TRANSCRIPT

ROAD SAFETY COMMITTEE

Inquiry into motorcycle safety

Melbourne — 7 March 2012

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Witnesses

Mr T. Walker, general manager, regional services, and

Dr K. Smith, manager, research and evaluation, Ambulance Victoria.

The CHAIR — Welcome to the final session of the public hearings before the Victorian parliamentary Road Safety Committee's inquiry into motorcycle safety. The committee has received some 74 written submissions since releasing the terms of reference and inviting submissions. In general terms the purpose of these hearings is to obtain evidence from selected witnesses covering the terms of reference. Hansard will be recording today's proceedings and produce a proof version of the transcript which will be provided to witnesses so that any typographical errors can be corrected. I ask observers here today to respect the rights of witnesses and the responsibilities of the committee by keeping noise and movement to a minimum and also to ensure that mobile phones are switched off or on mute.

I thank the witnesses here this afternoon for attending these hearings. You are reminded that anything you say or publish before the committee today is protected by parliamentary privilege. However, once you leave the hearing, anything you say or publish outside this room is not so protected. We can also take on board any evidence in camera — that is, evidence that is just for the attention of the committee on its own. With those words, I invite you to introduce yourselves to the committee, and you may then commence the presentation.

Mr WALKER — Thank you, Chair. My name is Tony Walker. I am the general manager of regional services with Ambulance Victoria. I am responsible for statewide operations and emergency ambulance response. I introduce Dr Smith.

Dr SMITH — My name is Karen Smith. I am manager of research and evaluation at Ambulance Victoria. I am representing that organisation today in terms of the data collection and analysis that we do around trauma patients.

Mr WALKER — If you are happy for us to do so, we have a presentation to make today that addresses the information that we collect with regard to trauma and motorcycles in particular. Dr Smith can take that through.

The CHAIR — Just for clarification for the Hansard record, are you a doctor of medicine or a doctor of science statistics?

Dr SMITH — PhD.

The CHAIR — In what field?

Dr SMITH — Epidemiology — public health research.

Overheads shown.

Dr SMITH — We have submitted a written submission, so the PowerPoint presentation is just a summary of the submission that we put in. This is the letter from the Road Safety Committee that we received regarding access to the type of data that we collect and how we collect the data and how it is stored. Basically the presentation is around those main areas that were mentioned in the letter from the committee.

The main source of our clinical data is collected in what is called the VACIS, which is an infield electronic data capture system, which is basically on a toughbook that the paramedics fill in at the point of care. Generally once they have transported a patient to hospital they will fill in their VACIS. The primary output of VACIS is an electronic patient care record. Now in Ambulance Victoria all of our patient care records are collected electronically, unless there are issues with a tablet or a printing issue.

The implementation of this started in metropolitan regions in 2005 and was pretty much fully implemented across the service in 2008. The key areas of data collection are around the event; the patient; the attending teams; any pre-existing conditions of the patient; the cause of the event and a free text description of the event by paramedics; vital signs and symptoms; a secondary survey which includes quite comprehensive injury data collection; paramedic management in terms of procedures and medications; their diagnoses; and the outcome of the patient. All the pertinent variables in the VACIS are time stamped. Most of the data is collected from drop-down menus so there is a minimal requirement for the use of free text, and there are mandatory fields for the paramedics that are specific to particular types of cases — for instance, when a trauma etiology is selected in the VACIS tablet, the user is directed to a road traffic accident screen.

Completed patient care records from VACIS are synced to a database and then go into the Ambulance Victoria data warehouse for analysis and reporting. We have submitted a variety of user guides and documentation around the VACIS.

This is the road traffic accident screen found in the VACIS, and it gives details of vehicle type, whether the motorcyclist was wearing a helmet, the extent of damage, the estimated speed and direction, and whether it was a major accident. For motorcyclists we classify speed over 30 kilometres an hour as major accident. Other definitions include if there has been ejection from the vehicle and vehicle rollover, and a variety of other choices.

Mr LANGUILLER — If I may: do you have protective gear type of questions?

Dr SMITH — No, we do not. The only thing is helmet, although paramedics are quite good at filling out the free text section of the case description, which is where they will often put a lot of information around whether their motorcyclist was wearing protective gear.

The CHAIR — Who did you liaise with when you were setting up the system in relation to what variables should be included?

Dr SMITH — Particularly for road traffic accidents we liaised with Monash University Accident Research Centre. They provided us with a lot of information and advice on that screen. More broadly in regard to the clinical data there was extensive liaison with various subject matter experts, paramedics, focus groups and international agencies that are using electronic data collection. So it was quite extensive when it was established. We originally had an off-the-shelf VACIS-type product and trialled it, but the ambulance service ended up developing its own product in-house.

The CHAIR — Was there any discussion that took place with the TAC or VicRoads in relation to the development of the system?

Dr SMITH — VicRoads might have been consulted in terms of the RTA. I would have to check that because it was developed quite a while ago. I can remember there was quite extensive consultation, but we would have checked with VicRoads.

Mr WALKER — We could take that on notice if you are interested.

The CHAIR — Could you report back on that?

Dr SMITH — We certainly liaise extensively with the TAC now and we collect information that we provide to the TAC. We are actually in negotiation with the TAC at the moment in terms of possibly being able to provide VACIS data in almost real time so they can start their compensation claims earlier.

The CHAIR — Yes. The committee heard from MUARC yesterday in relation to a new link data collection system. Are you aware of this and do you have any off-the-cuff remarks?

Dr SMITH — A linked data collection? Did they say what was being linked?

Ms JENKINS — Everything: police, accident, licensing, health, registration and administration. Everything.

Dr SMITH — Is it a research project by MUARC? I would think that they would be getting the ambulance data from hospital records for that. We do liaise with MUARC, but I have not seen that particular project.

Mr WALKER — That said, if they are doing a research project with this data and it adds value to the system, we work with a lot of providers to supply it. There are no barriers to our information being part of that if it is something they wish to explore.

Dr SMITH — The clinical data and all of our other organisational data is stored in what is called the Ambulance Victoria data warehouse. It is based on an Oracle platform. It has five business areas including our finance data, our computer-dated dispatch data and our clinical and HR data, so all of our data is brought together in the data warehouse. We use a tool called Discoverer to analyse and report from our data warehouse, and access to that data is dependent on the level required by the individual and the various privacy signoffs and

privacy training. We have quite an extensive case-patient algorithm. Because we generally have more than one ambulance attend what can be more than one patient we do not have a unique patient identifier, so we have put together a fairly comprehensive algorithm which matches patients within a case, and that is called our case-patient data. We are able to quite accurately pull out a patient at the patient level as opposed to at the event level.

We also have what is called the Victorian ambulance cardiac arrest registry. It was established in 1999 with funding from the health department. It basically collects data on all patients who suffer a cardiac arrest and are attended by an ambulance at any stage. The definition of cardiac arrest for us is someone whose heart stops beating at any stage. We also include patients who have had motorcycle accidents in that registry — for example, last year there were almost 300 patients who suffered a cardiac arrest due to motor vehicle accidents and were attended by ambulance. We also collect all their outcome data from hospitals and look at their longer term outcomes in the death registry. We are currently doing a quality of life follow-up on all of the cardiac arrest survivors across the state, and that will be ongoing. It is probably one of the most comprehensive cardiac arrest registries in the world; we have almost 56 000 patients recorded to date.

VACIS training is provided to new paramedics and there are also a significant amount of ad hoc follow-up sessions. If paramedics are identified as requiring more training, they are provided with that training. Information updates are provided on our intranet, which is on the AV portal, and paramedics are made aware when there have been updates. The next time they sync their VACIS tablet it is automatically updated. We thoroughly monitor patient care record documentation compliance and we report that externally to the health department. We do a random audit of our patient care records and we also have a targeted clinical review process. Discoverer training, which is the product used to analyse from our data warehouse, is provided in-house to the relevant people.

We have a number of definitions of 'serious injury', which was one of the other questions that was posed to us. We have what are called potential major trauma patients. These are patients who meet our pre-hospital trauma triage guidelines, and where a patient meets those guidelines they are required to be transported to the highest level of service in the trauma system within 30 minutes. We have three major trauma hospitals across the state: the Alfred, the Royal Melbourne and the Royal Children's for paediatrics. If a patient meets those guidelines and is within 30 minutes of one of those hospitals, they are required to be transported to one of those hospitals. Significant research has shown that transport directly to a major trauma service significantly reduces morbidity and mortality.

We have a very comprehensive report set up in our data warehouse to identify all of these patients, and we do a significant amount of research on patients meeting what are called our PMT criteria. We have provided that document in an appendix, but this slide shows it as well. If a patient has a trauma aetiology and meets any one of those vital signs criteria, they automatically fit the guideline. Or if they have specific injury, such as specific penetrating or blunt injuries or limb injuries, then they would meet our trauma triage guidelines. The lowest level is if they have a particular mechanism of injury and in conjunction with age, pregnancy or significant co-morbidities, then they are expected to be transported to a major trauma service. We audit every patient who ends up being a major trauma who is not taken to a major trauma service across the state.

The next definition of 'serious injury' is actual major trauma patients. The whole purpose of our guidelines is the capture these patients, so they tend to be highly sensitive. We have about a 97 per cent sensitivity at the risk of being not as specific, so we take a wider group of patients to the major trauma services who then go on to be classified as major trauma.

The Victorian State Trauma Registry captures data on all major trauma patients across the state; there about 2500 per annum. We work very collaboratively with the VSTR. I do not know if you have had anyone talk from the VSTR.

Ms JENKINS — The week after next.

Dr SMITH — Okay. It is managed by Monash University and funded by the Department of Health and the TAC. Basically patients are identified as major at the hospital level if they meet one of a number of criteria. It could be a death after injury, significant injury according to an injury severity score, urgent surgery, admission to ICU. There are a number of criteria and exclusion criteria.

We have extensive linkage with the state trauma registry, so we provide them with quarterly data on all the pre-hospital elements of major trauma patients via a probabilistic linkage data exchange, and they provide data back to us in terms of injury severity and various hospital classifications. We also provide extensive data for research. I think we about 45 current research programs up and running at the moment with external collaborators, but I have highlighted two that are specific to motorcycle accident patients at the moment. There is a VicRoads tender that went out and is currently being done by the trauma registry and the George Institute. Basically it is looking at the investigation of potential to enhance emergency response to motorcyclists. They are looking at ways in which emergency services can be alerted earlier, or at what observers at the scene can do.

Ambulance Victoria provided quite a bit of guidance in terms of the structure of that tender, and we have also provided a significant amount of data in terms of the XY coordinates of all the motorcycle accidents that we have attended from 2007 to 2010 and extensive case descriptions around those motorcycle patients. I know the trauma registry researchers are currently doing significant evaluations on that. I went to a meeting a few weeks ago where they had some quite interesting outcomes in terms of the mapping of the patients and also the injuries that these patients are sustaining. They tend to be younger males with significant pelvic injuries. I think the results of that are due in about a month.

Also the Monash Injury Research Institute is doing a collaborative project — a linkage project — that is involved with TAC, VicRoads, Victoria Police. Basically it is going to crash sites and looking and recording all the details of the crash sites with the aim of looking at whether they could improve safety for motorcycle victims. Ambulance Victoria has set up a daily data report from our data warehouse that is automatically sent to the researchers, which gives them the XY — that is, the latitude and longitude — coordinates for all the motorcycle crashes that we go to who are transported to hospital in the metropolitan region. The aim of that is for them to try and get to the crash sites earlier rather than waiting for hospitals to alert them about the patients. I think that is the end.

Mr PERERA — A particular focus for this committee has been the way that off-road riders are regulated and, once injured, access medical help. We understand that due to the nature of off-road riding, accessing riders can be quite difficult. What kind of planning has Ambulance Victoria undertaken in terms of identifying areas where helicopters can land in areas with high off-road use? Do you work closely with the Department of Sustainability and Environment and, if not, is that something you would do in future?

Mr WALKER — Certainly. To the best of my knowledge we have not identified specific locations in certain sites. That said, I am happy to take that on notice and confirm whether in our air ambulance operations area that is occurring. Certainly if we are not, it is something that we would be interested in looking at. One of the difficulties around a lot of these locations is the landing site terrain is difficult at the best of times, and invariably I expect that the pilots are looking for an appropriate site within proximity to it, or alternatively winching those patients out in circumstances where there is no nearby site. I am happy to take that question on notice and determine if we have got particular processes around it.

Mr PERERA — Thank you.

Dr SMITH — One thing that we did provide to the VicRoads tender was quite comprehensive mapping of the motorcycle patients and whether they were off-road or on-road. As part of that tender they are looking at how significant it is in terms of the off-road issue, and whether there is anything that could be done to alert emergency services earlier.

Mr ELSBURY — Thank you for coming here this afternoon and capping off what has been a very busy couple of days for us. This committee has identified the importance of data collection as a critical component of understanding the causes of motorcycle trauma and helping to find ways to reduce it. Different agencies collect different data, each for different uses, but often this means that policy-makers do not have enough information on all the right data to make use of it for new road safety measures. How difficult is it to collect data for purposes other than your own? Would you be open to collecting additional data when your members are treating the patient — for example, collecting information about the type of protective clothing worn by the rider rather than whether they were wearing a helmet alone. I did notice there was a fair bit of information in the RTA report that is ancillary to your purposes? Do you want to cover that one, Karen?

Dr SMITH — With VACIS we can add fields for specific purposes, although one of the things that we try to avoid is making all of the fields mandatory because the amount of time it takes paramedics to fill out the tablet is obviously counterintuitive to improving our response times, so that is always a balance. While we can always collect information for other purposes — and we are certainly open to that — the compliance by paramedics would be varied.

Mr ELSBURY — In relation to VACIS, that is a computer system that is compatible with something at a hospital that the hospital administration can download so that they have got that information as well, or is it just for your purposes?

Dr SMITH — No, it is both. At most of the hospitals at the moment we print what is called a hospital patient care record for them. There are VACIS printers installed at every hospital, but there are a number of hospitals where we are currently trialling an electronic transfer. The future aim would be that that happens across the state, but that is subject to resourcing and time.

Mr WALKER — We are keen to reduce the paper transaction as much as possible. We are also keen, if practicable, to share the patient unique identifier within the hospital, so from a longer-term research and evaluation outcome we could have data matching of our data to the hospital data to follow the patient's journey through. So some work we have been doing on a national collaborative is part of the VACIS project. It is certainly something we are keen to do and are starting to do in a number of health services. It has been designed to enable it to interface with the hospital systems.

Mr LANGUILLER — Thank you for giving evidence to our committee. Thank you for the good work you do in the community and for the state. The Victorian Auditor-General's *Motorcycle and Scooter Safety Programs* report recommended that the Vic Pol-Transport Accident Commission-VicRoads interagency data committee be strengthened by working with the Department of Health, the Department of Justice and yourselves. What are your thoughts on that recommendation from the Auditor-General, and what steps, if any, have been taken to that effect?

Mr WALKER — We are supportive of anything that compiles data in a way that actually improves outcomes, so anything that can actually improve safety and the clinical outcomes of patients is a positive thing. We would be supportive of that. We are currently doing some data linkage work with the Department of Health. I am not sure whether it covers off that specific issue. I can take that on notice and confirm that, but if it does not, we would certainly be open to it.

Mr LANGUILLER — Let me put it you differently, if I may. Have you been approached by these other agencies for the purpose of collaborative work and potential engagement at that data committee level?

Mr WALKER — Not that I am aware of.

Dr SMITH — Not about data.

Mr LANGUILLER — Has the Department of Health had any discussions with you in relation to the Auditor-General's recommendations?

Mr WALKER — They may have, but I have not been aware of it.

Mr LANGUILLER — Can you do that and then come back to us?

Mr WALKER — Yes, certainly.

Mr TILLEY — I am very interested in the tablets in particular with the VACIS system. This is just a costings sort of exercise. Are they personally issued to each paramedic, or are they issued to the vehicle?

Mr WALKER — They are issued to the vehicle.

Mr TILLEY — Roughly how many tablets would there be statewide?

Mr WALKER — I would expect we have close to 200 or thereabouts. I cannot confirm that, but I suggest it is about 200.

Mr TILLEY — To Ambulance Victoria, what was the cost per tablet?

Mr WALKER — I can find out for you, certainly.

Mr TILLEY — And the associated ongoing costs.

Mr WALKER — Yes.

Dr SMITH — Also on that, we have offered VACIS to the other states. Queensland has taken it on board, New South Wales is starting and Tasmania has taken it on. In order to take on VACIS, we do not have any IP around it and we do not ask them to pay for it, but they have to contribute resources to what is called a collaboration. Through that, we have managed to have some cost recovery defrayed.

Mr WALKER — That is right. We defray costs around that, and also it means we have consistency around a product on most of the eastern seaboard, which means from a benchmarking and data collection point of view we are collecting the same information.

Mr TILLEY — Does it have any sort of GPS or location on the scene when you attend a crash?

Mr WALKER — It does not specifically, but our vehicles do, and our computer-aided dispatch system does. As Karen was saying, we have the XY coordinates of every event based on the mapping and based on our vehicles' location.

Mr TILLEY — Going on, we have heard in this inquiry from a number of people and groups. Does Victoria see any benefit or gain in training motorcyclists in first aid so they can assist prior to the arrival of ambulance? I am not sure of the particular group that gave evidence — —

Dr SMITH — ASMA?

Mr TILLEY — ASMA. I think it was originally born out of the US. Are you familiar with — —

Mr WALKER — Yes, I am familiar with their courses. From an ambulance perspective we know that the care provided in the first few minutes of an event occurring makes a difference to clinical outcomes — control of bleeding, opening an airway, and those types of things. From a clinical outcome perspective, having people who are riding with other riders able to perform those skills would be beneficial. There is no question about that at all. I cannot comment on whether it needs to be motorcycle-specific training, but certainly at a standard first aid level we know from the events we attend that it is those types of things where initial first aid can make a significant difference on.

Dr SMITH — I know the VicRoads tender that is going on is looking at that in quite a bit of detail, and also the trauma registry are doing quite a comprehensive analysis of the type of injuries that are being sustained, and they were thinking that that could inform the type of courses that might benefit that.

The CHAIR — At the most basic level could the Ambulance Victoria system be adapted for use by, for example, Victoria Police?

Mr WALKER — I am not sure of the answer to that. I do not understand what Victoria Police's needs would be, so we would be happy to work with them if they felt there was value in it, but I do not know whether what we are collecting in that system would support what they are doing. If there was an opportunity, we would be open to talking to them about it.

The CHAIR — How do you ensure consistency of data quality in the use of the system?

Dr SMITH — Yes, that is an ongoing issue with any system like this. Again, we try to minimise it at the interface level in terms of restricting it to drop-down boxes and using mandatory fields and a limitation on free text. I think also that when you have the advantage of a number of teams attending and they are all required to fill out their own patient care records you have some cross validation there. Also we interrogate the data quite extensively, so we have extensive clinical indicators. We also have what is called limited patient screening, which is a system where you identify potential high-risk patients and you audit them comprehensively. So there is quite a bit of feedback from all those processes in terms of data quality, and there might be a targeted

educational program around one of the variables. The best way to ensure quality, apart from at the interface level, is just consistent use of the data so it is constantly interrogated, and then you know what the quality of the data is and you are constantly feeding it back, but beyond that — —

Mr WALKER — The other thing we do, wherever possible, is try to pre-populate the VACIS case from our computer-aided dispatch system, so rather than paramedics duplicating information that has occurred within our CAD, or computer-aided dispatch system, that information is actually transferred directly to the tablet via the Next G network — the 3G network — and can basically mean that that information is available and does not have to be repeated, as it is from the primary source rather than the paramedic's interpretation of times, et cetera. We are also implementing a system at the moment that allows all the clinical information from the cardiac monitor, et cetera, to be uploaded into that as well, so it is about trying to take it directly from the sources and placing it into the system rather than having the paramedic interpret that, which is where you can make qualitative errors.

The CHAIR — Has Ambulance Victoria been involved in the motorcycle components of the Victorian injury prevention strategy?

Mr WALKER — To the best of my knowledge, no, but I can take that on notice and check.

The CHAIR — If you could take it on notice and — —

Mr WALKER — Certainly from my perspective. Maybe we have been in other parts of the organisation that I am not aware of. It might be better to take it on notice and confirm it one way or the other.

The CHAIR — There has been an opinion conveyed by a research expert in this field that your work seems to be on par with the gold standard in data collection.

Dr SMITH — That is nice.

The CHAIR — Do you have any self-effacing comments, in a sense, that might enable us to form another perspective, or are you aware of any other industry leaders in your field in other jurisdictions?

Dr SMITH — I think the trauma registry is definitely touted as one of the best trauma registries in the world, and I know that Professor Peter Cameron, who basically travels worldwide advising on establishing trauma registries, says that. One of the strengths of the trauma registry is the VACIS data that is fed into that, because it is a pre-hospital site. It is pretty comprehensive. Apart from the VACIS collection I do not think other states have similar trauma data. What I am trying to say is that the reason why we are probably touted as quite strong is that we have the pre-hospital elements with a very strong state trauma registry, and we are very lucky to have been funded by the health department. It is a really powerful tool in terms of looking at preventable injuries and reducing morbidity and mortality.

The CHAIR — Are you aware of any other state-of-the-art leaders elsewhere?

Dr SMITH — Internationally or in — —

The CHAIR — Anywhere?

Dr SMITH — Specifically around trauma or motorcycle or pre-hospital?

The CHAIR — Pre-hospital trauma attention and collation of data.

Dr SMITH — I think it would be fairly safe to say that I do not think there is a similar system anywhere else in the world in terms of the number of patients that would collect data. We are lucky enough to be statewide services. You have the UK, where the National Health Service has trusts, so you might have some similar population sizes but they do not have the electronic pre-hospital data collections that we have, and then in the states your emergency medical services are very localised, so you could have 20 services doing the state of Victoria. They are quite political and there is private and there is public, so there are not many others, I think, worldwide that have the population base that we have and one single service and one single form of collection, so I think that is probably why it has got that strength.

Mr WALKER — It is also the collaborative nature of information where, as Professor Cameron was suggesting earlier, through the work we do with the Victoria State Trauma Registry and other research groups we see that information as being there to improve the system as a whole, so we are not broke. With that information with the right governance around it, we share that information and try and datalink wherever we can to improve the systems of care.

Mr LANGUILLER — Two questions, if I may. I admit to not being an IT person by background, but would you anticipate any benefits arising out of the national broadband network for your work?

Mr WALKER — Potentially. Most of our information at the moment is being synchronised using our own network across the state, so our own IT network, but certainly with increased capacity and increased coverage into it. We have it across the state, but we do struggle to get access to a volume-based internet service which could assist in allowing that information to be downloaded in a more timely fashion. Certainly we are excited about the potential opportunities created by a system, particularly moving into parts of the state that have not had coverage in the past.

Mr LANGUILLER — How wide ranging is that in those areas in regional and rural Victoria that do not have coverage?

Mr WALKER — From our perspective, it is often a lot of our smaller volunteers, so where we have volunteer teams and there is not necessarily good coverage into those communities, they are the locations that we would probably talk about, so it gives us an opportunity to expand some of these services into smaller rural communities where from our perspective we cannot access appropriate services.

Mr LANGUILLER — I am sorry to persist, but do you have an estimate of what percentage of the jurisdiction that you cover does not have adequate connections or services?

Mr WALKER — I do not, off the top of my head, but I can take that on notice and come back to you.

Mr LANGUILLER — I would not mind if you could come back to us on that.

Mr WALKER — Certainly.

Mr LANGUILLER — Finally, are there any thoughts on what our committee could do and recommend to reduce motorcycle trauma?

Mr WALKER — I certainly do not have any specific areas. I think we talked earlier about the first aid elements. I think the care provider at the scene early on is important; an education around that from our perspective can make a difference, we know that. Outside of that, I probably do not have enough background to the areas which the committee is delving into to give any more of an informed answer.

The CHAIR — Mr Walker, did you start off as an ambulance officer and work your way through the system?

Mr WALKER — Yes, I did. I have been working with Ambulance Victoria for the past 26 years, originally as an ambulance paramedic in Melbourne and then an intensive care MICA paramedic in Melbourne and in country Victoria, and I have worked through various roles in both clinical and care education and then operations management throughout my career.

The CHAIR — Just aligned to that — and I will just let my colleagues know that I am going to divert the dialogue just for a moment — we have taken on board some information from a plastic and reconstructive surgeon from the Alfred trauma area as well as some evidence today from an orthopaedic surgeon who works in the trauma centre, and I at a personal level have a partial interest in the magnitude of trauma and horror that they grapple with at one end of the spectrum, counterbalanced by enthusiastic riders who might be acquiring their 250cc or 1250cc motorcycle from Elizabeth Street in the city. There is just an extreme between the exhilaration of a country road and the lifelong trauma associated with paraplegia or quadriplegia, loss of limb, loss of brain function overall. I was just wondering whether you have had any illuminating moments that have given you an insight on those matters and how you might impart your insight regarding improving safety to the wider community, whether it be to the point of licence testing, whether it be on an area of training or safety equipment? Just take me across those areas which are part of our remit.

Mr WALKER — Certainly. I have to declare I have not worked operationally on road for over a decade, so I think my experience is from that point in time. The reality is that there is a risk in riding a motorcycle, but people take that risk because it is something they want to do. In my experience, people do not necessarily think they are going to have an accident until they do. It is that accident at that time that has that impact on that individual. I am not sure — and I am not an expert on this — but from my own experience I think there is a sense people do not think it is going to happen to them until it does. You see some riders who are very well protected, who understand the risks and will do everything they can to mitigate that possibility, and you see from time to time people who are enjoying the exhilaration of it and who are thinking it is not going to happen to them until it does. I have to be honest, I am not sure how you could educate someone to that. I think some of the campaigns that TAC have been doing are very good and identify the risks of not having protective gear, for example. I am not in a position to say whether that is influencing behaviour because we still see people who ride without that protective equipment.

The CHAIR — In your own earlier work, do you recall any moments where you saw people who had had a their skin degloved or — —

Mr WALKER — Absolutely. It is very difficult, so the reality is that our paramedics — and I have in my past — have seen people who have had degloving injuries. We see severe traumatic brain injuries and we see people who are in the prime of their life whose lives are changed at that moment forever and, while we will do our best to try and make them as well as we can and transport them, the reality is that the damage is done at that point, so I think it is a sense, as I said earlier, that when you speak to people, they do not think it is going to happen to them until it does.

Mr TILLEY — Between my colleagues, Dr Frankenstein — Stephen Conroy's next challenge for the job of communications minister — you mentioned some work in the country. Are you familiar at all with Albury-Wodonga?

Mr WALKER — Yes, I am.

Mr TILLEY — Terrific. As no doubt you are aware, Albury-Wodonga has a single health service now which crosses the borders of New South Wales and Victoria.

Mr WALKER — Yes.

Mr TILLEY — There are no doubt some challenges, but we heard some evidence during the inquiry specifically about data capture and some problems from the director of, I think it is trauma, in the emergency department, and they have some challenges and difficulties because no doubt they have been working under New South Wales arrangements. The health service now runs under Victorian legislation, so are you aware or do you know of any issues specifically in relation to Albury Wodonga Health?

Mr WALKER — In regard to data collection, not that have been brought to my attention. As part of the state trauma committee I chair the trauma quality group for the state trauma committee, so there will be from time to time. We do not have the same level of detailed information and follow-up that we would get from the Victorian hospitals if a patient has gone to Albury. On the same principle, we do not have the same information from the New South Wales ambulance service as we would have from the Victorian service. That limits in some ways our ability to look at whether there were potential issues that we can drill into, but from a day-to-day ambulance perspective, no.

Mr ELSBURY — Just in relation to your data analysis program, Discoverer, is that something that was off the shelf or is that something that you have developed also?

Dr SMITH — No, that is an Oracle tool. Our data warehouse is basically pretty much all Oracle software, so it is an Oracle reporting tool.

Mr ELSBURY — Similar to Mr Languiller, I do not have an IT background, but is that something that would be able to look at multiple databases and bring them together or is it — —

Dr SMITH — We store everything in our data warehouse. It does not interrogate beyond the data warehouse, so if we do extract something from our data warehouse and then want to extract from somewhere

else, we have to do a linkage exercise. We are currently in the process of updating our recording tool. Discoverer is a bit old and clunky now and we are doing OBIE, which stands for — —

Mr ELSBURY — We will take that on notice.

Dr SMITH — That will allow interrogation across different data sources.

The CHAIR — Are you aware as to whether the Department of Health uses an Oracle platform?

Dr SMITH — No, I am not aware, but I could find out what they use for — you mean for the VEMD and VAED?

The CHAIR — Yes.

Dr SMITH — No, I am not sure what they use. They probably do, but I will check.

The CHAIR — Thank you. Do you have a view on the role of emergency locator beacons?

Mr WALKER — They are certainly useful from our perspective, particularly from a helicopter emergency response. It may be in parts of the state where there is no mobile coverage. That will be the only way that somebody who is out riding could flag that there is an issue. We would be supportive of anything that enabled access in an area where they have limited mobile coverage and no other way of accessing the 000 service. In many of those cases, that will be where our helicopters would be responding to and can have the ability to track and to locate those beacons as part of that work.

The CHAIR — How many helicopters does the ambulance service have on fleet?

Mr WALKER — We have five helicopters. We have four primary response and one retrieval helicopter. The primary response helicopters are located at Warrnambool, Traralgon, Bendigo and Melbourne at Essendon Airport; and the retrieval helicopter operates out of Essendon Airport as well.

The CHAIR — As a matter of process in an emergency where there has been road trauma and the victim is deceased, is that an area where you would be involved in the transportation of the body, or is the local undertaker called in?

Mr WALKER — No, not normally. It would be unusual for us to do that. We have a process where if there was a reason — if something was so distressing to the family or something in consultation with the police — we could, but it is extremely rare for us to do that normally. Once we have identified that the patient is deceased, we would then support the bystanders and others around there, but Victoria Police would then take responsibility with the coroner to remove that patient.

The CHAIR — What happens with your emergency reporting in that instance? Do you not then report it, so it goes through a different system?

Mr WALKER — No. If we attended, that would still be captured as part of our VACIS, and the details of the incident and the fact the patient was deceased would be recorded in the VACIS electronic patient care record. It would not be handed to anyone; it would come back into our data warehouse and be available for us to interrogate.

The CHAIR — What would happen if there was a report of a death off-road in a country location where it was relayed through? Would that then not be recorded as part of your system, if there was no need for you to attend?

Mr WALKER — That is correct. It may be in our computer-aided dispatch system as being called to an event. However, if the Victoria Police, for example, or someone arrived at the scene prior to us and said, 'Look, the person is clearly deceased' and we never actually get to the scene, then you are correct, there would be no electronic patient care record completed, but the fact we attended that event and were called to that event would still be in our computer-aided dispatch system.

The CHAIR — Who then removes the body from a remote location?

Mr WALKER — Again I would expect that would be the responsibility of Victoria Police, with the coronial services. From time to time where helicopters have been responding, I know the helicopter and helicopters already in that location may assist in extricating the person from that scene.

The CHAIR — Would the body be more likely to be taken to the morgue for some sort of post-mortem?

Mr WALKER — If we were involved in that and it was a helicopter, it would probably be taken to a landing site where a coronial services contractor could take over responsibility for the body and they would then transport them to the Coroners Court. It would be rare for us to ever do that by road ambulance, or by air, other than to help in the rescue or extrication of that body from an isolated scene.

Mr LANGUILLER — Do you have any four-wheel drive ambulances in your fleet?

Mr WALKER — Yes, we do. In parts of the state where we have access issues we have four-wheel drive ambulances, which are a Nissan Patrol-type vehicle, and we also have all-wheel-drive ambulances. We have a fleet mix based on the geography of those areas to allow access.

Mr LANGUILLER — What about motorcycles? Do you have any at all? Do you need any?

Mr WALKER — We do. We are currently undertaking a three-year motorcycle trial in inner Melbourne. A motorcycle commenced with us in December last year and a second unit is coming on board in July, and we will be evaluating that to determine the impact it can have on our response performance and improving access in the inner city.

Mr LANGUILLER — What about off-road surfaces? Are you in need of any motorcycles for that purpose — that is, to attend very difficult geographical areas?

Mr WALKER — I do not think so. I think a helicopter would be a preferred option in that setting. Given the risk profile of using motorcycles in off-road terrain, and so on, and the reduced amount of time that we would actually use that, I think our preference would be not to be involved in it for off-road use.

Mr ELSBURY — I am interested in your opinion of how important the Essendon airfield is for moving road trauma from regional areas?

Mr WALKER — From our perspective it is very well located, particularly for fixed-wing aircraft. Helicopters have the ability to land at the health services, but we utilise our fixed-wing aircraft at Mildura, for example, and outside the range of the helicopters, which is 150 kilometres or thereabouts. We have four fixed-wing aircraft able to respond across the state for both emergency and non-emergency cases. They play a critical role in moving patients from those locations to Essendon Airport, then to transfer the patients generally to Royal Melbourne Hospital or the Royal Children's Hospital and occasionally to the Alfred. So Essendon Airport's proximity assists us in rapid transfer of time-critically ill or injured patients from regional Victoria to major metropolitan hospitals.

The CHAIR — Would you be able to comment on your motorcycle paramedics and perhaps in particular their motorcycle training?

Mr WALKER — Certainly. Our motorcycle paramedics complete a four-week training program. As part of the pilot we originally were to undertake that training with Victoria Police. They are restructuring their training program at the moment, so from a timing perspective we were not able to access that and we have accessed the Honda training program. They have undertaken detailed training to our staff, who all come with a motorcycle licence, and provide experience in how to utilise the motorcycle and how to operate it safely within their normal limits. That builds on the driver standards program that all our paramedics undertake as part of their initial training, which is taking a low-risk, considered approach, looking after themselves and taking account of their environment in the way in which they drive and respond to incidents.

The CHAIR — For how long has it been operating?

Mr WALKER — Since December of last year, so it is now into its fourth month.

The CHAIR — And there have not been any accidents on the part of the motorcycle paramedics?

Mr WALKER — No, there have not been, and we have actively chosen a motorcycle type that we think is best suited to the intercity. It is a Piaggio scooter, but it is a 500cc scooter that has dual front wheels. It is designed to be as safe as practicable, and we have tried as best as we can to make it as safe as is practical while working in an inner-city environment. The bike does not have to tip or have a stand; it stops and is able to be got off while it is standing. From our perspective it allows us to respond in that environment as safely as possible.

The CHAIR — I have a slightly tangential question. In relation to the WorkCover profile of the ambulance service, do you know how that benchmarks against other emergency service organisations?

Mr WALKER — No, I do not. I do not have that information available, or I am not aware of how we benchmark. As an organisation we are unique as a single ambulance service in Victoria. From the perspective of true benchmarking against other organisations doing the same care we do, it is difficult to benchmark. We do some benchmarking with, or are benchmarked by WorkSafe with, the private ambulance services — the non-emergency services, but outside of that I am not aware of any other benchmarking that has occurred.

The CHAIR — On behalf of the Victorian Parliament's Road Safety Committee I take this opportunity to thank you very much for your excellent evidence before the committee today. We commend you on the good work that has been undertaken in your data collection processes, and our research staff would be very keen to perhaps continue to work on how that might be more broadly disseminated and built upon. We thank you for your time.

Mr WALKER — Wonderful.

Dr SMITH — Thank you.

Committee adjourned.