TRANSCRIPT

ROAD SAFETY COMMITTEE

Inquiry into motorcycle safety

Melbourne — 17 October 2011

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Ms F. Diver, executive director, hospital and health service performance division, Department of Health.

The CHAIR — Colleagues, ladies, gentlemen and submitters to the inquiry, thank you for attending today. I welcome you today to the Victorian Parliament's Road Safety Committee inquiry into motorcycle safety. The committee has received 68 written submissions since releasing the terms of reference and inviting submissions. We are grateful to see you today, and thank you for the report that you submitted earlier this morning.

You are reminded that anything you say or publish before the committee today is protected by parliamentary privilege. However, once you leave the hearing, anything you say or publish outside the room is not so protected. Hansard will be recording today's proceedings and will provide a proof version transcript so that any typographical errors can be corrected. I note there are many observers in the room, and I ask them to ensure that their mobile phones are turned off. They should note that no recording of the proceedings is allowed. I ask those in the background to keep noise to a minimum.

I welcome you, Ms Diver, and invite you to speak to your submission, following which we would like to ask a few questions.

Ms DIVER — Sure. Thank you very much for the opportunity to attend. Just to be clear, I am an executive director in the Department of Health with responsibility for health service performance, which, amongst other things, is all about hospital funding, performance and also acute program policy, which includes the trauma system. My contribution today will really be about the treatment services for motorcycle-related injuries across the system.

I have prepared a dozen or so slides, hard copies of which have been circulated to you, and I thought that might be the best way to give you an overview of the system from my point of view. Feel free to stop me along the way if there are questions, and I am happy to take any questions at the end. If people are happy with that, I will proceed.

What I thought I could do is talk about the role of the department, talk a little bit about prevention, treatment services and information funding, and provide a high-level summary of trends in hospital activity. As I am sure many of you are aware, the Department of Health is responsible for policy, planning, funding and performance monitoring of public health services, but of course we have a role in public health functions, particularly prevention, which you would be most interested in.

Health services in Victoria are provided in both the public and private sectors, but of course the Department of Health has a particular role with public health services, and our public health services operate under a devolved governance arrangement, with their own boards. The Department of Health has a policy, planning, funding and monitoring role but the day-to-day management of health services is the responsibility of health service management under boards that are appointed by the Minister for Health. I can talk about the broad system and then you may have more specific questions about how the system operates, and I understand that other people will be presenting to you such as the Alfred hospital in relation to the specifics of day-to-day operations.

The next slide is headed 'Prevention'. It is worth noting that the public health and wellbeing plan was released in September this year — just last month — and I am very happy to provide a copy to the committee. The public health and wellbeing plan outlines a range of overall prevention activities to promote the overall wellbeing of Victorians. In the plan there is a statement, which I have quoted, which determines that there will be an injury prevention plan developed over the next 12 months. This is a new piece of work that the department has established that will be undertaken as the development of this injury prevention plan — and transport-related accidents are part of that intervention plan. It is something that will be undertaken as a whole-of-government thing and not just with the Department of Health and particularly alongside local government. But clearly the TAC and VicRoads have a role in that as well, so that is on the prevention side.

On the treatment side, which I am much more directly accountable for, I am not sure whether others have spoken to you about the Victorian state trauma system. It is about a decade old. There was a review of trauma systems back in the late 1990s which oversaw and recommended some significant changes to the way trauma services were provided in Victoria. The Victorian state trauma system provides for a very clearly established role delineation system where we have established levels of service. We have major trauma services and then we have other trauma services. The Alfred and Royal Melbourne hospitals are the major adult trauma services; the Royal Children's Hospital being the paediatric trauma service. We have two specialist trauma services — at the Austin for spinal and St Vincent's for microsurgery. The system of having major trauma services was

developed in line with some evidence that showed there was some avoidable mortality in trauma services and that if we defined a particular framework of where major trauma patients should be treated, then we would reduce that avoidable mortality.

Ten years later I would have to say that in terms of its system Victoria is held up as a pretty good system, where we have been able to show that we have had improvements, as in a reduction in mortality and morbidity-related to trauma, and that on an international scale we operate favourably when compared to other major trauma services in the world.

One of the significant changes in the trauma system was this moving of major trauma patients to major trauma services with a target of 75 per cent who should attend a major trauma service rather than a local service, and we are now exceeding that target. The latest data I have seen shows that we are achieving 82 per cent of major traumas appearing at one of those trauma services. That may be primary attendance, so it might be from the site of an incident straight to a major trauma service or it might be a secondary transfer, so they may go to their closest hospital and then be transferred to a major trauma service.

As part of the major trauma service there have been a number of collaborations with the Transport Accident Commission, and one of them in particular is the development of the registry, which I will talk a little bit about in a little while just to give you a sense of what information and data we have that you may be interested in and that you could seek further information about — and we have provided a high-level summary of the data. You may or may not be aware that hospital activity is captured through a number of major standardised datasets. These are national datasets using national definitions. They're generic in nature because they are major national datasets. It is the basis of our payment system to hospitals. But for some particular specialties we have registries. They are known as clinical registries. For example, there is one for cardiac and there is one for vascular, but there is also one for trauma. The trauma registry is what arose out of that review in the late 1990s and the development of the new Victorian state trauma system. We have an extremely well-developed registry for trauma services, which produces an annual report that I am very happy to provide to the committee. It has been producing an annual report now for nearly 10 years.

The other data we have is our emergency department data, which collects presentations to emergency departments in public hospitals only. We also have the admitted dataset, which collects admissions to hospitals — that is, admitted to an in-patient bed for both public and private. It is fair to say that the data collection is more robust for public health services, because that is the basis on which we pay public health services, so it is a pretty strong dataset. Activity on public hospital performance is available on that particular website that was released earlier in the year, but the department also provides an inquiry help service to respond to requests for data, and the details of that are also contained there. We often provide information to Victoria Police or WorkSafe or the TAC.

Moving on to the next page, the state trauma registry, which was established in 2001, monitors the activity, performance and effectiveness of the state trauma system in both public and private hospitals. The trauma registry is based at Monash University. Professor Peter Cameron is the director of the trauma registry, and he is a clinician and ED physician. It is co-located at the Alfred hospital. It is a separate registry which is funded jointly by the TAC and the Department of Health. That is the way the Department of Health monitors the functioning of the trauma service, but clinicians also use the trauma registry for research and service improvement work. We also provide that data to the Transport Accident Commission.

I will keep moving along to funding arrangements. There was a question put to us by the secretariat or through the terms of reference about the funding arrangements and perhaps some of the costs and the position of motorcycle-related trauma. Just in case people are not aware, hospitals are funded on an output basis; it is a casemix payment system — or else it is a combination of casemix, bed day rates and fee-for-service arrangements. Essentially there is a very large costing system. That costing system feeds into the development of casemix payments for like groups of patients, who are often called DRGs, which is diagnostic-related groups.

That is the way we fund public hospitals. We determine the casemix payments, so for a hip replacement the costing is all built in. A hip replacement is X, a hysterectomy is Y or a maternity patient is Z, and that is the case payment. That is for public patients. For private patients there is a different arrangement because of the private insurance arrangements. The private insurers pay a bed day fee or a casemix payment, and then the medical

staff are able to operate on a fee-for-service basis using the commonwealth medical benefits schedule as the guide.

The TAC as an insurer operates a bit like a private health insurer, so the funding arrangements for TAC to hospitals are slightly different to public patients. For public patients the Department of Health, from state government appropriations, will pay hospitals casemix payments. For Transport Accident Commission patients the Transport Accident Commission pays the Department of Health a rate for the casemix payment, excluding the medical fees. That casemix payment is based on our costing system and is determined with independent advice, most recently from KPMG, and it has complexity loadings and CPI. That rate is agreed upon between the TAC and the Department of Health, and then we pay that payment to a health service based on the actual activity. Medical staff operate on a fee-for-service basis and directly invoice the Transport Accident Commission. There are some subacute and rehabilitation payments that are also billed directly to the Transport Accident Commission.

It sounds like a complex arrangement, but it actually works reasonably well in most instances. There are also some other payments that are embedded in the system that the Department of Health will pay using the TAC funding — so performance incentives. For example, when the state trauma system was established an additional payment was paid to small rural or other metropolitan hospitals when they transferred a patient to a major trauma service to reflect the cost of transferring the patient and to encourage those health services to move the patients to a major trauma service. There is some specified funding for the major trauma services to help them meet the cost of providing the leadership role across the sector.

In terms of the cost of individual patients treated, this presentation outlines that the TAC WIES — WIES is our case payment — has a WIES weighting of 1.9, so it is a weighted case payment, and really what that last dot point is saying is that the TAC WIES was 1.9 compared to an average WIES for all other patients. It just shows you that the TAC patients are much more complex patients and are more than double — nearly three times — the cost of an average patient in a public hospital.

I will keep moving on to the data. The two datasets held by the department are the admitted episode dataset and the emergency minimum dataset, which I described to you earlier. That lists the data that we have provided to the secretariat separately. This data gives a detailed analysis of the last five years, which can really talk about activity, a little bit about the disposition or the discharge destination and what the cause of the original injury was.

I will move on to trends and hospital activity. Surprisingly to me, the number of presentations to public hospital emergency departments is actually only about 5000 per annum and has not necessarily increased in the last five years. The number of admissions to all hospitals in the last year for which we have complete data — that is, 2009–10 — was 3310, and that had increased. The growth in the increase in admissions was at the major trauma hospitals and the private hospitals, but the private hospitals were operating off a very low base with a very small number of admissions — only 200. I should just point out that admissions are all admissions for motorcycle-related injuries — that is, a patient who gets to inpatient bed. Major trauma is a subset of all admissions and is only the more serious cases. For the last year that we have complete data, which is 2009–10, there were approximately 300 of those patients.

We move to the next page, and the trauma registry data shows us that motorcycle accidents are ranked third in the 10 most common mechanisms of injury for major trauma patients. Whilst there has been no change in the overall incidence of motorcycle-related major trauma, the most significant change that we can find in the data is the incidence of off-road motorcycle-related injury, which has increased. The incidence of on-road injury appears to be stable or reducing in some age groups, but the off-road motorcycle-related injury appears to be increasing. It is true to say that in some of the datasets the mechanism of injury is not always completed, which makes it a little difficult to analyse the data.

Not surprisingly the majority of admissions related to motorcycle accidents are for males aged 16 to 49 years, but in fact the biggest growth in the admissions was in the older age group of 50 to 74-year-olds. There has also been a reduction in the number of admissions of children aged 0 to 15 years old.

I think I am nearly at the end of the data. The last two slides reinforce the point that there are some problems with the dataset and that in the dataset the specification of the motorcycle accident — that is, whether it is

on-road or off-road — was only identified in 50 per cent of the cases. The data is improving, but it does show that in the 50 per cent of cases where it was identified whether it was an on-road or off-road accident it was the off-road accidents that had increased more significantly.

The final point to make is that off-road accidents accounted for 58 per cent of the hospital admissions, which was almost twice as many admissions as those that resulted from on-road. The simple message to come out of that is that if you have an off-road accident, it is more likely to be more serious because you are more likely to have an injury. Those are the ones that are growing.

The CHAIR — Could you just clarify the statistic that off-road motorcycle accidents accounted for 58 per cent of hospital admissions?

Ms DIVER — Motorcycle-related admissions.

The CHAIR — Right. I thought I had a hold-the-front-page story for the *Herald Sun*!

Ms DIVER — No. My apologies. Off-road motorcycle accidents accounted for 58 per cent of hospital admissions related to motorcycle accidents. I am just making sure that is very clear.

Mr LANGUILLER — Thank you so much for your submission; it is a good one. It provides very important information for the committee. We note in your submission that the number of acute admissions for off-road motorcycle accidents is significantly greater than the number for on-road motorcycles — 4269 off-road versus 2835 on-road — yet the Transport Accident Commission thinks that the TAC's clients are generally on-road riders. Can you help us to understand the discrepancy?

Ms DIVER — Regarding off-road and on-road, the TAC is probably in a better position to answer you than I am, but my understanding is that the TAC does not cover care for off-road motorcycle accidents so the TAC would not have that data. The TAC only covers on-road accidents or 'traffic accidents', as I think they are described.

Mr LANGUILLER — By way of supplementary, what would happen if a person turned up and that person had an on-road injury? Would they be referred to the TAC via the same method?

Ms DIVER — Correct.

Mr LANGUILLER — And if the injury happened to be off-road, would it be treated and covered in terms of costs by the hospital, private insurance or other arrangements?

Ms DIVER — Correct. When a person with a transport-related injury arrives in a hospital a claim is lodged with the Transport Accident Commission. If accepted by the Transport Accident Commission, their care would be covered by the Transport Accident Commission, and that process of the Transport Accident Commission funding the department and us then funding the hospital based on the Transport Accident Commission arrangements would occur. If the person arrives in an emergency department with an injury — for example, an off-road motorcycle injury, which is not covered by the Transport Accident Commission — that patient will be treated in a public hospital as either a public patient or a private patient.

Mr LANGUILLER — Can I clarify this further? What is the basis, what is the knowledge and what is the understanding of the emergency department in terms of what constitutes off-road? I am not sure, and I am not sure that the TAC is sure of the definition. I know how it happens in emergency departments; it all happens very quickly, I understand that. Do you know?

Ms DIVER — It is a matter of a claim being made to the Transport Accident Commission that then accepts or rejects the claim based on whether it is part of its criteria for accepting the claim.

The CHAIR — There would be separation at the start, because it could be a TAC claim or a WorkCover claim if the person had been at work or even had an on-farm sort of accident, which is in a sense off-road. If they were working, there would be a WorkCover element to it. There is a third category of the recreational, off-road, dirt-track rider. Your advice is that that person would not be a TAC or WorkCover case. They would therefore be a public health patient or a private health patient. There is a separation between the two.

Ms DIVER — Correct.

Mr TILLEY — I am trying to think whether we have covered it sufficiently. Specifically my question relates to costs. In your submission you have not been able to provide the cost of motorcycle trauma as a whole figure. The committee has asked the department to provide the committee with that information. Has the department quantified the cost of motorcycle trauma specifically compared to other incidents of trauma, and if you have, are you able to provide that information to this committee?

Ms DIVER — I can take that on notice. I am sorry I have not been able to provide enough detail to you today, but I am happy to explore providing more detailed data on the total cost of motorcycle trauma. What I can say is that we can derive some of that information. If I make an assumption that motorcycle trauma is approximately the same as all TAC trauma, then the least weight of those patients is approximately $8000 to $9000 a case. I can multiply that by the number of admissions, then I can come up with some data. I can come up with some total costs, but it is derived from making assumptions between datasets. That is something we probably can do.

We can certainly give you some costing data. If you are interested in much more detail about data and trends, whilst I can give you relatively high-level data and certainly access to the information, Professor Peter Cameron, the head of the trauma registry, is probably somebody I expect the committee would like to have some engagement with because he is the head of the trauma registry. He has also published in journals on motorcycle-related trauma an article which I can leave for you if you would like me to.

The CHAIR — That would be very helpful, thank you.

Ms DIVER — There was a journal article entitled 'Motorcycle-related major trauma: on-road versus off-road incidence and profile of cases'. That was published in 2010 in the *Emergency Medicine Australasia* journal.

Mr TILLEY — If a patient presents at a public hospital as a result of a vehicle crash, in particular a motorcycle, is there a difference between presenting there and having some minor treatment and not being admitted? Would the data be captured only if you are admitted after treatment?

Ms DIVER — Yes. What you have picked up is that there is a dataset for emergency departments, and that dataset operates only for public hospitals. The private hospitals that have emergency departments do not contribute to that dataset. For emergency departments you turn up, get treated and maybe go home or maybe get admitted. That dataset covers our, now 40, 24-hour emergency departments.

Mr TILLEY — What we are missing is somewhere in excess of 2500 incidents of motorcycle crashes. Somewhere that is missing in all of this; somewhere it is not being captured. In your evidence you said to us that there were approximately 5000 whereas in fact off-road there are 4269 and 2835. That figure of 5000 per annum is somewhere short of around 2000.

Ms DIVER — What we are talking about is the difference between arriving in an emergency department and having treatment and then going home. But 3000 of those 5000 are actually admitted to hospital. Five thousand people turn up in emergency departments; they stay in the emergency department, they have some treatment within the emergency department — possibly minor treatment such as an X-ray or something fairly simple — and then they are discharged. Of those 5000, 3000 go on to have a hospital admission and go into a ward bed.

Mr TILLEY — Yes, all right.

Ms DIVER — The 3000 is a subset of the 5000. What we are missing, if you are looking for missing data, is patients who present to private hospitals. I do not have that data. However, the admissions to private hospitals are very low. Whilst there has been an increase in admissions to private hospitals, they are very low — 255 admissions to private hospitals in 2009–10 for motorcycle-related trauma out of 3310.

Mr TILLEY — Thank you.

Ms DIVER — Does that help?

Mr TILLEY — Yes, it does.

Mr ELSBURY — On that particular issue of the data, even though it is perceivably quite a small amount that we are losing, would the Department of Health be happy to report motorcycle incidents or injuries to a central authority — whether that be the TAC or Victoria Police — so that we have a repository for all of that data and that becomes mandatory for any health provider? Technically I could see my GP and say, 'I have come off my bike out in the paddock. Can you have a look?'. He removes something, stitches it up and off I go again.

Ms DIVER — In theory, capturing all that data would be helpful. What we have, I think, managed to do is have a very good dataset for major trauma rather than necessarily the dataset for absolutely all trauma. I guess the committee would need to make a decision about the benefit of the data burden — the cost of collecting data for everybody who goes to their general practice and to private EDs — and the level of depth of information that would be required to be collected for all trauma as opposed to what we have focused on, which is major trauma. Major trauma is where most of the cost and burden is for patients who are affected by motorcycle-related accidents. There is a balance there.

We have, I think, quite a deep dataset on major trauma. We have information from our 40 emergency departments on minor trauma in relation to all the presentations that arrive. Yes, it is true that in general practice and private hospitals there would be another number of patients, but I would put it to you that it is probably on the minor end of treatment. If people did turn up to their general practice for something that required some intervention and had a burden, then they are likely to require hospital admission so they would be scooped up in that next round of data.

Mr LANGUILLER — Just to be absolutely confident, I am assuming that all agencies use the same definition. So when you talk about major trauma, VicPol, TAC and VicRoads would be using the same definition. With respect, we are not necessarily comparing pears with apples or whatever else we may be comparing with. Is that correct?

Ms DIVER — Sure. Certainly in the health system the definition of major trauma is well defined. There are particular criteria of an injury's severity score: urgent surgery, required intensive care and threat to life or limb. There is a defined major trauma definition. I cannot tell you if VicRoads or TAC use that for any other analysis, but certainly in the health-related analysis, that is the definition of major trauma. TAC part funds the trauma registry and so it is across the detailed definitions, but that might be different from how VicRoads describes accidents. Not all accidents have injuries. If you look at VicRoads data — when I look at their submission — they have a much bigger number, but that is because not all motorcycle accidents result in an injury. Of those that have an injury, not all of them go to an emergency department, then not all of them end up being admitted and then not all of them are major trauma. You get down to a subset in the end of about 300, I think, from memory, major trauma cases for motorcycle-related incidents in a year in Victoria, but the cost of those is very high because those are the patients at the very complex end.

Mr LANGUILLER — So your definition, if I may say, is clinically based?

Ms DIVER — Correct.

Mr LANGUILLER — It is not cost based?

Ms DIVER — Correct. It is clinically based to determine which patients would get the most benefit out of being transferred to a major trauma service as opposed to any hospital and that is because the concentration of skill, resource, response and experience at a major trauma service is going to be much better than at a local health service. Having treatment at any of the emergency departments across Victoria is fine for most patients, but some specialty patients should move to the next level of care. For the purposes of that care there was a major piece of work done in the late 1990s, the ROTES review, that determined the injury severity score and those criteria that would move those patients to the next level of care. It said that the aim should be that 75 per cent of patients should get to a major trauma service. So the whole system was reoriented to get those patients to a major trauma service and give the major trauma services a role in ensuring that skills were maintained at local emergency departments so that they could be a primary response — you know, sort of a patch up — and then move to the next level of care.

Mr LANGUILLER — Your referral to a major centre would not be determined by whether the patient is under TAC or WorkCover. That is irrelevant; it is just clinically based?

Ms DIVER — That is a second-order issue. It is all about the clinical.

Mr LANGUILLER — Thank you.

Mr PERERA — Does the trauma service do more than a normal health service? Other than directly treating the patient, are there other aspects of it?

Ms DIVER — The major trauma service's role is particularly about the concentration of particular expertise and the multidisciplinary team. They are treated by not just a surgeon, but by a surgeon, a physician, an ED physician and an intensive care physician. It is about the multidisciplinary team and the access to immediate resources, so that is MRIs, CT scanners, theatre, treatment protocols and expertise. That is at the very acute end. Then of course there is the intensive care and ward-based care, but also importantly there is the follow-up care. Rehabilitation is an area in which there is also some specialisation and rehabilitation. Perhaps that is one area where there is a divergence of pathways for TAC patients and public patients, where TAC patients may have their rehabilitation in the private sector funded by the Transport Accident Commission but public patients will have their rehabilitation in the public sector, unless they have their own private insurance. Then of course TAC provides beyond hospital care. That is not my area of expertise, but TAC does have lifetime care for patients with injuries, whereas a public patient will go into the disability sector if they need long-term care.

Mr PERERA — Talking about the cost, does the type of motorcycle and the type of riding, off-road or on-road, have a bearing on the cost of treatment?

Ms DIVER — I will probably have to take that on notice, but I understand that there is some difference in the clinical profile of off-road motorcyclists, with increased head injuries in off-road. That is probably something that I would suggest someone like Peter Cameron from the registry would be able to give you a much better sense of, the clinical profile of the injuries of on-road and off-road. That is one contributor. The cost of the treatment of on-road and off-road is really secondary to what the clinical profile is and the rate of growth of the volume of injuries.

Mr PERERA — And on the type of vehicle or type of motorcycle?

Ms DIVER — I do not have that information.

Mr PERERA — The other thing is that you mentioned that motor vehicle accident patients are three times more costly than normal patients.

Ms DIVER — Correct.

Mr PERERA — Here you are comparing patients with the same injuries?

Ms DIVER — No. It is the average cost of all admissions to Victorian public hospitals, compared to transport accident costs — all transport accidents, not just with motorcycles. The only point I am making there really is that people with transport-related injuries are very costly because they are more complex than your average patient.

Mr PERERA — Whether it is on-road or off-road, because TAC does not cover off-road?

Ms DIVER — Correct. I have not got the information for comparing on-road to off-road, but if that is an area that you are particularly interested in, then I am very happy to go back and see what additional information we can provide to you.

Mr PERERA — That would be good. Thanks.

Mr ELSBURY — Accepting the fact that the key role of health in this inquiry is unfortunately to either put people back together again or get them back up and walking again, does the Department of Health have any initiatives that are aimed at reducing motorcycle trauma?

Ms DIVER — There are a number of areas that have been working on injury prevention. You will be familiar with the Monash University Accident Research Centre, I am sure. There have been in the past some initiatives around Kidsafe. There have been very small-scale projects funded by the department, but I think what we have really got now is articulated in the public health and wellbeing plan, a plan to do an injury prevention plan, which is broader than transport but includes transport-related injuries.

Mr LANGUILLER — I am very cognisant that there is only so much that an emergency department can do in terms of data collection, but I am sure you appreciate that we need the best and most data collection that we can have to make provision for and develop good policy. For example, when a rider turns up at an emergency department, let us say, would the data collected read, 'Rider wearing helmet, safety gear and boots', as distinct from another rider wearing helmet, a lovely Collingwood Football Club jersey and thongs? Would that kind of information be in that data-collecting exercise?

Ms DIVER — The routine data collection is generally more high level and of a general nature, rather than whether they were wearing thongs or not and did they have on a T-shirt or a leather jacket, which I think is where you were heading. That kind of information is more likely to be examined as part of research that is undertaken on a sample basis or from time to time — for example, the piece of work that was undertaken by Peter Cameron and the trauma registry that was published in a journal. Looking at trends over time or differences between different patient groups or different outcomes for different patient groups are less likely to be collected on a routine or regular basis, partly because of the data burden and the cost. That is where data collections like the registry become a quite useful source of detailed information. They can go and collect all that information, so that is probably where I would suggest it is most likely to be found.

That is an area that is probably worth exploring with research. Researchers love to collect lots of data, and we are very interested in a broad range of data, but it is about how you get access to that data. Do you get everybody to collect everything all the time, or do you get a basic dataset, find specialty areas where you need special data, and then give researchers access to that special data where they can go even deeper and explore variation and changes over time?

Mr TILLEY — I would like to go back to the previous question on initiatives that are aimed at reducing motorcycle trauma, and more specifically the findings of Coroner Ollie. Are you familiar with those findings and the recommendations from the inquest?

Ms DIVER — Yes. I understand that there was a coroner's inquest earlier in the year, that they made a recommendation and that that recommendation has been picked up through the public health and wellbeing plan to do an injury prevention plan.

Mr TILLEY — Can you comment on what has been done to date in relation to that recommendation and what the department has done specifically?

Ms DIVER — I would probably have to take that on notice. I can say that we are doing one. It is in the plan; there is one. However, as to the detail of the time frames, I think there is a 12-month time frame, from memory, wrapped around doing that piece of work. That piece of work is part of a broader piece of prevention work. The Department of Health is very interested in prevention work, but it needs to be undertaken collaboratively with the sector. In general, prevention work is undertaken with local government or other agencies. If you want more detail about those plans, we can provide that to you.

Mr TILLEY — In view of that, are you able to express what you would like to see come from this committee as far as the department is concerned?

Ms DIVER — In preparing to come to this committee and having a look at the on-road and off-road data, it was suggested that perhaps some of the prevention messages from TAC are working for on-road. It appears from the data that there has been a reduction in the number of children who have had motorcycle-related injuries. There appears to be at least stability and not particularly a rapid rise in motorcycle-related incidents on-road. You could form a view that the messages that are out there appear to be working. However, where there are not messages getting through to off-road, it is perhaps an area that needs to be explored, but clearly we need to have a significant look at that data to determine, as you say, whether this is about WorkSafe farm injuries in terms of off-road or whether it is about recreational users.

The CHAIR — In the absence of further questions, I would like to thank you very much for coming along and for giving your time in the preparation of the report to the committee. Should we have any further questions we will be in contact with you. You will receive a copy of the transcript. If you could peruse that and return it at your earliest convenience, it would be envisaged that we would place that information online to assist a wider public overview of the work of our committee. Thank you for being here today.

Witness withdrew.