T R A N S C R I P T

LEGISLATIVE COUNCIL LEGAL AND SOCIAL ISSUES COMMITTEE

Inquiry into Ambulance Victoria

Melbourne – Thursday 5 June 2025

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WITNESSES

Witness 1,

Witness 2 *(via videoconference)*, and

Denise Anderson *(via videoconference)*.

The CHAIR: Welcome to the closed hearings of Legal and Social Issues Committee. I declare that this Legal and Social Issues Committee session is open.

I acknowledge the Aboriginal custodians of the land pay respects to elders, past and present.

I would now like to introduce our committee. I am Joe McCracken, the Chair.

Ryan BATCHELOR: Ryan Batchelor, Member for Southern Metropolitan Region.

Renee HEATH: Renee Heath, Member for Eastern Victoria Region.

Ann-Marie HERMANS: Ann-Marie Hermans, Member for South-Eastern Metropolitan Region.

Georgie CROZIER: Georgie Crozier, Member for Southern Metropolitan Region and Shadow Minister for Health and ambulance services.

The CHAIR: We have got two members online as well. Dr Mansfield.

Sarah MANSFIELD: Sarah Mansfield, Member for Western Victoria.

The CHAIR: Ms Ermacora.

Jacinta ERMACORA: Jacinta Ermacora, Member for Western Victoria.

The CHAIR: Beautiful. What we might do to get this rolling is ask you, Witness 1, if you want to go first and just give a brief overview – we have probably got 3 or 4 minutes – then we will go to our witnesses online. Witness 1, over to you.

Witness 1: Thanks for the opportunity to come and present. I guess just a background on myself: I am a MICA paramedic of [redacted] both in rural Victoria and in metro. I have been in roles that involve being a team manager both for an ALS branch and a MICA branch, both in rural and in metro. I was a group manager in both sides of the business, rural and metro, as well as a regional manager [redacted], and I have also been a communications manager for rural and metro as well as currently now a MICA communications clinician in rural Victoria and still work as a MICA officer on the road. My submission effectively revolves around call-taking and dispatch, the issues of ramping, the current working conditions in the communications centre and obviously the workload associated with that and also looking at workplace culture and related OH&S and safety impacts and the impacts of that on paramedic morale both on the road and particularly in the communication centres.

I was a group manager in rural and I was effectively bullied out of leaving that role by a senior manager, and that was reported to VEOHRC; at this stage nothing seems to have occurred with that. I am currently a rural communications clinician in BALSECC, and the clinician group has been raising OH&S issues, workplace morale, extreme workload and physical and mental fatigue for about four years. All of that was documented substantially by the communications clinician group, and it was also basically documented by AV's own risk analysis in May 2024, which highlighted that the workload of the clinicians and the communications area was a significant health hazard and a major exposure to psychosocial hazards; that was documented by their own work as a result of that. The communications clinician role is a support paramedic to the people in the field as well as hospitals, patients and the specialist services of ARV, PIPER et cetera. We provide that liaison and also additional clinical support to ALS paramedics, particularly in rural; we work in the rural environment, so we are looking after single officers in Bairnsdale right the way through to Mildura and beyond. We also give a significant amount of support to the staff of Triple Zero Victoria. So in the call-taking and dispatch areas, we look after the call-takers in terms of additional clinical support, and we also look after the dispatchers in terms

of if they need to work away from their guidelines because they are, as you probably all aware, fairly strict in terms of that and they cannot move away from those guidelines unless they are actually authorised by a senior clinical person, which is us.

I guess as a result of the stress and the lack of support we actually presented to WorkSafe on four different occasions, and we have had four provisional improvement notices – two that were actually supported by WorkSafe, which we raised, and two that they have actually raised and they have implemented as a result of the stress. We have got a staff of nine currently that have been appointed, and relievers, and we have currently got five of those staff on WorkCover as a direct result of this. We would love to have them all back but we believe probably four will not return, and they have all got in excess of 25 to 30 years in the role. There are several clinicians that took sick leave, obviously as a result of working by ourselves on night shift from 7 o'clock at night until 7 in the morning. Several of the clinicians took some sick leave, obviously to manage the fatigue of being by yourself with very little breaks, and they were actually put through the fitness-for-duty process by AV to try and get them back to work, which subsequently now is a WorkCover claim and they are on WorkCover. I personally wrote to the previous CEO and also cc'ed the health minister about these issues on 24 July and was basically told to follow the process – hence, I guess out of frustration, my submission to you guys.

The CHAIR: Thanks very much, Witness 1. We will now move to Witness 2, if you would like to give a couple of minutes of your opening. You can take your submission as being read, but if there are any other comments you would like to make before we move on to questions.

Witness 2: Witness 2 is my name. I have been in the ambulance service [redacted] years, I think. I am a senior team manager [redacted]. My submission basically is around single officers responding to cases on their own and the psychological harm that it causes, the accumulation of stress over time and the emphasis on metrics rather than wellbeing of staff. The reason for my submission is watching people having to leave the job early or on WorkCover because of the mental overload of responding to cases on your own. What I am really looking for is a minimum standard that two paramedics show up at a case together. Now, they are supported by community officers, and they provide a physical support but they do not provide clinical or cognitive support. I have seen some of the most stoic paramedics – CSO MICA paramedics – have to leave the job under a WorkCover cloud and suffer PTSD. I have seen another paramedic grind her teeth flat with the anxiety of coming to work. And I can say some people are frightened to come to work. They have had to choose between their career and their own wellbeing.

Really the minimum standard is, generally across the state, two paramedics will show up to a case, but I think there are 31 caller locations left in Victoria where some are dual responders and some are still single responders. I am not saying that we need to get rid of single responders. What I am saying is two people need to arrive together at a case. If you are on call at a call branch, the call partners meet, usually at the branch, and then go to the job. But at all other times, whether you are SRU in metro or SRU in rural, you will get sent and your backup may come.

I can talk from my own experience. A few years ago, not that long ago, I got sent to a case that was a six-year-old drowned in a bath. My backup was coming from Tallangatta, which was 40 kilometres away. So the load, the stress that I felt – I went to one house: 'No, it's across the road.' Yes, having a partner in these situations makes a big difference. Even at a job when you are with an ACO, you have to watch what they do – if they put the dots on wrong on the monitor. They cannot give drugs; they cannot help you in a cognitive way. So then you are watching them as well as watching yourself. Then when you make an error you think. 'What am I going to do? Am I going to lie on my case sheet? I'm going to get a clinical review.' The stress of all those things over time accumulates on paramedics.

What I am really asking for is just two. You know, you have been in situations where you have gone to do something and your partner has tapped you on the shoulder and said, 'Oh, hang on a minute. We don't do that. Look at the heart rate.' And you go, 'Oh, thank you,' and you do not think anything more of it. But had I not had a partner do that, I would have gone home and agonised over that error and then worried about how I am going to cope with that. The clinical review – why did you do this? So it really is just that I want two people, paramedics, at a bare minimum to arrive at a scene together. And there is a safety aspect. New South Wales do not do it anymore; they have not done it for a long time. VicPol do not do it, and I think I put that in my statement. They do not do it either. So yes, that is the crux.

I think if you talk about culture – for me, culture is really just what you do on a daily basis, isn't it? Whether it is the food you eat, the clothes you wear, the race that you belong to, it is just how you go about your business on a daily basis. So how do we improve what we do on a daily basis as an organisation? And the organisation do make attempts, but I think there is a bit of a disconnect with the funding that they get and their ability. They have policies around psychological safety, but they are reasonably soft; they are about support rather than action and how we achieve these goals. So yes, I would rather not chase metrics and be run by a spreadsheet; I would rather there are human elements as well. We have policies and numbers to go by, but we also have to consider human factors. You cannot just let statistics make your decision. They need to assist you in your decision-making, but your decision-making still needs to be around people first.

The CHAIR: Are you happy to move on, Witness 2? We can explore some of those things in questions as well.

Witness 2: Yes, sure. No worries.

The CHAIR: No worries, Witness 2. Thanks. Denise, would you like to take your submission as read, and would you like to make any statements before we get into questions?

Denise ANDERSON: Yes, thank you. Thank you firstly for accepting my submission. I am speaking today as a resident and an employee of a private hospital, and I am a councillor in Towong shire. Our Ambulance Victoria performance report was very poor for our region, particularly Towong shire. It is my strong belief that ramping is a significant contributor to these results. Ambulance crews are unable to transfer the patients within a timely manner, preventing them from returning to base and attending to code 1 and to other code 1 emergencies. In rural areas like ours, where communities are small and close-knit, this often means that the responding officer personally knows the patient. The emotional toll of such delays should not be underestimated. There is a vast and critical difference between metropolitan and rural ambulance service delivery. This needs to be fully acknowledged in policy and funding decisions.

Being on the border community between Victoria and New South Wales introduces additional complexities, which – you have got no idea. There is often confusion over which hospital patients are going to attend. Ramping wait times and the overlap make decisions harder than they should be. Once upon a time the priority was always the patient and the seriousness of their symptoms. Sadly, that is no longer guaranteed, or appears to be, and that is nothing against the ambulance staff. As a councillor I have had many residents share their stories with me. What is most distressing is that while our frontline staff, ambulance and medical teams do their best, they are often operating with systems that are letting them down and in doing so failing the people that they are serving, and that weighs heavily.

I hope you do not mind, but I would really like to give an example that has happened to our mayor since – and I can do that in question time if you would like – of a heartbreaking experience he has had. It is up to you whether you would like me to briefly touch on it now.

The CHAIR: I am happy if you want to go through that now, Denise, and then we will go to questions.

Denise ANDERSON: Yes. After I submitted the statement our mayor Andrew Whitehead had a heartbreaking experience. His father had spent five weeks at Albury Wodonga Health with a blood infection before being transferred to Corryong. Corryong is way up the top of our shire. He was improving and beginning to feel better, but one Sunday he suddenly became unwell. An ambulance was called early Monday morning, and he left Corryong at 7:45 am for Albury, a journey that takes between 1½ and 2½ hours, depending on if there is a changeover with the ambulance. Due to the distance ambulances from Corryong are sometimes met halfway by regional crews, which sounds good in theory, but in practice this adds handover delays and disrupts the patient's continuity of care. That morning, after arrival in Albury, his father was then ramped for a further 5 hours before being admitted to the ED at 3:30 pm. A scan revealed his bowel blood supply was blocked, likely from remnants from the earlier infection. By then it was too late. His choice to have surgery or not was gone. He passed away the next day. This all happened when we went down to the rally in Melbourne, so it was very difficult for all.

Unfortunately, our mayor has had two experiences. His son recently had a serious fracture on the farm. His leg was badly broken, requiring air transport to Canberra. A helicopter was sent from Traralgon, but because of the distance fuel constraints became an issue. There was a doubt his mother could accompany their 11-year-old son

on the flight. Thankfully, the mayor was able to organise fuel from Corryong airstrip, but this should not be dependent on luck or personal connections.

Just one good thing: despite the challenges, I want to highlight a promising initiative, a trial in Mitta that has been started. Paramedics are trained and offer not only emergency care but also post-operative follow-up, district nursing, wound care and health education. This type of integrated model makes a huge difference in rural communities. It justifies additional paramedics and improves overall community health. These paramedics could also play a role with CPR and first-aid education and building community resilience.

For Towong shire, we have no choice but to go to Albury Wodonga Health. The long-awaited greenfield hospital has been scrapped in favour of a revamping of the current facility. That hospital is now consistently bed-blocked, with ED running at over 100 per cent capacity, while the recommended safe limit is 85 per cent. Sorry, there is a lot.

The CHAIR: That is all right. Thanks very much, Denise. I might start off with the questions first, and then we will just go around the different members of the committee. My first question is actually to you, Denise. You spoke in your submission about recruitment processes not being good, even in particular for volunteers and that sort of thing. Can you just expand on what you mean on that, please? Because I am interested to understand what you are talking about there.

Denise ANDERSON: We have a CERT team down our end of the shire, around half an hour from Albury–Wodonga. There have been several volunteers who want to be on that roster. It was taking them 12 to 18 months before they got a response. So I think they –

The CHAIR: Hold on. So you are saying that someone applies, and it has taken them 12 to 18 months just to get a response back? Is that –

Denise ANDERSON: Yes.

The CHAIR: Really? Wow.

Denise ANDERSON: I can get the actual stats on that. Our CERT team there has said that people have just given up because there was no response. I am not quite sure what the breakdown was. Admittedly, it was over the COVID period.

The CHAIR: Okay. Was it just one person or was it multiple instances?

Denise ANDERSON: No, there were a couple, I believe. I can refer or give you the contact details for our CERT team, and they can give you further details if you would like.

The CHAIR: Yes, if you could send that in, that would be great.

Denise ANDERSON: Yes, sure.

The CHAIR: You also spoke about the fire medical responses in your submission and the fact that they might be doing dual work. Can you just elaborate on that a bit more as well?

Denise ANDERSON: There was talk of the firies learning how to do CPR, but just speaking to our local members, they were so overwhelmed that they were hoping it would not be a preferred option for them. They felt that –

The CHAIR: So you do not think it is a good idea that that happens?

Denise ANDERSON: They felt that they are under enormous pressure with all the criteria that they need to follow now to become CFA volunteers, and they were concerned that that would just be another layer.

The CHAIR: Okay, that is fair enough. Witness 2, I just want to ask you a couple of questions as well. Your submission focused heavily on the need to move away from single paramedics turning up to jobs. I guess, from your experience – you touched on it in your opening. You said that it has a lot of mental health impacts. Can you elaborate on that and the impact that it is had, particularly on you?

Witness 2: Often it is an accumulation, or it can be a single event. But I am not sure how you would like me to elaborate other than what I have said.

The CHAIR: Can you provide an example of when you have turned up to somewhere or an experience that you have had – paint us a picture, I guess.

Witness 2: So if you turn up by yourself – you will get sent to a cardiac arrest, you are there by yourself; basically clinically all you can do is CPR, but there are more things that you could do if you had a partner, like airway management or giving medications. But really until your backup arrives you are just doing CPR, and the outcome of that is generally poor for the patient and then it is poor for the paramedic because he walks away from there feeling like he could have done more but he did not. He was not supported well enough, if that makes sense.

The CHAIR: No, that makes sense. I guess what you would like to see happen is generally a move away from that approach, to at least two paramedics turning up?

Witness 2: Yes. They do not have to be together as long as they arrive together, so that you walk in – and there are other occasions where female staff will be sent singly to a job, it will be dark, it will be a block of units and somebody will come out and go, 'Oh, you looking for me?' They may be drunk. People are getting put at risk just by entering scenes by themselves. There is safety netting but it is not always there, and the information that we are given is not always as accurate as it could be. So it is a safety issue. It is a mental health issue for paramedics. Like I said in my opening statement, some of the most stoic MICA paramedics that I have met have now left the job because they had to respond as a single officer. Another example I could give was an SRU paramedic sitting roadside at a motorbike accident. Single guy – his backup was so far away that he basically sat there and watched this guy die, and that affected him mentally to the point where he has now left the service.

The CHAIR: Wow. I am sorry. My time has run out, Witness 2, and I will pass to Mr Batchelor.

Ryan BATCHELOR: Thank you, Chair. Thanks, all of you, for coming in today. Mr Witness 1, I might ask you a couple of questions just about your experience as a rural clinician. I am trying to understand a bit better some of the specific challenges that rural clinicians face or rural paramedics face compared to what might exist in metropolitan areas in particular, so can you give us a short summary of what they might be?

Witness 1: Yes, 100 per cent. I spent 10 years in metro before I went to the country, and I have spent the last 20-odd years in rural. The biggest issue for the rural guys and particularly the rural clinicians is that we deal with crews but we do not have crews, so clearly after hours the amount of resources that we have is significantly reduced. Areas such as Bairnsdale or further down south – Portland, all those places and the surrounding areas, Kerang et cetera – have one crew probably on call. If we have got a transfer, for example, from Swan Hill or from Kerang to Bendigo, that basically takes that officer out for about 5 hours, so we can lose coverage for 5 hours.

Ryan BATCHELOR: Because you are doing a patient transfer?

Witness 1: Yes. The rural clinician is actually there to assist in terms of the patient's acuity – if they have got multiple IVs running et cetera, then we will work with them as to the best way to manage them. We will talk to the hospital about: 'Is it urgent? Does it need to go? Can we keep the coverage in the area clinically if the patient is not going for anything serious until the morning?' – for example. We will do that. Our role as the clinician in a rural environment is based around not only the clinical aspects but how best can we move these patients. For example, if we do not have air, and my last night shift we did not have air, because of the weather – they could not fly, clearly –

Ryan BATCHELOR: Sometimes that happens in Victoria.

Witness 1: Yes, 100 per cent. It is just the way it is. We had a patient up on the border that needed to come to Melbourne. We could not move that patient. We had all of the cars in that area ramped at the local hospitals, so they were ramped for –

Ryan BATCHELOR: Which hospitals – oh, they were ramped at different hospitals?

Witness 1: They were ramped on the border at both the hospitals that are up there. They were ramped for 5 and 6 hours. We spoke to air. Air could not move the patient, because they could not fly. By the time we actually got all of our crews back into the area, at the same time we were talking to patients in the community because they could not get an ambulance. The rural clinician will regularly ring back patients that have been waiting for a period of time to find out whether their condition has changed, if they are okay, if they need Panadol or if they have got somebody there that can provide some sort of relief and to get a general update on their condition. So that was still happening in the community. We actually got our crews back at about 4 in the morning. They had not had meals. They got back to have a meal at 5 o'clock. We could not then send a crew that had been out all night until 5 o'clock on a 5-hour trip.

Ryan BATCHELOR: Just briefly, and it sort of touches on some of the evidence we heard in the opening statements from everyone, how many of the challenges, do you think, in rural communities are being driven by resourcing or issues in the ambulance service itself, and how many are being driven by the interactions at hospitals, with emergency department capacity and issues associated with ramping?

Witness 1: Could I put a percentage on it? Some days I would say it is 100 per cent, and some days I would say it is 50 per cent. The interaction between the two is significant – like, really significant. We are leaving patients in the community that we cannot transport because the crews are ramped. We cannot get our cars back off for some of those on-call patients. As Witness 2 quite rightly said, the crews may have worked all day, and they are on call; they then do a long transfer, they go back and they are quite clearly fatigued. They have done16 hours or something during the day, so they have to go and have a break, and that then impacts on the entire area that is left uncovered.

Metro is always busy. I get that; I have worked there. I understand that we have ramping in the metropolitan area, and we have shortages in the metropolitan area very clearly. But the issue is that you can generally move a car from a further distance away and still have some sort of coverage, whereas in the community yesterday we had the entire area surrounding Hume with about two cars – for the entire area – and that was in the middle of the day.

Ryan BATCHELOR: Thanks.

The CHAIR: I might pass on to Ms Crozier.

Georgie CROZIER: Thank you, Chair. Thank you all very much for coming before the committee and providing your evidence. Ms Anderson, thank you so much for the story that you told us about your mayor. I am very familiar with that story, because they have spoken to me personally about it, and I find it absolutely disgraceful what occurred.

Can I go to you, Mr Witness 1 – thank you so much for your submission and the evidence you have provided – and go back to the issue around the rural clinician, that role that is incredibly important, and that interaction with Triple Zero, the dispatch and the call takers. Have there been any incidents where Triple Zero call takers have not had access to onsite clinicians that you are aware of?

Witness 1: Yes. We have had one single clinician, as I detailed before, overnight for multiple years, and that is hence why WorkSafe came in and actually did that. It is one of our roles, very clearly, and we take it incredibly seriously, and we have a great relationship with the call takers and dispatchers. They are absolutely brilliant. But we had an example of a lady in Geelong, unfortunately – I will not go into too many details, but it was in Geelong and she was pregnant. She had a PV haemorrhage, so she was bleeding. There was no rural clinician.

Georgie CROZIER: That is an extremely dangerous situation for both mother and baby. I am a former midwife, so I understand exactly what you are talking about. You are saying there was no clinician available to guide that 000 call? Is that what you are saying?

Witness 1: There was no clinician in the rural communications centre.

Georgie CROZIER: What happened?

Witness 1: The ambulance service Victoria decided that because of the WorkSafe PINs, WorkSafe improvement notices, the only way, instead of recruiting to the role, was for them to move the rural clinicians to Tally Ho in Melbourne.

Georgie CROZIER: So just to make that clear for me, you are saying that those roles are now based out of Melbourne, not in regional Victoria.

Witness 1: They actually tried that. We have fought that for 2½ years.

Georgie CROZIER: What has happened with it?

Witness 1: We have now actually got an agreement that those roles will stay, and they are going to go through the process of recruiting.

Georgie CROZIER: Sorry, so they are back in regional Victoria –

Witness 1: They are back now in regional Victoria.

Georgie CROZIER: but you had to fight for 2½ years with Ambulance Victoria to have that representation for rural and regional Victorians?

Witness 1: Yes.

Georgie CROZIER: Why were they wanting to move them into Melbourne?

Witness 1: To be perfectly honest, Ms Crozier, it has nearly broken all of us.

Georgie CROZIER: You said there is nine staff and five are on WorkCover. Is that part of the pressure, because you have been fighting with AV, not getting heard? Is that what I am hearing here?

Witness 1: Yes, correct.

Georgie CROZIER: Well, I am really concerned about this, because that means that rural and regional Victoria, with a large part of our population, is not being represented to the best capacity. I do not want to put words into your mouth, given what you are trying to do for that community.

Witness 1: Like I said, we have fought we fought this for 2½ years, and the evidence –

Georgie CROZIER: Who were you fighting with? Was it the CEO? Was it AV? Who was making that decision?

Witness 1: The communication centre management, HR, they all – I do not understand the funding. I am an accountant in a previous life, and I still do not understand the funding, to be perfectly honest.

Georgie CROZIER: Did they say it was a funding issue?

Witness 1: Well, we were told it was a funding issue. We were told that it was a resourcing issue, management issue, and hence WorkSafe came in and were brilliant. They actually put an improvement notice on AV themselves, because they said, 'You're killing people.'

Georgie CROZIER: What do you mean 'killing people'? Have people died because of this failure?

Witness 1: Five of those people have – well, they have not, you know, done any harm to themselves, but –

Georgie CROZIER: Oh, you mean the paramedics.

Witness 1: Yes. We were actually not in the rural communications centre. They wanted to transfer us all to Tally Ho.

Georgie CROZIER: Where do you live?

Witness 1: I live in Sunbury, and I go to Bendigo and work in Bendigo and Ballarat. A lot of our guys that work up there – I am the probably one of the closest. The others live in Bendigo, Ballarat, Geelong.

Georgie CROZIER: So they are expected to come to Tally Ho and work out of there to do this work, not in their community?

Witness 1: And they are not supporting the guys in the room.

Georgie CROZIER: Are rural and regional Victorian patients being put at risk because of this decision?

Witness 1: Oh, 100 per cent.

Georgie CROZIER: Thank you.

The CHAIR: We have got to move on, I am sorry. Ms Ermacora, you are up next.

Jacinta ERMACORA: Hello. Thanks for coming in, and thanks for being willing to share the stories that you have brought forward. We really appreciate it. I just want to clarify something before I go into my line of questioning, what I was thinking of. Mr Holman, you mentioned just now a lot of our guys and also rural guys. So do you use the word 'guys' meaning women and men ambos or just the male ambos? I just want to be clear on that.

The CHAIR: Ms Ermacora, I think you are referring to one of the previous witnesses.

Jacinta ERMACORA: Yes. Witness 1, sorry.

The CHAIR: Mr Witness 1. Okay, sure.

Witness 1: No, we use the word 'guys' colloquially. It is every one of us, males, females; we are all together.

Jacinta ERMACORA: I just wanted to clarify that. Also, I think, Witness 2, you mentioned 'he' too, and I wondered whether you meant the same as Witness 1 in terms of what we used to call the generic 'he', which was 'he and she'.

Witness 2: Oh, yes, definitely, unless I was speaking about an individual case, knowing the paramedic. In that example it was a 'he', but it was just generic. Yes, definitely there is no gender bias in any of this.

Jacinta ERMACORA: Okay. I guess I just want to understand some of the changes that have been going on that you referred to and with all of the experience that you have all had. Just in relation to diversity and inclusion, how do you see that challenge for a regional community?

The CHAIR: Who was that to in particular, Ms Ermacora?

Jacinta ERMACORA: Either – all three.

The CHAIR: Would someone like to respond?

Witness 1: I guess from my perspective, as paramedics and people that work in the field and in the health profession generally, we treat everybody equally. There is no gender inequality. We work hand in hand with males and females. We treat everybody exactly the same, as quite rightly we should. I spend a lot of time looking after people in rural Victoria, and clearly as a result of doing that the one thing I do see is that people in rural and regional Victoria have a much harder task in terms of accessing things that we take for granted, I guess, in the city.

Witness 2: I think to add to that, the role itself is a non-judgemental role. You are put in a lot of different environments with a whole diverse community. Basically, paramedics do not judge what they go to. They just treat what they see and they do not really judge people on their environment or who they are or what they are, and I think that extends to how we treat each other as well.

The CHAIR: Do you want to make a comment too, Denise?

Denise ANDERSON: No, that is okay. I did have an example for the ambulance ramping, that is all – when you are ready.

Jacinta ERMACORA: Oh, right. So perhaps going back –

The CHAIR: We have just run out of time, Ms Ermacora, but I am happy to give you one extra question because of the disruption.

Jacinta ERMACORA: Thank you. In your experience – perhaps this is for Witness 1 – how effective has Ambulance Victoria's management been in addressing the concerns raised by rural clinicians, which sort of goes a little bit to what has been talked about?

Witness 1: To be honest, it has taken an incredible fight to get where we are. With the help of the union, with the help of WorkSafe, with the help of the Fair Work Commission, we have now actually got – we think we have not got the staff yet, but we think we are in a reasonable position. Ambulance Victoria keeps talking about consultation and things like that. We were told about being moved to Tally Ho effectively with a week's notice. We were told that that was consultation. I was an ambulance manager, and to be honest, I would never have treated my staff like that. How they managed it – we should not have five of our most senior MICA paramedics on WorkCover, probably not to return. That would be my answer.

Jacinta ERMACORA: Awesome. Thanks.

The CHAIR: We will now move on to Dr Heath.

Renee HEATH: Thank you. Thank you all for your submissions and for coming in today. Denise spoke about the community emergency response teams – the CERTs – not recruiting, and that seems to be something that is happening across the state. In regional areas, do you think CERTs are something that need to be invested in and to continue on?

Denise ANDERSON: Thank you. Yes, absolutely. We would be dependent on Albury–Wodonga ambulance services, and they are quite difficult to get. I will use my example. I am a chronic asthmatic, and I would be very fearful if I had made that call and did not have the CERT within my vicinity.

I do have an example. A colleague of mine who is a medical professional was at home in Albury. In Albury and Wodonga, cross-border, the ambulances all work with each other. She was at home and she realised she was having a heart attack. They called 000 and followed the instructions to take the three aspirin, and a family member fortunately had them on hand because the operator then – she did not realise at the time, but that operator was beside themself – had to tell her that there were no ambulances available in the region, in Vic or New South Wales. They eventually got an ambulance from Wagga, which is in New South Wales, an hour and a half away, which happened to be 45 minutes away. So then she had to sit that out, that 45 minutes, waiting. She truly – and she has said this to me – believed she was going to die. Thankfully, she did survive. But this is where I find it is quite overwhelming, and I can imagine what the ambulance officers feel like. The people who have told me these sorts of stories – and we are not just talking about one or two, that is the sad thing about it; we are talking about lots of stories, and a lot of people do not know what to do with that, to unload it, where to go, who to talk to about it. Then there is that privacy thing, that they are also very guarded on what they say. And they really want to protect the ambulance officers because they have not done anything wrong; the staff have not done anything wrong. It is the system – that is the crux of it all. It is the system.

Renee HEATH: Yes. It would be important, though, because I guess CERTs play an important role in regional areas because there is someone local that can care while you are waiting for ambulances to make a long commute.

Denise ANDERSON: Absolutely, yes. We have a very big shire. In our shire we have 6675 square kilometres. We have three hospitals, only small, which have been scaled back, so of course the pressures on our hospitals are greater. In our western end we have a paramedic and volunteers. In the south we have two volunteers, which is the Mitta Arm, and then at our end we have the CERT team, and Tallangatta also has one ambulance. But often, as has been mentioned, they could be taken for the region. They try very hard to keep one there, but it does not always happen.

Renee HEATH: Thank you. I just want to ask you as well, Witness 1: do you think that the amalgamations of hospitals will have impact on Ambulance Victoria being able to arrive in appropriate times in regional areas?

Witness 1: I think anything that reduces the amount of areas that we can take patients to will clearly have an issue for ambulance ramping. We have got major hospitals in Bendigo and Ballarat and Wangaratta et cetera – Latrobe. But we would take a lot of the less high acuity patients to Warragul, take them to Leongatha, take them to Wonthaggi or take them to smaller areas where they might just need stitches or assessment for 4 hours for a head injury or stuff like that. So if we are amalgamating hospitals and we are taking opportunities to take some of those patients, then that means, from my simple perspective sitting in the control room, we have got to take more patients to bigger hospitals with the potential of being ramped.

Renee HEATH: More ramping. Yes. Thank you.

The CHAIR: Dr Mansfield.

Sarah MANSFIELD: Thank you. Thank you for appearing today and for your submissions. I am interested in what you have raised about the need to have two paramedics or at the very least two clinically qualified personnel as a mandatory requirement on all ambulances. I think it is a very reasonable one, and I think, Mr Witness 2, you made a very strong case about that. Is there enough capacity in the existing system to do that? Do we have the staffing resources, and is it a matter of reorganising it and creating different rules and expectations?

Witness 2: I suppose one of the issues in remote towns is housing. There would be the option of creating a resource hub in some of the bigger centres – say, Wodonga, Wangaratta, Shepparton or whatever – and then two paramedics would leave that branch in the morning and go and support these other branches. Right now the smaller rural locations with the single officers are actually coming into the bigger centres and doing the work in there because there are not enough staff in those centres as well. I suppose it comes down to funding. You know, that could do it. For example, Beechworth is a call branch, but it has two paramedics on the car every shift, whereas Tallangatta, Chiltern and Corryong have a single officer. So there is an inequity across the state. They have upgraded some of the call branches, but they have not upgraded all of them. I think they need to continue that upgrade. To me, the biggest thing they need to do is go to a two-officer model, with two paramedics on every car. But that explains that, and it would be funding, I am sure. If you are a graduate paramedic now, the wait time to get a job with AV is up to three years, so once you have graduated you can wait three years to get a spot. And there are lots of graduates; it is just the funding to get them.

Sarah MANSFIELD: So we have got workforce in the pipeline, but we would need more funded positions to actually get them out on the road.

Witness 2: We use an FTE-funded model, which I think is dated. For example, today there is a single paramedic in Wodonga, and there is a single paramedic in Chiltern, without an ACO. We could pair them up. But Chiltern's FTE funding is only a single-officer model, so we cannot even pair them up. We can call the duty manager and he can do it, but rosters cannot pair those two up. On a day where there are two paramedics, on a changeover day at a call branch, they have to run out of separate cars. They cannot run together, because the funding is a single-officer model, not a dual-officer model. That funding model is flawed, just like the LGA model is flawed for resourcing. Where Denise comes from – I am from the same area – Wodonga's LGA is 430 kilometres. It has two cars, day and night. Every other branch in the Indigo–Towong area is a call branch. When they are all on a fatigue break, Wodonga's response area goes from 400 square kilometres to 9000 square kilometres, so it is a 2000 per cent increase in their response area while the call branches are on fatigue breaks. Again, the LGA modelling may work in metro as far as resourcing goes. But in rural it does not work, so there needs to be a different model for resourcing. I think that comes more down to planning, as far as the FTE and LGA models go for resources. I hope that answers your question.

Sarah MANSFIELD: That is great. Mr Witness 1, did you have any comments on that?

Witness 1: I think what Witness 2 is saying is fairly valid. The environment of having a single officer covering towns is frustrating at times, there is no doubt about it, because if the guys do not have an ACO volunteer to support them, then we quite rightly, 100 per cent, need to send a double-officer crew from a fair way away. In the case of Kerang, as an example, we have to send somebody from Swan Hill or Charlton. Again, it has a compounding issue of actually denuding an entire area of coverage. The whole thing is

intimately linked because you then move a car. We have to move cars, for example, from Bendigo, when all the cars are ramped in Bendigo. We have to move cars from Heathcote, which is an on-call branch, to cover. We have to move cars from Castlemaine up the Calder. We do it every day; we do it every night. But that then leaves big holes in the coverage on the southern Calder. It is this compounding of rural and regional Victoria – which makes our job – and for call takers and everybody in the system – frustrating and stressful.

Sarah MANSFIELD: Thank you.

The CHAIR: Thank you very much. We will now move on to Ms Hermans.

Ann-Marie HERMANS: Thank you so much. And thank you, Witness 1 and Witness 2 and Denise – Denis is gone – for all the issues that you have been raising today. I notice, Witness 1, on your report initially from what I can see there were four rural clinicians today. You have mentioned five. So there has been an increase since you actually put in the report. Is that correct?

Witness 1: We have got a guy who has currently put in a WorkCover claim. He is on, we hope, short-term sick leave, and hopefully he will be back. But it is directly as a result of what happened.

Ann-Marie HERMANS: You have touched on the majority of these WorkCover claims being to do with stress and fatigue. Could you just elaborate on that a little bit?

Witness 1: Yes. When the model was first introduced in BALSECC in Ballarat in the call centre, the workload was nowhere near as great, obviously. Over the years everything that the government do and everything that we all do has increased exponentially, I guess. So having one clinician working by themselves was sort of doable; we got away with it. But now with the workload that is associated with the rural clinician – we authorise thrombolysis for heart attacks, so we now are the first port of call for the guys in the field to administer drugs to prevent and to actually resolve heart attacks. We deal with trauma, so we deal with Adult Retrieval Victoria, we deal with the hospital notifications, we deal with the stroke service and we deal with PIPER as well as supporting the guys in Triple Zero Victoria. The workload when you are by yourself – it is stressful if I am on a call to try and deal with a patient that is having a heart attack and I need to authorise a crew to thrombolyse a patient and a call taker hits the button and they need support. Who do I go to? And the stress of the ongoing arguments about trying to get support – it has hurt families. There would not be a rural clinician that has not been impacted. I will put my hand up and say after fighting for 2½ years I have felt the strain as well.

Ann-Marie HERMANS: Thank you so much for sharing that. You have mentioned that lack of management support as well, and I know that in my background we used to have what we called supervision. It was not to supervise you; it was actually to have the opportunity to express what you had just experienced and seen and to have that downtime. There does not seem to be that in the model from what I am hearing from Witness 2 and from Denise and from you, when you come back after you have had a large job, and also the CERTs do not have this model either. There is not built into the system an ability or a way other than with your own colleagues, which if you are on your own you do not have, to actually have that debrief session. Would that be correct? Could you expand on that?

Witness 1: The service provides peer support and we have access to clinical psychologists and things like that, but you make a really valid point. If I am by myself at 3 in the morning and I have dealt with a lady in Geelong that is having a PV bleed or whatever, or a heart attack patient or something like that, who do I talk to?

Ann-Marie HERMANS: So there is no-one that you can actually ring for a debrief – that is not built into the system whatsoever. You also touched on issues of being bullied within the workplace and that causing additional stress. Are you able in the last seconds to expand on that?

Witness 1: Yes. I was a group manager supporting teams in the Grampians, and obviously as a practising MICA officer I had a response car with all the MICA equipment. I had a fantastic manager who made it very clear that our role was to manage our people, look after our people, and if you are the only MICA paramedic in the area, you need to go and support the community. When he left, unfortunately, and the new manager came in, he told me that basically I was spending too much time supporting the community and not enough working as a manager and that I should stop doing that; otherwise I could look for something else to do. I joined the job

from being from being an accountant to actually look after the staff and to look after the community, and so I elected to become a clinician.

Ann-Marie HERMANS: Thank you for sharing.

The CHAIR: Thank you very much. That brings an end to our session of hearings at the moment, and I would like to thank our witnesses. I think Denise might have gone offline, but Witness 2 and Witness 1, thanks very much for your time today and your contribution. We will close this session.

Witnesses withdrew.