searching for further paradigms that would match this circumstance and help us reflect while on the go, we secured a useful resource, the Disaster Mental Health Response handbook. This was introduced by the NSW paramedic rescue team and enabled us to interact with other services with a more common language of intervention. It also became the theoretical underpinning of the team working with Todd and Brant.

(The Disaster Mental Health Response Handbook from the NSW Health's Centre for Mental Health is recommended to conference participants as valuable reading. It is a copyrighted document. (Copies may be accessed through inspsy@magna.com.au or through website www.nswiop.nsw.edu.au) This theoretical backdrop assisted us to make sense of individual mental health and also social phenomena exhibited within the disaster scene. We became much clearer about some of the fundamentals and differentiations in:

1. natural disasters and human-made disasters.
2. phases of community reactions and responses to disaster during and after events.
3. essential differences between acute stress symptoms, bereavement reactions, and depression, and some of the clusters of risk factors that may later leave them more vulnerable to Post Traumatic Stress Disorder. (We recognize that Australian definitions and interventions for acute stress disorders and Post Traumatic Stress Disorder have been posted in May 07 by the Australian Center for Post-traumatic Mental Health and the National Health and Medical Research Council. These can be accessed through www.acpmh.unimelb.edu.au)
4. the importance of psychological first aid – comforting, consoling, attending to immediate physical care, encouraging realistic goal orientation, facilitating reconnection with family, providing initial assessments and triage, linking people with systems of support and simply sharing the experience.

Debriefings

We also more formally reviewed the value of group debriefings and decided that there are ambivalent research findings.

Briefings were, however, a part of the miners' usual work patterns and were therefore utilized sparingly – an on-site debriefing with the small group that brought the body of the deceased miner to the surface, and an off-site (local pub) large group meeting with the shifts most associated with all of the events. Although we canvassed with the Occupational Health and Safety manager the idea of brief meetings with workers as they changed shifts, this never eventuated.

Systems theory

Our objective was to improve mental health outcomes for miners and families.

As ensuing events dictated that there was no clear end in sight to the events, a need to attempt some analysis of intricate intertwining relationships of the miners, their families and the community became apparent. Our conceptual approach was systemic. On reflection – well after the events - it seems to us that, as social work counsellors, systemic thinking was always likely to be one of our preferred approaches within a complex situation like this one. Systemic approaches that join family and mental health have an honored place in social work theory. Wood (2001) traces the influence - indeed perhaps the earliest documented nascent theory - of family systems thinking in social work and its impact on social work training. Social work academic activity in social policy, political science, and structured analysis of conditions that contribute to family system troubles leads the social worker to thinking about relationships between different systems in the family's environment.

To quite a large degree the various systems (including ambulance division, paramedics, EAP program, and more) involved directly with the rescue made it difficult to coordinate mental health interventions.

Central to systems inquiry, is the concept of *system*. In the most general sense, system means a configuration of parts connected and joined together by a web of relationships. (Bethany, 1997) Although therapeutic aspects of systemic training came into prominence when working with individual families, we had to fathom many complex and highly emotional interactions between different groups on-site. As more resources and people poured in from outside of this system,

making a relatively closed system now an open system with the one major objective of rescue, the more complex became the issue of attending to positive mental health outcomes. In this highly charged environment we needed to anticipate likely hotspots of distress. We were essentially asking the following questions:

1. What activity was being designed or organized?
2. Who was doing it?
3. What is this person's authority?
4. What is the stated purpose of this activity? And, most importantly,
5. What might be the likely impact of these decisions on mental health for our client base?

These were important because of (what we perceived to be) competition between different groups and individuals to make a positive difference. In our field we had one group of independent psychologists, one lead Employee Assistance Program's worker, a backup Employee Assistance Program worker, a consultant from an interstate Employee Assistance Program plus local and interstate ambulance emergency recovery groups – all of whom were attempting to contribute from their professional bases to the well-being of all personnel and families of miners. By the beginning of the second week it seemed to us that nearly everybody wanted to have a say in every decision. These interactions may have reflected a weariness and intense desire to have the rescue completed.

Then there were the comings and goings of the families of the trapped miners. In the early stages they were directed to us. We simply touched base with as many immediate family members as we could. At one level we were listening for those things that concerned mental health. On the second day we began to accompany a mine employee as they visited each family home at regular intervals night and day to provide pre-worded updates. Visiting family members off-site, particularly in their homes, we became acutely aware of all of those family dynamics that had now come under tremendous strain. To make sense of these it seemed to us from the way we briefed with each other that we tended to discuss issues in systems terminology.

The families and extended families of the deceased miner and trapped miners came under intense pressure. The personal tensions associated with grieving and waiting were exacerbated by the active presence of media, politicians, visiting community and family members, thousands of well wishers sending cards, and other variables. Because of the need for confidentiality we are unable to speak publicly about the pain they were suffering. Like many other family systems under distress we worked with presenting issues familiar to structural family therapists: power differentials and hierarchies within and across interrelated family systems, boundaries of acceptable behaviours, some re-alignments of filial attachments, triangulations and rivalries of various family members. Family assessments of the meanings of events, lacking time for discussion and assimilation, began to be problematic. The relatively stable sets of equilibriums, whether positive or negative, were no longer sustainable for some families. Home visits enabled us to provide space for education in relation to trauma, especially in normalizing some of the more erratic family behaviour.

Practise:

And so... our role. We had to create it ourselves. Our clients: mine workers (some of whom were private contractors) rescuers brought to the site, and their families. Our goal: To reduce the impact of a critical event and to accelerate the normal recovery of people experiencing an abnormal event.

We began our work responding heuristically – by the seat of our pants. We were immediately drawing upon our experience of:

1. working with clients presenting with signs of general and traumatic stress and
2. with various interventions consistent with critical incident interventions.

While we expected to engage in mental health work - what some current literature refers to as "psychological first aid" - we came to realize that some of the competing interests meant that we were also to engage in family therapy work. Some of the trapped miner's families were not only members of the local community, itself in actual and vicarious shock, but were also past or current employees of the mine.

First up, we found a room and seconded it! There were some politics of ownership so we managed to move to the first aid room, in easy view of miners as they came and went, particularly on shift changes. And there we protected our space, making it difficult even for the ambulance personnel to set up their own base. The need for psychological "first aid" far outweighed the use of the room for physical first aid. This easy access to us, although exposed, proved very important.

Our work began with the interventions and interactions with miners. We walked and checked and waited. Many miners were regarding this counseling stuff as a bit 'namby pamby'. We were aware of the importance of not alienating the workforce with demands of mental health check-ins. Within two days there was a relative acceptance by many that checking was a good idea.

Within the confines of the administration block and sometimes beyond, the three things we checked and checked again – How are you eating? How are you sleeping? What have you done today (with someone you care about) that is not related in any way to the mine? We were of the opinion that immediate attention to two of the most important physiological requirements for normal functioning, sleep and food, were likely to be the two things that the miners could talk to us about and would be a clear indicator if psychological health was in crisis. The "doing something different" component was to remove miners from a sense of entrapment in a trauma zone and engage in constant cognitive reconstruction of their normal lives. We mingled with workers who were waiting to go down the shaft and those who were coming up. Our rationale was to ensure normalization of their lives with anchoring points of behaviour and relationship other than the mine and its personnel, ensuring clarity of thought and therefore judgment for shift work, and noticing changes that might reflect some sense of cognitive or affective struggle.

Communication

Landline telephone lines were for normal mine use and jammed a lot of the time under the increased pressure. Mobile coverage in Beaconsfield is limited and hampered by the tin lining of the office block. The car-park was not always free from media eaves dropping.

The Community Recovery Centre was in the centre of town and not part of mine management priority. Sometimes we were the only communication line for them to provide accurate updates to worried community members and sometimes we couldn't tell them what we knew.

Regularly driving to multiple households containing large groups of distressed people, where current rescue team members have already been, to provide a short pre-worded statement proved very difficult but a necessary approach in ensuring some emotional safeguards for family members.

Visiting immediate family members to collect letters for Todd and Brant was a necessary part of assisting Todd and Brant's emotional equilibrium but proved very difficult for their families. Providing regular family messages for the trapped men, that weren't too emotive, demonstrated a semblance of normal living above ground and did not reveal the extent of fear held for their safety, added to the strain. Families also expected those notes to be immediately passed to the trapped men and did not always comprehend why the team working with Todd and Brant withheld or delayed some of those letters. The emotional/ psychological needs of the above ground family did not always coincide with the two men underground.

Self care

When it became clear that our services were to be required for an extended period, and that our long shifts had potential to draw us into the trauma zone we discussed and attended to the following: having external supervision every 2-3 days, going home to family at regular intervals for a reality check, and sleeping in one's own bed. It was also good modeling for rescue workers.

We acknowledge that there was to some degree a burnout component for us and some vicarious traumatisation for our families. We both experienced a great weariness for up to six months following cessation of activity at the mine-site. Dreams were intense and waking up in the morning was sometimes accompanied with some disorientation whether we were at home or the mine! (This was very similar to the experience of the majority of miners.)

Reviewing our decisions in light of some of the literature of self-care we believe that we made decisions that were consistent with good health, but that our role made it sometimes difficult to separate home from work. Todd (2007) for example, has reviewed the literature and sums up the key components as: establishing balance/ separating home from work, finding human support for self-care, having supervision and attending to our personal "meaning" in life.

Once the morning disorientations evaporated, it was the weariness that remained. Following Todd's summary of potential dangers for the counsellor – heightened emotions, increased sensitivity to disasters, intrusive imagery of client's stories, somatic complaints, compulsive/addictive behaviours, impairment of daily functioning, detachment or distancing from clients – we were not strongly affected. Just the tiredness.

Social Work, not just counselling

There were times when our Social Work approach was required:

The media air craft hovered consistently over the tin office buildings where all the planning and telephones could not be heard. A no fly zone was needed and difficult to get. The Security guards had some contacts in Hobart but not in CASA (Civil Aviation Authority). The criteria for obtaining one are very specific. There had never been one approved in Tasmania. It took the dedication of Social Work to track down all the links for the Security guards to proceed with the final call to ensure we got our no fly zone.

The ambulance officers reported to us that rescuers were not eating well or regularly and were not going home for the required breaks. A word with the office staff resulted in a fax from a dietitian, regular deliveries of fresh food which office staff made into rolls, soup, fruit stalls and cooked meals 24 hours a day between phone calls.

Sleep became a problem and campervans arrived in the car park for those who refused to go home. Some offices became dormitories with sleeping bags provided.

In conjunction with Todd and Brant's medical and psychological team we worked on a recovery plan to provide psychological responses for the rescue team and families immediately after recovery. We also developed a planned response in the event that a more serious accident occurred during the rescue. This remained a constant working plan throughout as the situation at the mine and in the town was constantly changing.

Confidentiality was difficult in this environment and could not always be expected. A lot of the work took place in the car park, the courtyard, multi use offices, in the mine yard outside the shaft, in family homes where extended family and friends were gathered. Management sometimes required immediate feedback about rescue crew before they went back underground.

Media interests found intrusive ways of trying to obtain information including boom mikes in the bush above the car-park and following us to family homes. So protecting confidentiality took on new meanings and required new skills.

Working with stressed and frightened families in their homes and workers at the site, knowing that workers were inside a mine that had already collapsed once and the media reporting aftershocks required great consideration and importance to be placed on individual and company confidentiality. We were consistently aware that we often had current information that could not benefit the community response if shared at that time.

In the rescue not after

There is an assumption that most psychological first aid happens after the event not during and training usually focuses on this however this incident continued to unfold over many days. It became clear very quickly that the rescue effort had a changing emotional dynamic with each shift in the mood of Todd and Brant and with each new phase of the rescue attempt. If either of us spent too much time off site it was difficult to catch-up with the emotional tide. Change-over briefings could not quite catch the constantly shifting dynamics. It was also apparent that by spending so much time on site in the middle of the office block, there was a risk that we would become part of that emotional dynamic and lose the objectivity required to do our work. Shorter periods off site, regular supervision and more attention to this issue in shift briefings became invaluable.

Our own families became part of the recovery dynamic. They were at home trying to live normally without us, seeing the sensational media reports and worried about our psychological and physical safety: were we down the mine? They too began to deal with a confusing array of emotional responses which needed attention. We tried to bring in locums after the first few days but relationships were already established with mine staff and workers did not take well to new people at this time.

Reflections:

Operating space

First rule is – find your space. Make sure it is strategic. Make it clear that it is not shared by other personnel from other services without consent!

Communication

From this and other critical incidents we have been involved in, we are aware that the usual communication processes we rely on become overloaded or malfunctioning. The importance of accurate, up to the minute, confidential information is crucial. The best way, we discovered was to have a running log-book from which case notes could be drawn later. Regular team time on site is also crucial. In our debriefings after the event we acknowledged the need for one team member to work solely as a communication person between management and our team. We also acknowledged the need to have a person within the mine management team who was responsible for liaising with ancillary support staff. The Occupational Health and Safety Officer is the usual person but they can be torn between their role within the incident and their role to manage information sharing and support personnel. Insisting on a dedicated information officer could prove crucial to providing adequate support services.

Corporation Incidents vs Community Incidents

Most critical incident professional training is focused on community recovery. Some attention needs to be paid to responding to workplace accidents which are more likely occurrences and require different skill bases.

Psychological first aid

It is the most important consideration. Workplace incidents inevitably move one into medico-legal situations where there is most likely a cut-off point where the initial counselors are replaced by other professionals who carry the responsibility of assessment and recommendation for injury and worker's compensation concerns. The initial counsellors may not get invited to do the long term work; therefore providing strategies that could be used later is an important consideration.

File notes

Keeping good notes is essential but difficult in the hectic, non confidential environment of a continuing rescue and knowing there will be future legal and insurance issues. In our case we kept a running log of activities, noted at the time of all interventions or close to the times. We kept separate notes for any one- to- one work we engaged in with our clients (miners and family members). Counsellors were also operating in shifts and needed access to at least the running log but sometimes each others notes. We found the logbook approach worked best.

Staffing

A working list of professional locums is essential. Start off with more staff at the incident than you need because it is difficult to bring in new people once the events are unfolding. In our case we found that there were certain ways that miners could be approached. This reflected some distrust of "outsiders", and so it was important to keep the number of new people entering the site at later dates to a minimum.

A mental health plan

A mental health plan needs to be flexible. No one expected an incident requiring a month's 24 hour attendance, two weeks in the critical zone and two weeks on-site (for diminishing portions of time). The mental health plan requires constant updating. It is also the theoretical base for making decisions in times of crisis and a strong base for standing professional ground when asked by management, who do not understand our ethical base, to perform tasks which may not be appropriate.

Work culture

It is important that the culture within the work place is understood and respected if interventions are to have a chance of success.

Sources:

Bela, Bethany The First International Electronic Seminar on Wholeness, A Taste of Systems The Primer Project: The International Institute for Systemic Enquiry and Integration. (December, 1996 to December, 1997.)

Deacon, Sharon A. Contemporary Family Therapy. Springer Netherlands (Volume 18, Number 4 / December, 1996 P.549-565)

Disaster Mental Health Response Handbook, NSW Health, Sydney. NSW, and NSW Institute of Psychiatry, NSW. State Health Publication No: (CMH) 00145. (2000)

Lovre, Cherie. Models of Crisis Management www.cmionline.org.(2007)

Mitchell, J.T. and Everly, *Critical Incident Stress Debriefing: An Operations Manual.* Ellicott City, M.D: Chevron. (1996)

Southwick, Richard. Ph.D. *Critical Incident Stress Debriefing – Providing Support to Survivors of Traumatic Stress.* (1998)

Todd, B. *Assisting the Traumatized: Vicarious traumatization and the preservation of meaning*, Psychotherapy In Australia, Vol 13, No.3, (May, 2007)

Whittaker, M, *The Healing Game*, the Australian, June 28,2008

Walling, Anne. M.D. *Debriefing after Psychological Trauma may not help Recovery*, The American Family Physician, (January, 2003)

Wood, Andrew, *The origins of family systems work: Social workers' contributions to the development of family theory and practice*, Australian Social Work, Sept 2001, Vol, 54, No.3