P R O O F V E R S I O N O N L Y

LEGISLATIVE COUNCIL ECONOMY AND INFRASTRUCTURE COMMITTEE

Inquiry into the Increase in Victoria's Road Toll

Melbourne—Monday, 10 August 2020

(via videoconference)

MEMBERS

Mr Enver Erdogan—Chair
Mr Bernie Finn—Deputy Chair
Mr Rodney Barton
Mr Mark Gepp
Mrs Bev McArthur
Mr Tim Quilty
Mr Lee Tarlamis

PARTICIPATING MEMBERS

Dr Matthew Bach
Ms Melina Bath
Dr Catherine Cumming
Mr David Davis
Mr David Limbrick
Mr Andy Meddick
Mr Craig Ondarchie
Mr Gordon Rich-Phillips

WITNESSES

Dr John Crozier, and

Mr Christian Kenfield, Royal Australasian College of Surgeons.

The CHAIR: Welcome to the Economy and Infrastructure Committee's public hearing for the Inquiry into the Increase in Victoria's Road Toll. I wish to welcome any members of the public that are watching via the live broadcast. My name is Enver Erdogan and I am Chair of the committee. Mr Bernie Finn is the Deputy Chair, and Mr Rod Barton, Mr Mark Gepp, Mrs Bev McArthur and Mr Tim Quilty are also fellow members of the committee.

All evidence taken at this hearing is protected by parliamentary privilege as provided by the *Constitution Act 1975* and is further subject to the provisions of the Legislative Council standing orders. Therefore the information you provide during this hearing is protected by law. However, any comment repeated outside the hearing may not be protected. Any deliberately false evidence or misleading of the committee may be a contempt of Parliament. All evidence is being recorded. You will be provided with a proof version of the transcript following the hearing. Transcripts will ultimately be made public and posted on the committee's website.

We welcome your opening comments but ask that they be kept to a maximum of 5 to 10 minutes to allow plenty of time for discussion. Could I please remind members and witnesses to mute their microphones when not speaking to stop any interference. If you have any technical difficulties at any stage, please disconnect and contact the committee staff using the contacts you have been provided. Could you both please begin by stating your name for the benefit of the Hansard team and then start your presentation. Thank you.

Dr CROZIER: Thank you, Mr Chair. My name is John Crozier. I would like to acknowledge from the outset and pay respect to the traditional owners of the land from which I present today, the Cabrogal clan of the Darug nation, and pay my respects to elders past and present. I acknowledge the disproportionate representation of our Indigenous people in death and serious injury in road crashes in Australia. I acknowledge the privilege of participation in this important inquiry into the road toll in Victoria. This is an important inquiry.

Addressing this silent epidemic is given special poignancy as we manage the clear and present threat of the coronavirus pandemic. On another poignant note I acknowledge the initial chair of this inquiry, Mr Nazih Elasmar, member of the Australian Lebanese Association of Victoria, and personally and on behalf of the trauma committee of the Royal Australasian College of Surgeons express our combined sympathy and support following the tragedy of the explosion six days ago at the port facility in Beirut, with the resultant horrific loss of life and injury.

As a vascular and a trauma surgeon on staff of Liverpool Hospital in south-west Sydney and as chair of the national trauma committee of the Royal Australasian College of Surgeons, I have been privileged to participate in the inquiry into the national road safety strategy at the request of the Honourable Darren Chester, then federal minister for infrastructure, on 8 September 2017. I commend the recommendations of that inquiry, tabled in the federal Parliament in September 2018, to this committee. They are referred to in the college of surgeons submission.

Now, this jurisdiction, Victoria, has led the world in many important aspects of road safety. In partnership with Victorian state authorities the Royal Australasian College of Surgeons had a role in introducing mandatory seatbelt wearing legislation in 1970. Victoria was the first jurisdiction in the world to do so. Victoria also led the way with mandatory roadside testing for blood alcohol on the breath of the driver. In the Safe System we refer to the post-crash response pillar. This has benefited greatly in Victoria from the establishment in 2000 of the Victorian trauma system. This is the first trauma system integrated at a jurisdictional level in Australia. A major trauma outcome study prior to its implementation had highlighted an almost 30 per cent preventable death rate in survivors in Victoria of motor vehicle crashes. I acknowledge the valuable contribution of Dr Peter Danne in the conduct of that study and his leadership in the field of trauma care in Victoria. That level of care has been dramatically improved with the integration of prehospital care and expeditious delivery of appropriate patients to major trauma centres.

Now, significant funding and support must be acknowledged from the Transport Accident Commission in the establishment of the Alfred hospital as a level 1 major trauma hospital, and the continuation of quality research and the contribution by TAC to that must be acknowledged. I acknowledge also the significant leadership by Professor Mark Fitzgerald, who is an emergency physician and a close colleague, in his role as director of trauma at the hospital. And also I want to acknowledge the recent appointment of Dr David Reid, a surgeon, to the role of trauma director of the Royal Melbourne Hospital, the other major designated Victorian level 1 trauma hospital.

Now, a truism, and this is very important in this committee: data directs our responses and it informs effective policy. I commend the Victorian State Trauma Outcomes Registry and Monitoring Group, also known as the VSTORM, and its significant efforts to acquire high-quality, high-integrity data aggregated rapidly. For it is this data provided at a level of accuracy and, particularly if it is geocoded, matched to the site of the crash to allow its matching with other crash-relevant datasets, which informs effective policy development. I particularly praise the work of Belinda Gabbe, Emily McKie, Peter Cameron and Ben Beck. Their recent work highlights especially the increasing burden of death and serious injury on vulnerable road users, pedestrians and cyclists in Victoria.

I am particularly touched as I read through the large number of personal submissions to this inquiry that have come directly from pedestrians and cyclists, and I emphasise the need to heed their reasonable requests. Ultimately all of us are pedestrians, and we are very fragile creatures. I want to make this committee aware of Dr Christian Kenfield's work in promoting increased understanding of the fragility of the human frame when it is exposed to the forces generated in road crash impacts. There is a humanoid called Graham who is currently on display in London. This is a fantastically innovative educational opportunity. It has been provided by funding and support of the Transport Accident Commission.

I particularly also want to use this forum to highlight the very sophisticated technology developed in Victoria, providing cameras which detect in-car driver mobile phone usage, and I want to cite the Victorian company Acusensus, which incorporates the intellectual property of Alexander Jannink and his team. This road safety enhancement system with the necessary enabling legislation has recently been implemented in the first jurisdiction in the world—and no, unfortunately it is not Victoria; it is New South Wales.

I would also especially like to acknowledge that there is a dashboard at BITRE—the Bureau of Infrastructure, Transport and Regional Economics—that does inform in a positive way where local government authorities have achieved no fatalities for periods of five years or beyond. Now, clearly these local governments are doing something, and that should help inform other LGAs. In Victoria I particularly want to highlight what has been achieved by the Mildura Rural City Council. They have moved an amenity in the direction of decreased crash with resultant death and serious injury reductions, working in partnership with community, with a range of cost-effective measures, and that learning can be rolled out widely across Victoria. I do commend the content of many of the proposals in many of the submissions.

I want to close by making two key statements. I want to highlight the current paradox of our response to the coronavirus pandemic. We united in a non-partisan way with appropriate technical advice, which was incorporated and actioned rapidly, and that at a national level has reduced a significant number of deaths and disability from the coronavirus. Any of us watching our television sets at night can see the nationally aggregated figures, which detail the number of tests performed, the numbers of COVID-19 positive patients, the numbers of survivors, the occupants of intensive care beds. That data is on easily understood dashboards available to all members of the community. Would that that capacity existed to highlight the reality of the 100 or so people who will be hospitalised today around Australia following injuries sustained in road crashes.

In closing now, I do lend support to the Royal Australasian College of Surgeons' submission to this inquiry. I especially want to very publicly praise the efforts of Lyn Journeaux, who has been an administrative officer with the college of surgeons for 14 years. Her tenacity and endurance magnifies the work of many within the college of surgeons committed to the best outcome for victims of road crashes, but more critically in working in partnership with other agencies to achieve the prevention of road crashes and ultimately the realisation of a vision of zero deaths and serious injuries on our roads by 2050. Chair, I thank you for the privilege.

The CHAIR: Thank you, Dr Crozier, for that informative opening. I would like to pass around for questions. Who would like to go first? I will go to Mr Barton.

Mr BARTON: Thank you, Chair. Thank you, Dr Crozier. I will just go straight to something that I am interested in, which is driver distraction, which has become a huge issue. It is now competing against people who are affected by drugs or people who are affected by alcohol when they are driving their cars. I just cannot recall where I saw the data, whether it was through the insurance industry, but it was something like one in four accidents now are through distraction. We are going to have to start being far more serious about dealing with people with distraction. I acknowledge that New South Wales has got the cameras, but I believe that Queensland has just started a trial, and I believe we are going to start a trial in Victoria very shortly as well. So I suspect that that camera detection of people using their phones being rolled out in Victoria is not too far away, and I look forward to that. But there are other avenues in the commercial sector: people who drive professionally—fatigue management, making poor decisions leading to distractions and all those sorts of things. Have you got any thoughts around things about other distractions, apart from the cameras and phones?

Dr CROZIER: Thank you, Mr Barton. One of the privileges of working on the national inquiry into road safety has been working across a range of domains that a surgeon would not usually, and seeing the commitment of a number of road traffic safety engineers, automotive industry management and fleet managers. There are a lot of existing technologies which go a long way toward mitigating the real and present risk that you made reference to—the rising component of distraction as part of the matrix which culminates in crashes.

I gently note that you did use the word accident as you framed the question. A key element in addressing this issue of preventable crashes is acknowledging things like distraction as an element to what might otherwise have been a preventable crash. You are right. There are technologies that monitor gaze and can tell when a driver's gaze is distracted off the road for a certain period that go a long way toward protecting fatigue. There are a range of technological solutions which help mitigate that risk of distraction. And I will just close again: there are a multiplicity of solutions that go a long way toward mitigating that risk within the levers of the individual drivers. At a jurisdictional level, the local government authority in the jurisdictions of the state and federally, there are operationally available solutions that can be implemented, and we do have to stop prevaricating. We have got to use a number of these options available to us, at whatever level.

Mr GEPP: Thank you, Dr Crozier and Mr Kenfield—a fantastic submission. You have covered all the terms of reference that the committee will be considering—and obviously very well thought through. I was wondering if either of you could give us a real sense of the day-to-day impact of road trauma, both fatalities and injuries, on our health system and equally important, of course, the impact on our health workers. I think we are only too aware now, with the COVID-19 situation, that it is our frontline health workers that are seeing the worst aspects of the impact of COVID-19, and that too would be the case from our paramedics to any of our first responders and then when people are taken to medical facilities following a road trauma. I was wondering if you could give us a bit of a sense, an overview, of what our health system endures on a daily basis?

Mr KENFIELD: I think as surgeons and emergency and operating room nurses the ability to deal with the injuries that come through is obtained on an incremental basis, as we go through our training. There are other staff in the emergency department and in the operating theatre who do not have that ability to see incremental worse things over time. A good example of this is the trauma room resuscitative thoracotomy, where the chest needs to be cut open, often without the patient having had the normal preparation and drapes put on them, to relieve blood that is tamponading in the heart and to try to save the patient so that they can go up to the operating room and be operated on. This is a barbaric operation for anyone to see, especially those who are not trained, and quite often the junior nursing staff, sometimes even junior medical staff but certainly the orderlies that we have as part of our treating team to move the patient from one place to another, they often need to take the next day off or the next couple of days off because they have seen someone essentially make an incision that is half the diameter of the chest and put both hands in to try to resuscitate this patient so that they can then be treated. Now, that is a very extreme scenario but it does happen on a regular basis in the trauma centres around Australia, and that is why many of the patients do not actually die and are in the statistic of serious injury rather than deaths.

Mr GEPP: Thank you. What about the impact in terms of the utilisation of resources? What does it take when we have a spate of road trauma? What does that do to a trauma hospital that just has a spate of injuries turning up on a daily basis? It must have a devastating effect for the operation of that system at that place in that time.

Mr KENFIELD: It is incredibly disruptive, even in the biggest of trauma centres, because quite often, with our capacity being at break point at the moment and in the last few years, there will not be a dedicated theatre set aside for trauma and if there is it may be used for another trauma. So quite often what will happen is people who have been waiting weeks or months for their operations will have that operation cancelled and all efforts from the resuscitating team will go into dealing with this patient, often for several hours, which will not only delay other operations but then take nursing schedules and doctors' schedules and push them out. The resources in terms of the physical resources—the drapes, the bandages, everything else—are quite significant, often with multiple operating teams operating on one patient, sometimes at the same time, sometimes concurrently.

Mr FINN: Thank you, Mr Chairman. Thank you, Mr Kenfield, for your graphic description of the opening of the chest. I think I might have to take a day or two off after just thinking about it, much less actually seeing it. But, Dr Crozier, I am very interested to hear you talk about the aim of zero deaths by 2050. Now, we heard this morning from a witness that that sort of thing is fanciful, that deaths are just with us and that that is the way it is going to operate. What is your comment on that? Is that a realistic possibility?

Dr CROZIER: We are very fragile creatures. The paradox of life is that the day we are born we are given a death certificate. So we come into the world with the inevitability of death. We never know when we are going to cash it in, though. We do not have to die in a road crash. We do not have to be seriously injured in a road crash. We have an ability in our mind to see a better way of living in the world, and that is what shapes us and defines us as a species. Now, we have worked a long way, and I have highlighted a few of the leading-edge international legislative changes, technological changes that Victoria has paved the way for for the rest of the world. There is a combined view by reasonable people, reasonable agencies, around the world that we do not have to sustain the forces in road crashes that kill or seriously injure us. So by 2050 this is not an aspirational goal in the minds of very reasonable people and large numbers of agencies, including the UN, including the WHO, including large numbers of vehicle manufacturers, including large numbers of legislators. This is a real and achievable goal. If we accept a lesser standard, if we accept the inevitability of accidents, then we continue to see preventable death and serious injury, and I gently close by saying that every member of this panel as he or she came to this station today may have used a form of transport. They would not have anticipated spending the day in hospital, and they certainly would not want a funeral to be the reality for their family. It need not be, and that is why these sorts of inquiries are so important. We can and we must do better than we have. Thank you.

Mr FINN: Doctor, what is the single biggest thing that we could do—the single biggest recommendation or perhaps most important recommendation that we could make—to make that 2050 aim a reality?

Dr CROZIER: Well, there is not a magic bullet. There are a series of recommendations that we have tabled at a national level in that inquiry which I made reference to. There is a requirement for leadership. Now, we have seen non-partisan leadership. We have seen when technical advice is followed at a national level with the coronavirus pandemic how effectively things can be done and how quickly things can be done. So too with the management of this silent epidemic: the reality of 1200 of us being killed and the equivalent of a small—when I say small, I mean a medium-sized—country town being hospitalised each year. Picture the population of Mildura. That whole population equivalent will spend at least a day in hospital in these 12 months. It is a $30 billion spend. In 10 years that will be 100 000 dead. It will be $300 billion that we have needlessly squandered. We have got to do better than that. We have been very, very integrated at a national level with coronavirus, and so too we can be with the silent epidemic of road crashes with death and serious injury.

Mr FINN: Thank you.

The CHAIR: Thank you. I have got Mr Meddick, then Mr Quilty.

Mr MEDDICK: Thank you, Chair, and thank you, gentlemen—both—for presenting here today and for your submission. Might I also say thank you to all in your professions and throughout the hospital system for doing the work that you do to try and piece human beings back together after these very traumatic, obviously, experiences. As Mr Finn said, it is certainly something that—even while you were speaking, Mr Kenfield—the images that it evoked in your mind were just absolutely horrific. I cannot imagine the trauma that people would suffer having to witness that and do it and walk away from it. It takes a very special kind of person.

I have a number of questions. The first one is a repeat of a question I asked an earlier witness. We have heard that people who, for instance, smoke cannabis on some sort of basis, whether casually or reasonably regularly, a day, two days, three days—whatever it might be—afterwards will still have some sort of residual effect in their system or a level of it. In your opinion is that an impediment? Will that restrict or inhibit the person's ability—their reactions and ability—to drive? Or is that a non-issue? Should it just be removed from the equation?

I will get all my questions out now, if I can. In terms of car affordability, I noticed in your submission you were talking about the removal of a certain amount of taxes, perhaps on 5-star-rated cars, and I agree with that completely. But I have a little bit of insight there because I had a very good mate some years ago who worked as a fleet valuer for one of Australia's largest auto importers. He told me, when recently speaking to him about this, that when we removed the 22.5 per cent sales tax on new vehicles that we used to have here in Australia and instituted the GST, all that simply happened was that the car manufacturers ate up that 22.5 per cent to become company profits. The car prices did not drop at all. If they did, it was only marginally, and then the 10 per cent came in, to take up. This became a profit margin. My concern would be that the same would happen here: if we significantly reduced the retail price of these cars by initially removing all these tax impediments, manufacturers would just simply use that to incrementally eat that up and we would come back to where we were. So any gains that we might make would just be negated, and it has been shown to happen in various industries.

We had an earlier witness talk about speed on country roads. They argued for a reduction, not on the main thoroughfares—the main highways were meant to remain the same—but a reduction in all those feeder roads, if you like, because they are just not up to scratch to take the current speed limits that we have of, say, 100 kilometres when they should be even as low as perhaps 60 because they just cannot handle the traffic and the subsequent problems that arise from that.

The other thing I want to ask you about is, you just made mention there, Dr Crozier, that a number of recommendations have been made at the national level. I would like to know what the reaction to those recommendations were and the willingness on behalf of federal governments, of whatever persuasion they might have been when they got recommended, to take those things up and to actually implement them at a national level. I know that is a lot to digest there, but I have all these questions. It is the one submission, I think, that I have been really looking forward to and I had all these questions about, so thank you for your patience.

Dr CROZIER: Thank you. I am not sure, Christian, if you want to talk to drugs and luxury cars, and I will cover off on speed and the national—if you like.

Mr KENFIELD: Very happy.

Dr CROZIER: Did you want to start the ball rolling with the cannabinoid issue?

Mr KENFIELD: Yes, certainly. In regard to the effect of cannabinoids, I am unsure as to how long the effect does stay in the system. But certainly at the time of intoxication with that substance, the driver alerts and driver reaction times are significantly impaired. We were initially unsure about the denominator here. We were unsure what proportion of drivers on the roads are under the influence of one of the drugs.

I might mention a pilot study which is being performed by the two major trauma centres in Victoria, the Alfred hospital and the Royal Melbourne Hospital, consisting of 1400 drivers and passengers and also bike riders, motorcyclists and pedestrians over a 12-month period, where each of these patients were swab tested in their mouth. There were almost no refusals to have this done, given that they were completely of the understanding that there would be no punitive actions taken. The preliminary data has been compiled and it is just about to be submitted for publication so I am not able to go through the details of this, but it suggests that the number is very, very significant and is certainly in the order of those who are affected by alcohol. This is certainly one area—and I would like to go through this a little bit when I do my submission—where we need to put a lot more effort. With recreational drugs, although we do not want to ease up on them, we do not want to give the impression that it is okay to take them, but we certainly need to look at harm modification strategies—knowing that there is a significant proportion of people on the road who are taking them—and try to improve that.

Dr CROZIER: And if I could pick up—these questions have come from submission 143 by the Liberal Democrats. Speed is poorly understood. The road crash tests that equate to a current 5-star rating are tests that are conducted at a crash into a stationary object at 64 kilometres per hour. Now, with the current suite of

measures, at a crash into a wall front-offset you will still have injuries and you will almost certainly need to be hospitalised for 24 hours. When we increase that speed above 64 kilometres an hour and the closing speed with a similar mass object is the same, that is the equivalent of running straight into a brick wall. We actually have a very poor concept of those crash forces on us, but if I invited you to fall from a four-storey building unprotected that is in essence the force that is being distributed to the human body in a front-on or front-offset collision at 60 kilometres per hour, and most of us as we drive do not appreciate those forces.

When we increase the velocity it is not a direct linear relationship of the energy that is available. It actually squares in relation to the velocity, so the difference in impact forces between 110 and 130, which is posed in the Liberal Democrats submission on the open roads, is a move by almost a 30 per cent increase in the energies available to disperse on the body. There would be a very high fatality rate and there would be a very high probability of serious injury rate if you have the fortune to walk away from a crash at that speed. Now, the reality if you are travelling 100 kilometres across a 30-minute interval, the difference between 100 and 130 is one Slim Dusty record. You will arrive if you have listened to that Slim Dusty record better rested. The increase in attention to the driving task moving from a velocity of 110 to 130 is a disproportionate increase in the work of the task of driving. It actually does not mitigate against fatigue. It is a much more onerous task to manage a vehicle travelling at 130 kilometres an hour than it is at 110 kilometres an hour.

So coming back to the question that I was asked about a single bullet: it is speed. We could reduce some of our existing speeds and preferentially direct people off some of the secondary roads or direct that they be a lower velocity road—which is the desire of a number of our local government authorities—but unfortunately state authorities and particularly heavy vehicles that want to travel over those roads can trump the desires of the local engineers in small rural LGAs that know the higher velocities of particularly the heavy vehicles travelling across these road surfaces exponentially degrade them, increase the work and the cost of those local government authorities in repairing those roads and increase the degradation and increase the threat of death and serious injury of the locals who drive on those roads and who are disproportionately represented in the fatality statistics.

The reality again is just as you have indicated, that we will get a tremendous win in return for effort in lowering some of the existing speeds promulgated particularly on those secondary roads approaching communities like that of Mildura. This is what Mildura have done. They have preferentially lowered speeds to 80 on some of the approach roads; they have improved the quality of those approach roads that are 100 or 110 kilometres an hour, so people preferentially then approach the community on those roads; and then when they get to the township there are a number of low-cost roundabouts at intersections and there are speeds that calm the overall flow of traffic to velocities of 40 kilometres per hour or preferentially in high pedestrian precincts 30 kilometres an hour. That increases amenity. It is an amenity win for the community. The fact secondarily of a decreased crash or severe injury rate has not been the primary consideration. That has been the way that that very effective reduction has been achieved, and it is a model that I do commend.

The uptake of the national recommendation again is a bit like a curate's egg—good in parts. There have been some moves towards effective action, but as is the case far too often in the decade that we have just witnessed in our commitment to a 30 per cent reduction we have failed as a nation. And we have failed because we have within our remit operational elements that, had they been acted on, we would have been closer to where we had set ourselves: the 30 per cent target by 2020. And again I gently challenge all of us in whatever capacity—those of us that are surgeons who can do it better day by day within the hospital, and a number of us outside of the hospital—there are actionable things that will substantively make a difference. We cannot keep prevaricating.

The CHAIR: Thank you, Dr Crozier. I am wary that if there are any questions that you cannot respond to in the short time, we will put them in writing so hopefully you can have a chance to respond in writing. I do note that the next person I have got on my speaking list is Mr Tim Quilty, who is a member for the Liberal Democrats in the Legislative Council. Then I have got Mrs Bev McArthur and then me. We are the last three to ask questions. I will pass over to Mr Tim Quilty, a member of the Legislative Council.

Mr QUILTY: Thank you. I have got a couple of questions. Medicine and vehicle safety vehicle technologies have improved markedly in the last few decades. What proportion of people involved in crashes survive today that would not have survived 30 years ago, and is that hiding the fact that safety measures that have been implemented on the roads themselves have been far less effective than claimed?

Dr CROZIER: I cannot give exact figures, but I can say that the reductions are substantial across a range of the domains. So a safe system is about safe road infrastructure, it is about safe vehicles, it is about safe driving, and it is about the post-crash response. To quantify which has the greatest return, it is difficult for me as a surgeon even with the access to the body of knowledge that we were required to consider as the inquiry came to a conclusion. There are some returns on investment that are accepted that are incorporated, and I do make reference to a submission that Alex Gallacher commissioned, and I can feed that to this committee, that aggregates, if you like, the national cost that we pay. There is a business case incorporated within that, that justifies, if you like, why the focus should be on some of those different pillars as we try and come closer to zero by 2050.

Mr KENFIELD: I think it is important to mention that the road deaths in Victoria have reduced steadily and significantly from 1970. In 1970 there were 1061 deaths in Victoria, and that equated to just over 30 deaths per 100 000 people. Last year it was 263, which equated to four deaths per 100 000 people instead of 30. So I think in 1970 people would have said, 'If we are going for four deaths per 100 000 people, that is fanciful', but through a range of safety improvements, especially through some of the legislation with seatbelt wearing and drink driving, that has steadily come down and can again.

Dr CROZIER: And if I can make a quick supplementary observation. On the Transport for New South Wales website, and I commend Bernard Carlon for his Centre for Road Safety website, there is reference to the Norwegian plan for the next decade, and within that there are a range of business cases cited for each of the components that you have just made reference to—median separation, speeds and their impact on crash and fatality rates, vehicle safety standards and the returns on the expenditure. So there are internationally referenceable bodies of that sort of evidence, which I can forward to this committee.

The CHAIR: That would be very helpful, Dr Crozier. Thank you.

Mr QUILTY: My second question is in regard to drug testing, and we sort of half covered over it. You have called for zero tolerance, but we know that some people who smoke cannabis several days before and still have residual levels in their system are being picked up even when they are not impaired—and there are other drugs that we are not testing for that definitely do impair. Do you think this is an issue? Is it pushing people towards drugs that we are not testing for, for example, and punishing people who are not impaired?

Dr CROZIER: If we kill a child with a handgun, we are guilty of murder. If we drive a motor vehicle and cause the death of a child, it is a lesser species of homicide. The courts almost never prosecute at the level of murder. There are preventable tragedies where an element of the crash matrix is a drug-impaired driver, and that does not get meted the same level of enforcement punishment that is the case with a range of other murders and homicides. Be in no doubt that the task of driving a car, controlling the forces—we are poor creatures of self-observation. We do not fully realise the distraction when we are talking on a mobile phone with bluetooth. The science behind a range of these things is quite chilling, and so too with drugs. With a very minimal amount of alcohol on board, the quality of the driving degrades very rapidly. So too with THC, the cannabinoid molecule that is responsible for cognitive impairment and the degradation of motor skills. Virtually every jurisdiction that has promoted the free availability of recreational marijuana in the United States has seen a tripling of presentations to emergency departments with crashes where THC is a significant element of the crash matrix. So it is very reasonable. The person who makes the choice about driving has to be quite clear that there is a significant risk of degradation of their motor skills if ethanol has been consumed, if alcohol has been consumed, prior to the task, and similarly too with THC and a range of other drugs.

Mr KENFIELD: In the pilot study that has been done, it is actually not the cannabinoids that are the problem. Of the positive patients, 20 per cent had more than one drug involved, and 77 per cent of the drugs were amphetamines. The amphetamines is a much larger issue, I think, than the cannabis use. Not to say that the cannabis use in any way is benign and does not impair reaction times and driver ability, but it is the amphetamines which is the real problem at the moment. Anecdotally, I am sure you have all seen crazy drivers. I am sure it is amphetamines that they are on when they are cutting off people in lanes and, you know, much of the road rage incidents that we see in the news.

Mr QUILTY: I guess we also have various prescription drugs that are not being tested for or that are impairing. Do you think that is an issue?

Mr KENFIELD: I think it certainly is an issue. There is a very common post-operative analgesic that we give called Endone, oxycodone. Patients are advised not to drive whilst they are on it, but there is certainly an undercurrent of prescription medications that are abused in Victoria and throughout Australia, and I am sure that is one of the ones that is abused. It is a morphine derivative, and certainly whilst patients are on it in their hospital beds they are often not very coercive and comprehendible.

Dr CROZIER: Still, I guess, I want to leave the committee in no doubt that alcohol is still the most common cause associated with crashes leading to either death or serious injury. It is ubiquitous, it is so [Zoom dropout] underappreciated [Zoom dropout]

The CHAIR: Dr Crozier is frozen.

Dr CROZIER: It is with great concern. We watch the statistics from those jurisdictions that have allowed the legalisation and the liberal use of cannabinoids, particularly with respect to the driving task.

The CHAIR: I might pass to Mrs McArthur. She has a question. And then I have got one last question also.

Mrs McARTHUR: Thank you very much, Dr Crozier and Mr Kenfield, for your erudite submissions. There are a number of things that fascinate me about this, and what has come up in many submissions is the lack of data that many government policy decisions are being made on—without data. And do you agree that we should have the data of all road accidents supplied comprehensively, publicly and in real time so that we can ensure that where accidents are occurring, even if an ambulance is not called, we can then make adjustments to road work? And secondly, you have discussed some of the distractions, but wouldn't there be distractions like children in the car, animals in the car or eating in the car? Should we ban children, animals, eating, drinking and water in the car along with drugs, alcohol use and mobile phones to get to this zero level?

Dr CROZIER: Christian, shall I take the data and you take the distraction?

Mr KENFIELD: Sure.

Dr CROZIER: You are absolutely right, Bev, in relation to data. Data is key, and while we have the crash data that a death is involved with and we have that pretty close to when it occurred—death is a dichotomous variable—the richer dataset is where damage to a vehicle is sufficient to trigger a response but particularly where a serious injury occurs. Good quality data integrated and rapidly available in a transparent way is key to a better understanding.

I commend the Centre for Road Safety in New South Wales, and again Bernard Carlon's unit has a wonderful portal that the person with interest can go to and can see on the road system within New South Wales where crashes are occurring, can see the demographics of the party involved, can see the vehicle type involved and can see the pattern of injury—a single-vehicle-run-off-road or an intersection crash. That data is de-identified so the individual cannot be identified. It is also matched to police and to ambulance data. The integrity of some of those linkages does slow, if you like, the acquisition or the integration of that data. So, within bounds though, you are right to suggest that the more rapid aggregation of good quality data will go a long way toward improvement for all of us as road users. It will make the process of allocation of funding much more transparent. The commonwealth can be more confident that money distributed to jurisdictions reaps the safety reward that the community reasonably expects. So just to close on that point—again, you are right. The quality of data needs to improve. A key part of the health statistics is linking the geocoding of the crash site to the health data. Thank you.

Mr KENFIELD: John, could you please also mention the national road safety data hub through the Office of Road Safety?

Dr CROZIER: Certainly. BITRE goes a long way towards trying to aggregate the datasets that come forward from the jurisdictions. It is a frustration. Some of the habitual relationships that are established in one year dissolve the following year. Relationships between the coroners' provision of death data and evidence from police and ambulance in a year might be established at a good level in some jurisdictions and then fall over later on—change of Parliament, change of personnel. We have got to get beyond those processes. And I put it to you that we spend $30 billion on our seriously injured each year. Now, a lot of the data that is informing at the national or commonwealth level is acquired and presented four years after the event.

Australian Institute of Health and Welfare data is four years after the event before it gets to the commonwealth level. That is not the speed with which we need to be validating. Money that has been rolled from Canberra to achieve a highway upgrade is reaping the safety dividend that the commonwealth might reasonably expect for that dollar investment. So it might be the case, for example, that funding to a major highway also obligates the state to put a point-to-point, a speed average camera system, in as part of that bill. That will go a long way toward the commonwealth being confident that they do have a safety win—a reduced crash risk, a reduced death and serious injury risk—for that commonwealth spend on that bit of infrastructure. It is data, though, that will allow both sides of that contract to be confident that they are getting the value for the dollar.

The CHAIR: Thank you very much for that. I had a question actually along the same lines. Now I am worried we are thinking alike, Mrs McArthur! It was about: where are the gaps in the data collection, and do we need a nationally integrated model for data? But it seems you have kind of touched on those two points already. On that note, I would just like to thank you both, Mr Kenfield and Dr Crozier. And I would like to thank the Royal Australasian College of Surgeons, being our frontline workers in trauma units across the nation. We wish to thank you and everyone in your profession for doing the job you do, and thank you for your submission and presentation at today's public hearing.

Dr CROZIER: Thank you very much.

Mr KENFIELD: Thank you, Mr Chair.

Witnesses withdrew.