# TRANSCRIPT

**ROAD SAFETY COMMITTEE**

**Inquiry into motorcycle safety**

Wodonga — 30 November 2011

Members

Mr A. Elsbury
Mr T. Languiller
Mr J. Perera
Mr M. Thompson
Mr B. Tilley

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Witnesses

Mr M. Chadban, group manager, Upper Hume, and

Mr G. Cook, regional manager, Hume region, Ambulance Victoria.

**The CHAIR** — On behalf of the Victorian Parliament's Road Safety Committee, I would like to thank you for attending the specific inquiry into motorcycle safety. The committee has received over 72 written submissions since releasing the terms of reference, and the purpose of these hearings is to obtain further evidence on a selected basis to complement our research work. We thank you for taking the time to travel from Wangaratta to be with us today. Hansard will be recording proceedings today and providing a transcript of evidence. You are invited to correct any typographical errors and then get the corrected transcript back to the committee, whereupon it will be placed on the Web as part of our support documentation. What I would invite you to do is speak generally on your submission, and then my colleagues will be able to fire a few questions to you. For the purposes of Hansard, please give your name and postal address so that we have an address for the transcript to be sent.

**Mr COOK** — Thank you very much. I am the regional manager for Ambulance Victoria for the Hume region. I guess you are all familiar with the regional structure. My postal address is <address confidential>.

Today we have two parts to our presentation. I am going to cover off some statewide data that the ambulance service collects through our patient care record system. We have broken that down to definitions of major trauma and motorcycles, so we have the inclusions of what that is and the exclusions of what that is by the definitions. I will not go through those definitions today unless you want me to, because I think they are perhaps already covered in the terms of reference. I am happy to come back to that if we have time and if you would like.

**The CHAIR** — Yes. Go on.

**Mr COOK** — It is in the package. The data we have looked at is from 1 January 2007 to 31 December 2010, so it is not the current year; it is a four-year grab across that period. During that time Ambulance Victoria attended motorcycle collisions that met the major trauma criteria, totalling 674. There would have been other motorcycle-related incidents that did not meet that particular guide and they had been filtered out. I do not have the total number. For example, just to provide some clarity around that. an on-farm incident involving an ATV may not have necessarily been included within the dataset. In terms of those 674 transports, 406 of those, or 60.2 per cent, were transported by road ambulances and 268, or 39.8 per cent, were transported by air ambulance. That will be relevant to some extent as to the destinations that patients move to once loaded. That is a very high percentage — almost 40 per cent — of motorcycle road-related trauma patients who were airlifted away from the scene during that time.

One of the things that was of interest to us and that I would like to bring forward in terms of understanding is the time of day these 674 incidents occurred, in particular the time frame between 12.00 p.m. to 6.00 p.m., or from 1200 to 1800 hours, so through the afternoon. A total of 230 road trauma incidents occurred in that time frame. For 184 of that 674 incidents we do not actually have a specific time in which they occurred, so unfortunately there is a large gap. But just looking at the trend, it would suggest that a very large percentage of the incidents occurred in that lunchtime to 1800 hours timeslot during the day. Of interest is the next group, which is the day of the week. Of the 674 incidents, 135 of those occurred on Sundays, or 20 per cent, and 158 occurred on Saturdays, or 23 per cent. So 43.4 per cent of the total numbers occurred on weekends. Afternoons and weekends seem to be a very high trend. I am not unsympathetic to the fact that motorcycling would be seen as, in a lot of locations, a recreational activity, so it is not necessarily that unusual for us to see that. Matt will talk a little bit later about fatigue or fatigued riders being an anecdotal contributor from on-ground paramedics to give those two timeslots further significance.

What I have now is an aggregation of the regions across the state where motorcycle collisions occurred. Across the Barwon south-west region there were 25 in that period, or 3.7 per cent of the state total; in the eastern metropolitan area, 116, or 17.2 per cent; in Gippsland, 71, or 10.5 per cent; in the Grampians, 24, or 3.6 per cent; in Hume, 66, or 9.8 per cent; and in Loddon Mallee, 20, or 3 per cent. Then we go back into the metropolitan regions. Northern metropolitan had 92, or 13.6 per cent; southern metropolitan, 149, or 22 per cent; and western metropolitan, 90 incidents, or 13.4 per cent. That totals 653. There were 21 of those 674 that were not identifiable in terms of the specific location from the data that was retrieved.

If we talked about the real hot spots in terms of percentages of incidents, it is clearly metropolitan Melbourne, but Hume and Gippsland in eastern Victoria had very close to a double-digit percentage share of that overall total, whereas the western regions of the Grampians, Loddon Mallee and Barwon south-west had around 3 per

cent. So it would appear that the frequency of events is on the eastern side of Victoria and less so in metropolitan Melbourne and western Victoria.

Having been a bit of a motorcyclist myself and having spent time working in western Victoria, this part of the world and also in Gippsland, I think for anyone that drives the roads and understands the nature of the roads there is added interest from the motorcyclist fraternity in riding in this side of the state purely because of the geography and the hills. I would say that it could also represent a percentage of volume in terms of where motorcyclists frequent.

I have a map which unfortunately I cannot give you now but I am happy to pass it around. This is what we call a heat map of frequency of incidents, and the blue tints indicate 1 and the red is up to 25. It is a density map. What is very clear is that obviously the metropolitan area is very dense, based on those numbers we gave before, but there is an arc which is sort of fanning out from metropolitan Melbourne particularly to the north-east, east and probably south-east, which is also indicative of those numbers that we gave before. Again, there are more dots on the eastern side of the state than there are in the west and that is also again indicative of where it would appear the traffic goes.

That is the data-analysis side of things, and we will obviously answer some questions shortly. Matt is the group manager for Upper Hume and I will let him do his own introductions. In context he is responsible for the on-road paramedics but he also has a lot more contact. He has spoken to a number of the team leaders and team managers at our branches about this subject matter and taken what we would call the witness-type statements from paramedics on the ground which we thought would be valuable to bring to this committee to add to the data.

**Mr CHADBAN** — Matthew Chadban, group manager for Upper Hume, Ambulance Victoria. My postal address <address confidential>.

I would like to cover anecdotal evidence which comprises statements and information fed back from paramedics who have a significant amount of experience over time of working in areas where we experience a high number of motorcycle accidents or motor vehicle accidents. The paramedics that I specifically spoke to, and others who provided written evidence via email, work in areas that we would consider remote and in areas where the roadways are designed as such that they attract motorcycle injuries. This is purely anecdotal evidence. This information that I am about to go through has been gathered because paramedics in certain situations need to ask certain types of questions and often a lot of it is about the motorist's experience. Have you had any injuries before? Have you experienced an accident like this before? What are you doing in the area? The theme that came through was that the rider often has less than two years experience and that fatigue is often a contributor as riders will travel great distances to ride through certain areas of the state. This is apparent during motocross events. Motorbike events at Phillip Island and such will get a large number of riders through the state coming from New South Wales and Queensland to get to Phillip Island. Compared to motor vehicle drivers involved in accidents, a relatively high percentage are interstate riders. The anecdotal evidence suggests that more often than not people are from out of the area or out of the state.

Most of the patients we transport are surprised to find themselves bound for Melbourne for treatment. My interpretation of these comments, along with the other paramedics, suggests that most people who have an accident in regional Victoria would anticipate they would get a high level of care close by, but we still have to transport them and they are often surprised we have to do this.

There is also a heavy reliance on mobile phones as a platform for seeking emergency assistance from remote areas. When someone has an accident the first thing they do is grab their mobile phone and often there is no coverage, so that is an issue. Because of the fact that riders are often from outside the area the difficulty in providing accident locations, due to riders having limited knowledge of the area they are in, is an operational issue from the perspective of being able to get the right location from motorcycle riders or people from interstate.

I spoke to about 15 paramedics, who between them had about 180 years of experience, and no-one could ever remember a motorcycle accident where a motorcycle rider had their own first aid provisions.

From the motorcycle users' perspective — and we broke this down into on-road and off-road users — animal strikes or avoidance of animal strikes often contribute to an accident and that is reported in our case sheets as

well. Accidents often occur on the same stretch of road and often on the wrong side of the road. My interpretation of that is that in certain areas, say, in the alpine area, we would expect certain kilometres of the area in which accidents would be more likely to occur. Regarding the comments about accidents occurring on the wrong side of the road, the information that I was given was that the patients were generally found on the opposite side of the road more likely than not. It appears anecdotally that riding in groups also contributes to dangerous riding behaviour.

From an off-road users' point of view, they are usually well prepared in location knowledge, so they have a good understanding of the area they are going into. They are poorly prepared from a first aid perspective, and, from an Ambulance Victoria emergency services' point of view, we often have difficulty accessing and communicating with them for a number of reasons.

I tried to get some information out of staff and gave them the opportunity to provide some suggestions to this committee. These were the main suggestions gathered from about six written submissions: positioning devices to assist locating rider and incidents — that is, GPS navigation systems; increased road signage in known areas that attract motorcycle users; identifying to other road users that motorcycles are in the area; emergency markers located in such areas, — for example, in the alpine region and frequently used bush areas; the introduction of first aid kits for off-road users; and educational pamphlets to be sent out with registration renewals, which information could include the dangers associated with certain areas and comments about phone coverage, medical services available et cetera.

**Mr COOK** — As you say, that is a bit of a combination of actual data derived from our clinical information systems and also some anecdotal information given from an on-ground paramedic perspective. Obviously it is like anything else. It is very hard to substantiate anything without data, but the people, particularly those that have been experienced in the area for some time, particularly those who are out on the road attending these incidents, tend to pick up on the trends.

**The CHAIR** — Thank you very much. The quality of data is emerging as a significant theme for the inquiry. Can you just run through the aggregate range of information your organisation collects; and at what stage do you collect the data?

**Mr LANGUILLER** — What systems do you use, if you may share that with us, please?

**Mr COOK** — I should add that this period of data collection saw the merge of the three ambulance services in Victoria. During that period there were three systems of data collection and that is maturing to the point now where I think it has high-level maturity and will continue. VACIS, the Victorian ambulance clinical information system, which captures patient care records electronically onto a database, is now our platform for capturing patient care information statewide. That is the data field that is providing this information. Over the period of time I have referred to there were potential anomalies or situations where data was not able to be 100 per cent accurate. In 2007 and early 2008 in Rural Ambulance Victoria patient care records were still completed manually — handwritten — and the migration to the electronic VACIS system only occurred in 2008. There has been a significant improvement in the data quality, but it is fair to say that during the period we have looked at there would be some anomalies. That is the system of data capture at the moment.

I should also add that we have just completed the moving of all of our emergency telecommunications, call-taking and dispatch to ESTA via the Ballarat call centre, so all regional Victoria is now having call-taking and dispatch information taken through there. We now have CAD data statewide as well, so from a systems perspective and data capture perspective the future is much brighter than where we have been in the last few years.

**The CHAIR** — You collect information through the VACIS platform that is prepared manually on site, or is it fed in electronically from site?

**Mr COOK** — It is used on a laptop device.

**The CHAIR** — A laptop on site collects it?

**Mr COOK** — Yes, and it can be done. Matt might be better qualified to answer your question and he can correct me if there is more to be added. The paramedic's first priority is to treat the patient. They will take hand

notes about treatment, types of drugs or whatever the case might be. The patient care record is something that is handed to the hospital on handover of the patient or is completed at the hospital before the crew leaves. That is the preferred method. Sometimes that does not occur. For various reasons they might get dispatched to another case before they get that completed, but the patient care record is completed usually within a very quick time frame of dealing with the patient.

**The CHAIR** — Is that a manual document or an online document?

**Mr COOK** — It is an online document. The system is what we call synced. When the crew get back to the branch it is synced and goes to the central data warehouse. It is not a stand-alone operation.

**Mr LANGUILLER** — What type of information do you collect?

**Mr CHADBAN** — From a data point of view?

**Mr COOK** — On VACIS — the patient care record?

**Mr LANGUILLER** — What sorts of questions do you ask yourselves?

**Mr CHADBAN** — It is primarily a drop-down menu. There will be a list of medical issues or presentations. To go through the system, we would take patient details and we would take details on the incident. The details we get fed through from a pager point of view so it is the details we get electronically, but we also take details from the patient because often what we get sent to and what we actually get to are two different things. That is just human error. Then we would go through past medical history, allergies, previous history, including medications, and any type of stuff we would relate to from a medical point of view. Then we would go through a history of the current presenting incident and how that relates to the last 24 hours or 12, depending on what it is. For example, if someone had chest pain we would talk about what they did for the 12 hours previously and any past history they have.

**The CHAIR** — In terms of collection, do you go to the location where the accident occurred?

**Mr CHADBAN** — Yes, we do. That goes back to the two different bits of information. We would write down on the VACIS where we got dispatched to but we would also write down on the VACIS. If the dispatch information did not marry up with where we actually ended up, we would include that information as well.

**Mr COOK** — The pick-up point of the patient is recorded. Initial dispatch information can sometimes be inaccurate. Somebody might say, 'There is somebody off a motorbike between Dinner Plain and Omeo'. That is pretty vague information but that might be all you can get from a caller ringing in about an emergency. If that patient happens to be between Dinner Plain and Mount Hotham, for example, further up the road, whatever the case may be, usually the information about where the patient was found will be recorded.

**The CHAIR** — I seek guidance from our research staff, but there can be a difference if the accident occurred on a private property as opposed to being on a road, so to speak. There can be some different insurance implications, is that right?

**Mr CHADBAN** — Yes.

**The CHAIR** — Are you aware of any issues having occurred in that context?

**Mr COOK** — I am not, no.

**Mr CHADBAN** — I am not, no.

**Mr COOK** — I can understand how it could occur but I am not aware of any incidents — not being pursued through ambulance.

**Mr LANGUILLER** — Thank you for your submissions. We are very cognisant of the statements you have made that your primary role is to assist the patient and to treat and not necessarily to collect data. But from our point of view as a committee that is looking into road safety and looking at ways in which we can avoid or diminish pain and so on, the amount of information we get for the purpose of recommending policies and

legislation, regulation and so on could become critical, as I am sure you appreciate. In that context — and I invite you to focus strictly on motorcyclists — do you, for example, ask yourselves, 'This is a motorcycle rider. Was he or she not wearing a helmet? Was she or he not wearing protective gear, boots, gloves?'? Is that kind of question commented on in your report?

**Mr CHADBAN** — Yes. For motor vehicle accidents there would be a section where they would describe the scene. It is more focused on a motor vehicle accident, I will admit, but there are questions like speed, whether a seatbelt was worn or whether they had a helmet on or not. That information is gathered and it would also be written down in detail. If someone is wearing the correct equipment or good safety gear, that is not always commented on. Anecdotally, some of the information provided by the paramedics was that more people are wearing the appropriate gear these days than they were, say, 10 years ago.

**Mr LANGUILLER** — Do you mind if I ask you specifically — you mentioned speed: what kind of questions do you have to answer on speed?

**Mr CHADBAN** — It would be whether it was a high, medium or low-speed area. There are definitions for that. I would have to check them before I comment. Low speed may be below 60 kilometres per hour, medium would be between, on average in my experience, probably 60 and 100 kilometres per hour. High speed would be greater than 100 kilometres per hour. I would have to check that.

**Mr LANGUILLER** — Thank you.

**Mr COOK** — In relation to the data collection and taking your point, we actually gather a lot of data. One of the things for us is being able to influence patient care, so the type of patient we respond to and then the administration of care provided by the paramedics allows you when you aggregate a significant amount of data to ask, 'Are we using the right drug to manage pain? Are we using the right splints to manage breaks?'. Capturing the data is quite valuable. The question that is raised when we talk in a forum like this is: is there data that we might be able to capture that could help inform this sort of environment to get a better outcome? Without going through all of the fields — and there are so many domains you can have in these, and Matt talked about drop-down boxes — clearly, whilst the data we collect is very much about patient care and patient care improvement, if we can use that same data to prevent or mitigate risk in other domains then that clearly adds value.

**Mr LANGUILLER** — Thank you. On the basis of submissions received by a whole range of agencies — health, VicRoads, TAC, Victoria Police — it appears clearly that the Department of Health and your data collection in hospitals is the most accurate and the best there is available anyway, for all intents and purposes. Who do you share that data with? Where does it go to?

**Mr COOK** — Obviously for the Department of Health it is available, but apart from the privacy issues associated with patient care identification, the data — the aggregated numbers — is effectively just ambulance numbers. When they are depersonalised or deidentifiable the data can easily be presented — as we have done today — to anybody in that sense. In terms of ambulance work and numbers, we are into the hundreds and hundreds of thousands of jobs where we call them per annum, so we have lifted out a very small sliver of that here today, but it shows you can cut the data through to suit the needs of a whole range of things. We do a lot of work with the cardiac registry, for example, to try and improve cardiac arrest outcomes in Victoria. We are doing a lot of work with stroke patients and brain injury and brain trauma. There are a lot of different fields where we try and improve the whole spectrum of the patient outcomes.

**Mr LANGUILLER** — Thank you.

**The CHAIR** — Perhaps if I could just interpose for a moment on some statistical matters, I note that 27 per cent of records are missing in terms of the time of the day. Are you able to explain why that data is not available?

**Mr COOK** — No, I am not, I am sorry. I did make a telephone call today. I have highlighted mine in red, because a lot of the parts that were in red were the issues that — —

**The CHAIR** — One of the issues with our inquiry is data and accuracy of data. In order for us to make recommendations it is good to do so off an informed base in terms of the trend, so if that consolidated that

12-till-6 time frame that the other statistics allude to, it just reinforces the matter. If it is random data and random time, then one might surmise that the available — —

**Mr COOK** — The trend would continue.

**The CHAIR** — That the trends are indicative, so to speak. That is where I am coming up with the data. The other issue too that is just a little bit interesting, looking at the days of the week, is that obviously all Saturdays cover the highest number of accidents, followed by Sunday, and then it is a bit of a toss-up between Friday and Monday. Even with the Mondays it becomes of interest as to whether that might be Easter Monday or Labour Day or another public holiday, so it is not Monday per se but it is those higher possible road use days. Sometimes that can be just a little bit interesting as well to allude to. I just make that more as a comment in passing.

**Mr COOK** — Yes, I agree. In fact Matt and I did talk about this as well — that is, for us it would be very good to get this even by month, because we would anticipate that because, for example, in the high country the tracks are generally closed from 31 May through till 1 October, so I would suggest there is probably a higher level of activity in that off-road domain in the eastern ranges, I suppose — through to Jamieson, Licola, Marysville and all through that area — in the summer months, but we have not got that today. My own feel based on history and knowledge around trail bike riding would be that would be a higher end. We know that during the Phillip Island grand prix we get a lot of people with perhaps a little bit more adrenaline running than normally, either en route or in particular returning from the race. That is almost predictable in a sense that it will be the case, and that is also just about volume. There is a massive number of motorbikes that commute through the region, and through this region in particular moving south for that major event on the calendar. For us to plot the spikes in that we think would be valuable as well.

**The CHAIR** — While we can probably plot the deaths, the injuries are also indicative of where adverse behaviours are taking place and their adverse outcomes?

**Mr COOK** — Yes. The 674 are major trauma, so some of those will have resulted in death, but of course there are a lot that are not.

**The CHAIR** — It is additional information from another data source; the coroners reports may not — —

**Mr LANGUILLER** — On the Monday it could be a Construction, Forestry, Mining and Energy Union RDO. The CFMEU might want the day off?

**Mr COOK** — Yes.

**The CHAIR** — I will leave it to John, one of our research staff, to ascertain whether any further breakdowns might be helpful in making certain suggestions and recommendations and localising that information as well. There is a trend that October in anecdotal terms is a month that brings the motorcyclists out into the country and up into the Yarra Ranges or the Black Spur.

**Mr CHADBAN** — In 2007 I was the acting clinical support officer for ADAS, the Alexandra District Ambulance Service. There used to be three services before we amalgamated the services in rural Victoria and then we amalgamated with metro. From my experience in spending three months from August through October to mid-November, I know that in the week leading to the Phillip Island grand prix I did a major motorcycle incident every day for seven days. By major, all of those were transported to Melbourne hospitals. I can only talk about that one week, but it was well expected by the then CEO, Peter Savage. Basically he said it was historically an issue in the area.

**Mr TILLEY** — I will try and localise it. You mentioned that 40 per cent or something is extracted by rotary wing aircraft. On a local level, in responding to that, is there a significant amount of trauma on off-road surfaces and things? There were comments about GPS and EPIRB and getting in. I want to talk about a whole range of things, but with the extraction how much of this area is covered by or is available to the rotary wing aircraft?

**Mr COOK** — We can get rotary wing access to a large percentage of the area. The nearest rotary wing to us is in the Latrobe Valley — this is the Victorian rotary wing — Essendon or Bendigo. They are all similar and almost equidistant in terms of flight time to around where we are here today. We also use the services of

Southcare, the helicopter out of Canberra, which is again probably equidistant to the north-east from here. There is a significant geographical area where we are on the cusp, on the edge, of the flight time in terms of refuelling to load and, then again, depending on the destination. If it is major trauma and it has got to go to Melbourne, then obviously that is a very significant flight leg as well. It is fair to say that there is an area here where we are not necessarily as well serviced as other parts of Victoria in terms of air access to rotary wing air for retrieval for these types of incidents.

**Mr TILLEY** — In comparison, you utilise or access Southcare from the ACT, Bendigo, Gippsland and Essendon. On a demand rate, where does the Hume region sit as far as demand for those services?

**Mr COOK** — That is a really good question, and I have not got the specific data to answer that in an accurate sense. We certainly have our fair share of trauma with alpine resorts, for example. That is another activity that creates trauma for a period of the year. It is a high tourist attraction area for a lot of what I will not call extreme events. But there is a lot of fairly extreme mountain biking and motorcycling-type events. Of course the cycling events are becoming more and more popular in the remote areas of the region, particularly around Bright and Mount Beauty. There is the Three Peaks Challenge, Audax and so on. The risk profile says we have fairly high exposure to trauma, and that is based predominantly around the tourism-based activities that occur across the whole of the Hume region and particularly what we call the north-east portion of the Hume region as well.

**Mr TILLEY** — So I suppose if there were a wish list, we could certainly use a service located out of here or in the region?

**Mr COOK** — I do not think from an ambulance perspective, if that were able to be delivered, that anyone would not be in agreement with that. When it comes to patient care and being able to access patients, Matt, who is a MICA paramedic, could explain, but certainly for high-end trauma there is the golden hour in terms of getting patients to definitive care. The more quickly you can retrieve a patient and get to definitive care, the better the chance of their making either a full recovery or certainly having a better shot at it.

**Mr TILLEY** — In those remote areas and off-road crashes, particularly as this is a motorcycle inquiry, if a motorcyclist comes off on an unsealed road wearing a helmet, with some of the helmet removal, jaw-thrust et cetera, can you give us some commentary on patient treatment in that area? Are we talking about the golden hour and getting there?

**Mr CHADBAN** — I will comment from a sick patient perspective, for someone for whom I would call time critical, so once again it is the golden hour. I will talk about the process and how we would normally move someone like that. An example I will use occurred in Corryong earlier this month. We had a motorcycle event that started off in New South Wales, dropped down into Victoria and moved back up. From memory, they covered 130 kilometres of Victorian off-road. We got a significant increase in the amount of work that day. Corryong would normally do about three jobs in a 24-hour period.

**Mr COOK** — No, it is a bit less than that.

**Mr CHADBAN** — It is a bit less than that. We got six motorcyclists out of that and pushbike riders; there was another pushbike riding event in the area in that 8-hour period. If someone came off and urgent transport to Melbourne was required for definitive treatment, the best possible scenario was that a helicopter or a fixed-wing aeroplane was available and would move into the Corryong area, given the weather, terrain and all that stuff, and transport the patient directly to Melbourne. What normally happens is that the patient is met by road crew. The road crew would send in a situation report, and then it will be dispatched on that situation report, unless the information that was received prior to it arriving is significant enough to dispatch it there. It is sometimes difficult due to weather to get in these helicopters and fixed-wing aircraft. The patient would be treated by a MICA paramedic on scene, or one would be sent if they do not have a MICA paramedic in the area, and then they would rendezvous and continue the transport down. So for the upper Hume area we would go across to the Albury hospital. Then the patient would be seen by the medical team. That takes up time, and then the air transport would be arranged down to Melbourne from that point in time.

In other areas — for example, in southern Hume — if we had a similar incident in the Seymour area, it would be more likely than not that they would get seen by a road crew, but air, because of its proximity to Melbourne and its availability, would probably be co-dispatched or would respond a bit more quickly. The normal trend for

what I would call an average motorcyclist who is down would be transport by road to the nearest major hospital and then on to an appropriate hospital — the Alfred, for example. The further you go out into the state at times, the more difficult it is just to get air support because of the transport time for air to actually move into the area. I could not comment on what the transport times are in Hume. From Bendigo to the Wangaratta area, for example, it is about a 40-minute response.

**Mr COOK** — Flight.

**Mr CHADBAN** — Yes, flight. We can get crews on the ground much more quickly than that normally. Often the crews will get there and cancel air, or will ask for them to continue on. Normally that is what happens. From a patient perspective, a major trauma case would receive IV fluids, pain relief and, when necessary, would undergo a rapid sequence induction process, where they would essentially be put to sleep, paralysed and intubated and put on a life-support treatment system that we would use and get them to the nearest appropriate hospital. If we were to do that, the way that the ambulance service works, we would normally provide air support for that patient. A comment from my experience is that it is a double-edged sword. If we take a patient to a hospital, the doctors there will do what they need to do, but sometimes it is an unnecessary stepping stone down to Melbourne. Air removes that stepping stone. I am not saying it is always a good choice because often it is not, but often transport to Melbourne straightaway is the appropriate transport.

**Mr TILLEY** — Just going back to the helmet, we have heard evidence from ASMA, Accident Scene Management Australia, which has a philosophy of getting other like-minded riders who are qualified to ride in groups and share the love in relation to having at least a cert III in first aid and having some other skills attached to that. Specifically they said some things in relation to when a bike comes down as they are riding recreationally as a group and removing the helmet. Generally you have a group where no-one has any experience with those sorts of conditions where there are possibly some vertebrae or back or neck injuries and things like that. There are some procedures in relation to jaw-thrust.

**Mr CHADBAN** — Do you mean basic airway manoeuvres for an unconscious patient?

**Mr TILLEY** — I think it is more about the long-term and ongoing injuries if the helmet is removed.

**Mr COOK** — If I am hearing you right, Bill, what you are talking about is when somebody comes off a motorbike there are three, four, five, six or whatever riders around and none of them are actually skilled in any sort of first aid, and you have somebody who potentially has spinal injuries or some other injury. Do they take the helmet off or do they not take the helmet off? It is the scene management before a paramedic arrives?

**Mr TILLEY** — Yes.

**Mr COOK** — Have we seen evidence of that over time, where care has been compromised because of some of those behaviours?

**Mr CHADBAN** — In my experience I would say no. With a major incident the helmet is normally left on. I am not a motorcycle rider, but clearly some people are, and when most people fall off and hurt themselves they feel a bit battered and bruised, and if they do not have any neck pain or head injury they take the helmet off because they feel better. They want to relax.

**Mr TILLEY** — This is all about response. In the last week the Victorian government announced, I think, three world-type motorcycle metropolitan and city responses for getting through traffic. I am painting a scenario in remote bush localities. In any case we have to stabilise a patient and get them out there. It will either be by a rotary wing or getting the truck in there.

**Mr CHADBAN** — Yes.

**Mr TILLEY** — Do you see any place where MICA paramedics or suitably qualified paramedics with the appropriate training can get in for motorcycle-type situations when we see a heightened number of incidents, statistically on Saturday and Sundays — those types of things? I am just trying to paint a bigger picture to minimise those sorts of things.

**Mr COOK** — The difficulty from a resourcing perspective is like what is good, and what is bad? I do not know of any other models like that around. If you look at the density, even a day a week, and then plot that

across the whole of regional Victoria, it would be pretty hard to thermally map or put a predictability model over where would be the best place to have that. In fact Murphy's law would apply. It might be, 'Look, we think putting somebody at Licola today would be the right place', and the incident happens at the back of Harrietville. That would be the difficulty in terms of the frequency of that type of event. Our air paramedics can winch — they do not necessarily have to land — down to a patient. In fact that is one of the drills that they frequently need to do.

**Mr LANGUILLER** — On every occasion?

**Mr COOK** — In terms of every paramedic that is on the helicopter?

**Mr LANGUILLER** — Are you able to winch on every occasion, on every incident? I understand you cannot land, but has there been a circumstance where you could not actually winch somebody out, where you could not actually get to the patient?

**Mr CHADBAN** — From an air perspective?

**Mr LANGUILLER** — Or on-road. That is where the third option applies.

**Mr COOK** — If I recall, one of the former ministers of the government was in the high country.

**Mr LANGUILLER** — I am glad you got him out. Others may not feel the same!

**Mr COOK** — I think in that circumstance because of weather conditions at the time they were unable to winch. There are a lot of circumstances. The pilot flying the helicopter is in charge of the aircraft, and the safety of the craft and the crew are paramount. There will always be circumstances that might arise.

**Mr CHADBAN** — It would be very rare that we would send a helicopter by itself to an incident, regardless of what it was — whether it was for a motorcyclist or a bushwalker. They would normally be supported by a ground crew. Most of the time the ground crew will reach the patient before the helicopter does, unless they are really remote. If they are in an area where it is difficult to get to, or because of the time frame or the weather, an emergency management team — with ambulance, police and SES in local areas who know the area — would prepare and go into an area before we would send air. Once again, it comes back to our being given a location. Sometimes that location is not where the incident is, so we send the people in who know the area.

**Mr TILLEY** — This is by no means an inquisitorial sort of investigation. We are just trying to get to the truth of the matter. We have heard evidence in relation to police and their response, whether it be in Geelong or Bendigo. In Wangaratta and here we have heard pretty open, honest accounts from the police in relation to resourcing and response. Is Ambulance Victoria, or this region, experiencing similar difficulties in resourcing in being able to reach out to respond to those critical incidents from time to time, or being able to just cover their area? The police have similar numbers of police resources as they have had over the last 20 years. There has been no real increase to be able to cover their area of operation.

**Mr COOK** — Emergency services is a dynamic game. Some days you have got plenty and others you have got not enough. Again, it is pretty hard to predict the game. Data helps us in terms of enriching our predictability and knowing where we are going and whether we have got enough to cover those things off. The thing that actually gets us and catches us short is where events are organised — significant events — that generate workload that we do not understand, or where people choose to for various reasons not inform ambulance.

**Mr TILLEY** — It is developing those contingencies?

**Mr COOK** — Correct. I have used some of the major cycling events, for example, that occur and we have generally good lead times on those, good foresight in terms of the number of participants. We can run a risk model and we can actually put on additional crews to deal with that on the day, so it does not impact on service delivery to the general community, which has got almost a predictable workload. The key for us in that is in being able to predict and be informed about what is occurring. It is off this subject, but we had a rave festival at Tocumwal on the weekend, right on the Murray River but on the New South Wales border. The Cobram ambulance in Victoria provides the response to Tocumwal.

**Mr LANGUILLER** — How do you find out about these events?

**Mr COOK** — We did not.

**Mr LANGUILLER** — So you do not? Is it a requirement of local government to notify Victoria Police, Ambulance Victoria and so on when there are events held of that kind so that you know? Is there any conversation taking place between you, Victoria Police and other agencies?

**Mr COOK** — Yes, there is. If it is on a road reserve and VicRoads gets involved, then VicRoads has very tight conditions where they will consult with other people. But there might be other events that could be on private property, that might be in a national park or that might be in other areas that do not necessarily involve or hit triggers for notification. We work with local governments to try and make sure that if something comes through in a planning notification, that they give us the heads-up and we can know about it, but there are events that occur that are just under the radar in terms of the local government notification.

In the event on the weekend I just referred to, which was called Strawberry Fields, there was clearly a communication breakdown. It was managed by one of our New South Wales municipalities, so there is not what I will call direct relationship, although informally there is; for some reason or other that broke down. To answer Bill's question, from a resourcing perspective, that is where we get caught. If I can just return to this subject, a motorcyclist on Boxing Day who has a spill on the top of Mount Hotham is going to encounter a minimum of a 1-hour response. The nearest ambulance is in Bright. That is also a busy time of year for us tourist-wise in Bright. We will have additional resourcing structures in place in the alpine areas, particularly in the Ovens Valley, but that could add a significant delay to a response. At best it is going to be an hour to get an ambulance to the top of Mount Hotham.

**Mr TILLEY** — I think we are all fully aware that when it comes to response and KPIs and meeting those, in remote and rural areas when you are working in your major centres and then you get a job outside that area, that that adds to response times unfairly.

I want to go back to a couple of other things. Going back to helmet jaw-thrust and ASMA, John has heard what I have been trying to articulate and he has kindly provided me with a couple of documents. It is out of the US and it is called the Bystander Assistance Program. I am not sure whether you are aware of a Vicki Roberts-Sanfelipo. I want to draw your attention to the opening line. It says that the goals of the Bystander Assistance Program are to reduce injuries and fatalities to motorcyclists. They are like-minded riders. Vicki in particular is a qualified nurse. Through ASMA, they are trying to introduce some of these philosophies and ideas from the US. There is another document that John has handed me. If I could pass it over. It has highlighted details on jaw thrust. Could you give us some idea of what exactly that means?

**Mr CHADBAN** — It is an airway manoeuvre, basically to keep the airway open. If you think of the airway as a tube, we want to try and remove any chance of kinking. When somebody is unconscious their muscles relax, and it is quite easy for the jaw muscles to relax and to close airways, so jaw thrust — —

**Mr ELSBURY** — This happens on a weekly basis.

**Mr CHADBAN** — There are a couple of jaw thrusts, but I will explain one type, which is putting your fingers behind the jaw and pushing it forward. For another one, imagine that Garry is lying on the ground. I could do an airway manoeuvre where I would tilt his head back and with a pistol grip pull his chin forward. It is basically just an airway clearing manoeuvre.

**Mr COOK** — The issue is: if the helmet is on, how do you do the tilt?

**Mr CHADBAN** — It is difficult to do that. If I were a first aider and wanted to leave the helmet on, I would probably do the head tilt manoeuvre and leave the helmet on.

**Mr TILLEY** — With ASMA, are you familiar with a gentleman by the name of Phil Lemin? Not from the area? He is a former paramedic and has kindly given us evidence on this stuff.

**Mr COOK** — Yes, I am aware of Mr Lemin.

**Mr TILLEY** — Are you able to provide the committee with some insight, from a professional perspective from our major provider for these sorts of things, whether there is a place for or a role in this type of thing for training amongst motorcyclists, getting these sorts of philosophies, how they might work, how they might not work?

**Mr COOK** — If I gave the Ambulance Victoria philosophy about the reason we collect data, the whole idea is either to make patient care preventable or, if possible, to minimise risk and associated ongoing morbidity as a result of any injuries sustained. Then we would say that anything that is at the front end of prevention — we are a response agency, so, in blunt terms, we have to fix up somebody's mistake — if we can prevent the mistake or minimise the impact of that mistake, then at the end of the day the person is going to be better off. Our job is in sequence with somebody having made a mistake — we then have to fix it up. In relation to motorcycle trauma, I would have to say that we would support anything that created or minimised some of the risks that might be taken. Whether that is education or provision of appropriate basic training and things like that, we would have to be in support of that as a concept.

**Mr CHADBAN** — If people learnt those basic skills for motorcycle accidents and then were involved in an incident that did not involve a motorcycle rider or saw someone with an occluded airway, I am sure they would still use those skills. They would have wide-ranging benefits.

**Mr TILLEY** — I want to go back to the jaw thrust briefly. Would there be any risks with teaching jaw thrusts?

**Mr CHADBAN** — If you leave an airway occluded, there is a definite outcome: the patient will arrest and, with the inability to breathe, potentially die or have an increase in brain trauma or injury. If you need to clear an airway, you need to clear an airway. That is it. There probably are some risks, but there are also risks associated with not doing it. Does that make sense?

**Mr LANGUILLER** — What does that mean? I do not have a medical background.

**Mr CHADBAN** — Okay. For example, if someone collapses and is unconscious and they are sitting with their airway occluded, they are going to stop breathing at some stage because they cannot breathe, they cannot take in oxygen and potentially they will go into cardiac arrest or die for a number of reasons. It could be airway occlusion, or if they are unconscious, they may be unconscious for another reason. There are a number of reasons why they would pass away. But if you do not clear the airway, they are definitely going to get worse. If you do clear the airway — yes, when you do the action you may cause an injury, but you may also save their life. Definitely if you do not do anything, then you — —

**Mr LANGUILLER** — The options for that are two, as I understood from you, or three?

**Mr CHADBAN** — There are three different methods.

**Mr LANGUILLER** — Can you explain the third one, which you did not do before?

**Mr CHADBAN** — Essentially there are two types of jaw thrusts. There is a jaw thrust from behind. There is the pistol grip or there is the head tilt. They would be the three main ones.

**Mr LANGUILLER** — Are there any other measures that you would use?

**Mr CHADBAN** — From a first aid perspective? Just position as well — the recovery position or lateral position as well. I would not anticipate that most people would move a motorcyclist onto their side, if we are talking purely about motorcyclists; they would probably just do a head tilt or clear the airway by moving the head back. But for unconscious people, you might put them on their side, tilt their head back and put them in a recovery position.

**Mr TILLEY** — Matt or Garry, are you aware of any litigation issues for members of the public who come across a crash and render first aid? These sorts of things in line, do they create problems?

**Mr COOK** — I am not aware of any from either my experience in the ambulance or other domains. I am not sure whether you have come across that, Matt.

**Mr CHADBAN** — No, I am not aware of any. The only thing I would suggest with trauma treatment and first aid treatment, but trauma treatment specifically, is that it is an ongoing process that changes because of better practices or a change in opinion within the health system. If you had somebody perform first aid that was out of vogue or out of date and they had not updated their skills, then that may open them up to litigation.

**Mr TILLEY** — Just a closing question, and going back to the data briefly, once the job is done the information is entered into the system and everything is post event, is the information just handed over? Does anything happen post event, such as collation? Does the organisation manage that data or does it just go back into DHS?

**Mr COOK** — The data, the patient care record, goes into the Ambulance Victoria data warehouse; it does not go to the department. But statistically we provide information to the department out of that, in a sense. Ambulance Victoria has its own central data warehouse. As we speak, there will be patient care records being completed right around the state, and when they are synchronised that is where they will head to.

**Mr TILLEY** — Okay.

**Mr COOK** — I guess the reality of the business is that a case is completed and it will not be too long before the paramedics are on their next case. In terms of organisational review of a particular case, there are things like peer support. We have the ability to trawl through the data on a daily basis and our peer coordinators can find a case that has some sort of exceptional attribute. If it looked like it was a really nasty case, then they may be proactive in terms of activating things. So there are organisational systems that back up behind that as well.

**Mr TILLEY** — So post event the organisation uses the data, when it is synced, for strategy or planning?

**Mr COOK** — Yes.

**Mr CHADBAN** — Yes, absolutely. We also have a clinical audit process as well. Each paramedic who works on-road as their normal job would have their case histories reviewed through internal processes.

**Mr TILLEY** — Yes, terrific. Thanks for letting me steal so much of your time, gents. I appreciate it.

**The CHAIR** — We are running into a timing deadline at the moment, but we have a couple of questions that we need to run through here.

**Mr ELSBURY** — Just very quickly, what importance would you place on Essendon Airport as part of your infrastructure for providing health services?

**Mr TILLEY** — We are moving Essendon to Albury.

**Mr ELSBURY** — You are not touching my airport. You might have guessed that I have a bit of a vested interest in the airport. In any case, how much of an emphasis would you put on Essendon Airport as a piece of your health infrastructure?

**Mr COOK** — I probably should qualify this by saying I am not the air ambulance expert for Ambulance Victoria, but that is where the air ambulance and Adult Retrieval Victoria are based from an ambulance perspective. That is where our infrastructure is set up. In terms of transport legs — aircraft landing, then passengers moving into the major hospital network — because of the Tullamarine Freeway the major hospital infrastructure in that area is quite accessible. Yes, it pretty important to where we are now. If that were to change, then we would have to look at what the consequences of that would be. As I said, it is pretty accessible in terms of where it sits at the moment to move passengers in and out of the Melbourne hospital network.

**Mr ELSBURY** — You mentioned that you seemed to be going out to the same stretches of road, dealing with motorcycle injuries, almost constantly. Has VicRoads done any work in areas where you have found that the number of incidents has dried up?

**Mr COOK** — I am not aware of that. In terms of that statement, it is one of the anecdotal statements we put in. We do not necessarily have the rock-hard statistical information about that, but there are, for example, sections of winding road that I am aware of from Omeo through to Bairnsdale, along the Tambo River and places like that, that because of the shape of the road they are — —

**Mr ELSBURY** — They are what they are.

**Mr COOK** — They are what they are.

**The CHAIR** — We might leave it at that point. You have noted that the police have their own methods of logging accident locations.

**Mr COOK** — Yes, as I said, it was in our anecdotal statements. We do not have any data to support it.

**The CHAIR** — Thank you.

**Mr PERERA** — Just a final question, apart from what your staff have listed in your submission, are there any other things that you would like to see come out of this inquiry?

**Mr COOK** — I have nothing prepared in that sense. I saw what had come forward from the staff, and I tended to agree with them as being fairly practical solutions. I have nothing further to add. I am not sure if Matt has.

**Mr CHADBAN** — The only thing I would like to see from an ambulance perspective is a review, when an event is organised, of the type of emergency services that are required to support that event. I am not right across the policy or the procedure when we support an event, whether it be a motorcycle event, motor vehicle event or concert of some sort.

**Mr PERERA** — When you say 'event', are you talking about an accident?

**Mr CHADBAN** — An organised event. It is often difficult — and once again I am not party to this; I am an end user within the organisation — to come up with enough resources for an event. By that I mean, to negotiate with an event coordinator, to identify what is needed from an ambulance perspective and what is not. If I were to offer up or ask for something to be looked at, it would be that. That is my comment. You probably need to hear back from the organisation rather than just from me.

**Mr LANGUILLER** — Can I just make a comment? As I understand it, from speaking to a federal member and colleague, following September 11, the events in Madrid and London and so on, some modelling, and simulations interestingly, have been done between agencies in terms of what to do in those situations — what would be the role of the paramedic, what would be the role of the firefighter, what would be the role of police — and if there are a number of casualties or mass casualties, what to do, when to do it and who should intervene first. I have heard informally that there is some very interesting stuff around what decisions have to be made, what are the criteria and who should intervene first. If you have 10 people in front of you and you do not have the resources, what decisions do you make and on what basis do you make them in order to maximise the saving of lives and so on? Going down that path, it seems to me that perhaps a recommendation that contacts and discussions with other agencies occur, possibly with federal agencies, is the way to go. It is certainly something that has been explored in other countries and in Australia as well as I understand it.

**Mr COOK** — In relation to that, we do have what I would call very good emergency management arrangements in Victoria across the agencies. There are emergency management arrangements at a municipal level, regional level and state level in Victoria. Ambulance Victoria works under the State Health Emergency Response Plan, which is designed to deal with mass casualties or escalating events that involve patients — the more patients, the more escalation. There is the relationship with infield doctors as well in terms of calling upon resources, so field emergency medical officers and things like that. There are pretty robust arrangements in place. In fact we just recently ran an exercise with our field emergency medical officers to test our Hume region arrangements around mass casualty incidents. We do do that, and clearly at the regional and municipal levels as well we are heavily engaged in broader emergency management. There are good arrangements in place. If there were one thing that we struggle with, it would be our ability to be able to deliver our on-road services — keeping ambulances on the road — and have enough capacity to be able to simultaneously participate in exercises. That is what pushes us from a resourcing perspective.

**The CHAIR** — Thank you, Garry.

**Mr TILLEY** — I want to go back to some of the data stuff just very quickly. Is Ambulance Victoria represented on any significant road safety groups through VicRoads, Victoria Police or the TAC?

**Mr COOK** — That is a good question that I cannot answer, sorry. I am not involved, nobody from my region is, but from a corporate ambulance perspective I would be very surprised if we were not represented in those forums because of the work that we do, but I do not sit on them. I know we have involvement in the major trauma structures, committees and processes that run at the state level. Out of those would come subsets of that, and I am sure we would be integrated into that by other people in Ambulance Victoria. But I do not know specifically who or what.

**Mr TILLEY** — Sure. In that case would it be fair to say that in relation to data and data-collecting committees and those sorts of things that once it is into the pool it would be at that higher executive level? We will pursue that.

**Mr COOK** — As I said, we are in a number of forums at a number of levels in terms of participation. The data is what it is, and providing it is depersonalised and unidentifiable, then essentially it can be used anywhere for anything. But that is for the good.

**Mr TILLEY** — Terrific, thanks.

**The CHAIR** — Thanks, colleagues. Thank you, Ambulance Victoria. We hope we only see you again in a social context. Thank you for taking the time to provide us with your insights and your expertise and the resources of your organisation. Thank you to other people who have contributed here today.

**Committee adjourned.**