Supplementary Submission No 78a

THE MANAGEMENT AND OPERATIONS OF THE NSW AMBULANCE SERVICE

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Date received: 25/07/2008

The Director
General Purpose Standing Committee No 2
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This submission to the Committee concerns several issues that highlight the inadequacies of Ambulance Management. They include the introduction by management of a hospital destination matrix, which often only serves to compound the already untenable hospital block situation and leads to ambulances being unable to respond to emergencies. It also looks at the failure of management to address the issue of inappropriate use of ambulance resources – i.e. use of an emergency ambulance when not clinically appropriate, which, in turn, leads to demands for increased staffing and therefore an increase in costs associated with training and wages.

Finally, the submission draws to the notice of the Committee to dealings that can only be described as shonky – nevertheless, these dealings led to the abandonment of legitimately developed policy that was well set to see the Ambulance Service o NSW truly become "Best Again" – not just in words, but in a clinical setting.

Availability
While response times are of course an important performance measurement, another important benchmark seems not to be measured – availability.

Keeping track of how often and for how long a period towns serviced by an ambulance station have no ambulance available to respond to the residents (in a timely manner) is a yardstick worthy of monitoring. With the electronic systems we have in place today this should be able to be monitored quite easily.

Readiness to Respond a good term and deserves at least equal – if not more importance than response times. In fact it was used as the title of an Auditor General's report. As I see it, response times are a retrospective analysis whereas, measuring how often and how long a community is devoid of ambulance cover is rather more proactive and should well demonstrate if we are maintaining a readiness to respond or not. Surely we should be looking at this measurement – after all, the community does have an expectation that when they call an ambulance – one is waiting – in a state of readiness to respond.

As an example, while there may be two ambulances at Nelson Bay on day shift each day, if one monitored this statistic, one might see that both these ambulances are often tied up for eight or nine hours of a ten-hour shift on most days – yet for most of that time, cover is still maintained and an ambulance is held ready to respond. However, when one looked at Tanilba Bay, one would see that community had many hours were no ambulance was ready to respond – why - because it was stolen to cover Nelson Bay which has a higher population and workload. This means response times might look ok – because they have robbed Peter to pay Paul - but only through luck – and by denying the people of the Tilligerry Peninsular a readiness to respond.

Inappropriate use of Emergency Ambulances
In 2001 the NSW Auditor General stated[1] *"Arguably the single most important performance indicator for any ambulance service is how quickly it responds to an incident and places the patient in the care of skilled ambulance officers."*

Many factors can influence response times but whether or not an ambulance is available to respond must be considered a key factor. Of course, many factors influence availability however, management seems to do little in a proactive or imaginative way to enhance availability.

The Performance Audit in which the Auditor General made this comment was very critical of Ambulance response times and at least for a period after it, response times became the "hot topic" amongst management. However, despite the fact that road staff are very dedicated and generally respond as quickly as possible in a time critical incident, management applied considerable pressure on road staff to reduce response times even though the real delays were caused by other unrelated factors such as - the time taken before the call leaves the communications center, insufficient resources, under use of Patient Transport Services – (which are also under resourced). Most experienced on road officers would also cite hospital block and over use (abuse) of emergency ambulance services by those who are "entitled" to fee free service as major factors that limit the availability of ambulances to respond to crisis calls.

While some improvement can be demonstrated in response times, this is more likely due to tweaking of reporting systems and maybe some reduction in the time taken to get the call out of the "control room" and to the car (probably due to introduction of computer aided dispatch). All other areas remain the same – regardless of what figures show - hospital block is as bad as ever – because management won't play hardball with hospital administrators – the only people they play hardball with is their dedicated staff.

Nor will they support road staff when we point out to a "fee free" abuser that use of ambulance resources in this fashion represents abuse and places untenable demands on resources. Moreover, they declined the opportunity to introduce a co-contribution fee to help limit this abuse. If the patient lodges a complaint – the officer who pointed out the abuse will be subject to an investigation and invariably found in the wrong despite the Gleeson Inquiry finding as far back as 1980 that such abuse was occurring and set in place clear guidelines for the use of ambulances resources.

The Gleeson Inquiry also set clear guidelines as to when a medical officer should consider use of an ambulance for non-emergencies and Ambulance delegated certain officers as "Inappropriate Transport Officers". These officers continued to work the road etc as normal but also took on the role of identifying cases where a doctor or nurse had booked an ambulance for a non-urgent case, which would have been suitable for transport by alternative means – eg. With relatives, self drive, community transport services and in many cases – even public transport. Gleeson's guidelines are set out below in brief saying the patient must either:

- Require close management or monitoring – these often involve the transfer of an unstable patient from a peripheral hospital to a referral hospital capable of managing the patient.

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[1] Performance audit report : Ambulance Service of New South Wales : readiness to respond / [The Audit Office of New South Wales]

- Require stretcher transport
- Suffers a condition that would cause gross embarrassment if public transport is used – eg. Incontinence – gross disfigurement or scaring

Unfortunately, Ambulance Management has a short attention span and dropped the positions of inappropriate transport officers and abuse of emergency ambulances has steadily increased.

Since management withdrew the positions of Inappropriate Transport Officers road staff have been left to try to educate doctors etc in the appropriate use of resources. Unfortunately we are left doing this without a safety net knowing if a complaint is lodged against us we will not be supported.

In a recent incident, officers at Nelson Bay attended a local surgery to transfer a patient to a referral hospital in Newcastle. When the patient walked out carrying her bags and obviously in no distress, they queried the doctor as to if he thought ambulance was the most appropriate means of conveyance for the patient. The doctor became quite argumentative and took affront to his decision being questioned by lowly ambulance paramedics and demanded they transport her without question. He subsequently made a phone complaint against the officers in essence challenging the right of these officers to question the decision of a doctor with many years university training. Managements response was that it was not the place of paramedics to question a doctor's decision and that they would be spoken to.

This statement is utter nonsense – of course they can question a doctors decision. Indeed, there are times when one is duty bound to question decisions if it appears flawed lest we would be a party to negligence if we failed to. I have questioned the decisions of doctors and other allied health professionals on may occasions – and often the decision has been altered after such challenge.

Nevertheless, this patient DID NOT fit the transport criteria set down by the Gleeson Inquiry and rather than immediately jumping to the conclusion that the attending paramedics were at fault, the case should have been properly investigated and lead to the doctor being re-educated as to the appropriate use of emergency ambulance resources – but no – the usual practice prevailed in which the first and only rule is – *"The ambo is always wrong"*

Management take this approach simply because we are the softest target.
It is clear that the value of an ambulance is directly related to how swiftly it can arrive at a crisis and if it is tied up transporting someone who is more than capable of traveling with a relative or friend and the ambulance is being used merely as a free taxi it is less likely to be available in a timely manner when a crisis arises.

Moreover, the unwarranted use of emergency ambulances for taxi runs contributes to overall usage and workload statistics, which are then used to justify staff, increases. We force our union to demand staffing increases because we know management will do nothing to reduce inappropriate demand. Clearly, employing additional highly qualified paramedics is not the most cost effective means of providing drivers to transport these patients. It would be far more cost efficient to identify inappropriate use such as and putting mechanisms in place that prevent it such as the reintroduction of Inappropriate Transport Officers to re-educate doctors and nurses who book ambulances indiscriminately.

Moreover the introduction of a co-contribution scheme, which could make ambulance transport for inappropriate cases more expensive than a taxi, would discourage

patients from applying pressure on the doctor to order an ambulance and would also discourage them from calling 000 when other means of transport are more appropriate.

One easily implemented means of achieving this would be to introduce a co-contributions scheme where by default; patients pay a minimum fee for service regardless of their Centrelink status. Provision could of course be built into such a system that would allow officers to note if a call/case warranted the use of an ambulance. In which case they could simply tick a "No Bill" box and the patient would not be required to pay the co-contribution. Ambulance paramedics are entrusted with patients to care for as well as their belongings and are also entrusted with drugs including accountable drugs of addiction that if misused or administered indiscriminately would have severe consequences. Clearly, officers are trustworthy and just as we don't administer drugs indiscriminately – nor would we use the "Bill" or "No Bill" box indiscriminately either.

IPART offered Ambulance the opportunity to introduce just such a system but in their infinite wisdom, management declined the offer. One must seriously ask why they would do that when ambulances are struggling to meet response time targets and staff can work a whole 10-hour shift without the opportunity to have a cup of coffee or a meal break.

Hospital Matrix – Adds to Hospital Block and Limits Ambulance Availability
While this submission looks at the situation at Nelson Bay, the same issues are repeated at numerous locations across the state. I am firmly of the belief that a review of the hospital destination matrix would help reduce the impact of hospital block because it forces us to take patients direct to an already clogged up referral hospital rather than to a local hospital even when their condition is not time critical and they could comfortably wait in a local hospital while receiving good care and waiting for a bed to be freed up and transferred later in an orderly manner.

Hospital block is a never-ending saga but in a supposed attempt to address it, management introduced a hospital destination matrix in conjunction with local area health services. This matrix directs ambulances to take patients to a hospital with the "inpatient" services the patient may require. This concept is not entirely without merit and in time critical cases is essential. The flaw in the matrix is that it only looks at "inpatient" services – not Emergency Department services. As such it casts too wide a net and patients who have an urgent need that could be relieved at the closest hospital are directed to a more distant hospital – perhaps an hour away and unless the attending officer over-rides the matrix, critical treatment is delayed but up to an hour.

I cite as an example, a patient suffering a myocardial infarction (heart attack) where a blockage has occurred in one of the coronary arteries. With each passing minute, the area of the heart muscle normally fed by the blocked artery is deprived of blood carrying oxygen so with each passing minute more and more of that part of the heart dies. The result is healthy muscle becomes ineffective scar tissue incapable of participating in the vital function of pumping blood around the body. In major metropolitan areas, it may be appropriate to take this patient to a hospital only a few more kilometers away so that they can be taken straight to a cardiac catheterization lab where the artery can be opened up and a stent put in to keep it open. However, in country NSW these facilities are some distance away and the patient would be better taken to the closest hospital where a drug can be administered to dissolve the clot so that circulation is restored within minutes prior to sending the patient to a referral hospital for ongoing care.

The matrix as it stand now directs officers to take these patients to hospitals up to an hour away when heart saving treatment is available only minutes away. Moreover, by looking only at inpatient services, the matrix forces us to take many patients whose condition is not time critical direct to a referral hospital – even if the patient will not receive definitive treatment for a day or two.

As an example here I cite a patient who has fallen and suffered a fractured hip. If this patient is on warfarin (as many are) it is unlikely they will be operated on until their warfarin levels are checked and given time to fall out of the therapeutic range. One hardly wants to perform a major operation on an elderly person if their bleeding will be uncontrollable – lest they die. Nevertheless, the matrix forces us to take this patient direct to a major hospital. This means we immediately load the patient and head off to a hospital an hour away. In areas that only run one car per shift, such as night shift at Nelson Bay, this means the rest of the community is left without emergency ambulance coverage until one is stolen from another station and sent up to cover.

When a crisis occurs before the replacement ambulance arrives (if one can be found to replace us) there is no ambulance in close proximity to the call to respond in a timely fashion. This of course impacts on emergency response times and for no net benefit to either the emergency call waiting for an ambulance or the elderly person with the fractured hip. She will still lie in a bed for hours or days before being operated on and could just as comfortably do that in a bed at a less busy local hospital.

Even when the referral hospital is in bed lock the matrix still doggedly tells us to take the patient to the referral hospital. I don't care how much management say it doesn't do that – they don't work on the road and have no idea what is really happening. This means it is very likely she will be left stuck on our bed or a makeshift bed in bed block for hours. It would make far more sense to take this patient to the local hospital where she can be made comfortable, have basic pathology tests commenced and an orderly transfer arranged when a bed becomes available.

Moreover, in the situation at Nelson Bay, the area health service has recently commenced a patient transport service operating out of the local hospital. This is comprised of a non-emergency ambulance staffed by a driver and nurse. This type of patient is eminently suitable for transfer by this level of ambulance and does not need immediate transfer by a high level emergency ambulance especially if it means the community is left devoid of emergency ambulance cover.

Despite the introduction of the patient transport service at the local hospital – Ambulance has not reviewed the patients the matrix forces us to take to a more distant hospital – consequently, the community is routinely left without emergency cover – while a lower care inter-hospital ambulance is sitting idle at the local hospital!

The question must be asked – why does the hospital destination matrix only look at inpatient services and not Emergency Department services. Ambulance has admitted previously that part of the reason is to try to avoid secondary transfers, and while this may be worthy in metropolitan areas such as Newcastle where the difference going to say the Mater Hospital or John Hunter may be only 5 or 6 minutes and a few kilometers, one must challenge the worth of it when it calls upon officers to transport the patient to a hospital over 60 kilometers away when clinically, time is not of the essence.

Matrix Contrary to the Medicare Principles

Other than patients suffering time critical conditions, the only body that really benefits from avoiding a secondary transfer is the area health service, which would otherwise be billed for that secondary transfer. By taking the patient direct to the referral hospital the area health service avoids the bill for transferring the patient. It must be remembered that it is the area health service that advised Ambulance which patients should be taken to which hospital so it leaves motives open for discussion.

Because ambulance charges on a per kilometer basis, instead of the patient receiving a relatively modest bill for transport to the closest hospital – in the area I work, the patient is charged the full cost of transport all the way to Newcastle – over 60 kilometers away. If taken to the closest hospital he would receive a modest bill and the subsequent 60 kilometer transfer would be billed to the hospital because it is not his fault that the area health service has failed to adequately resources the smaller closer hospital.

This matrix system which forces officers to bypass closer hospitals appears contrary to the Medicare Principles as defined by the Australian Health Care Agreement. This agreement forms the basis on which the Federal Government makes money available to the State for the provision of public hospital services and requires the that State has arrangements in place to avoid penalizing the patient for the States failures.

Management have been made fully aware of these concerns in the past but have not even seen fit to reply to my concerns – let alone modify billing arrangements so I now draw your attention to Part 2 of the Australian Health Care Agreement[2].

Australian Health Care Agreement

PART 2 – OBJECTIVES AND PRINCIPLES

6. The primary objective of this Agreement is to secure access for the community to public hospital services based on the following principles:

(a) Eligible persons are to be given the choice to receive, free of charge as public patients, health and emergency services of a kind or kinds that are currently, or were historically, provided by hospitals;

(b) Access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate period; and

(c) Arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location.

I draw your particular attention to the part that says patients will have equitable access to hospital services regardless of their geographical location. In this instance the reference to equitable access means the State must have arrangements in place that prevent a patient being financially disadvantaged simply because they live in a geographical area in which the State has failed to properly resource the hospital and that it is wrong to make the patient pay additional costs that the matrix places on him to access the clinical care his condition demands.

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[2] Australian Health Care Agreement between the Commonwealth of Australia and the State of New South Wales 2003-2008

In support of this claim I further draw your notice to comment by the NSW Auditor General in a performance audit of emergency department planning, which seem to clearly support my interpretation that this is such an arrangement. Viz:

The Medicare principles require the provision of public hospital services equitably to all eligible persons regardless of their geographical location. However, this does not require a local hospital to be equipped to provide every hospital service (including an emergency department) a person may need. In these instances, the State accepts responsibility for referring or transferring the eligible person to a hospital where these services are available.[3]

This is why, if a patient arrives at my local hospital - Tomaree Hospital by private transport and it is later deemed they need to be transferred to a referral hospital via NSW Ambulance, we bill the hospital – NOT THE PATIENT! This practise has been the case for the whole of the past 28 years that I have worked as an ambulance officer. It is clearly an "arrangement" referred to in paragraph (c) in the above section of the Australian Health Care Agreement. The destination matrix circumvents this and forces the patient to pay the significant costs of what would otherwise be a secondary transfer paid for by the area health service.

While it may be the case that many of these patients are covered by health insurance or Commonwealth benefits – many are not. Moreover, these schemes exist for the benefit of members or the disadvantaged – their existence is not to provide a means whereby the area health service can escape its responsibilities.

Moreover, as it is based on "in-patient" services rather than a combination of emergency department services and clinically appropriate timeframe, it seems designed to cast the widest net reasonably possible and presumably in turn – the area health service avoids the cost of inter-hospital transfers as much as possible.

I have no doubt in my mind that the decision to base destinations on "inpatient services" was at least in part motivated by a desire to shift the costs associated with what would otherwise be an inter-hospital transfer onto the patient – rather than the area health service where those costs rightly lay under the agreement.

Management was provided a detailed submission concerning this matter a good couple of years ago but I am yet to receive a reply. I know they received the submission because it was provided as an attachment to the reply I was required to provide after a patient lodged a formal complaint related to this very matter. Management did reply to that part of the concerns stating I had no case to answer but made no comment about the detailed reply I gave which supported the position the patient had taken.

That complaint stemmed from an incident in which I had to take the complainant's son direct from his home at Anna Bay to a hospital in Newcastle. The father received a bill from ambulance for the full cost of the transport. However, he could not understand why he had to pay so much because his wife had been a patient at the local hospital previously and when she required transfer to Newcastle the area health service covered the cost. It had previously been explained to him that they covered the cost because it is not his fault the area health service failed to adequately resource the local hospital. He also knew full well that the only reason we were taking

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[3] http://www.audit.nsw.gov.au/publications/reports/performance/1998/hospem/planemrg.htm (First paragraph)

his son to Newcastle was because the area health service had not provided the local hospital with the resources it needed to care for his condition.

Management seem determined to press on with this matrix even if it means areas are left devoid of ambulance cover for extended periods while ambulances immediately take patients direct to referral hospitals even when they are already bursting at the seams and in doing so pass a cost which should be carried by the area health service onto the patient.

The destination matrix should be reviewed so that, unless it only involves a handful of kilometers, only patients suffering time critical conditions are taken direct to a referral hospital. Reality is, once stabilized (pain controlled etc) many can quite reasonably be taken to the local hospital, where as recommended in the Sinclair Report, they can be cared for until a bed is arranged and the most suitable means of transport is determined and arranged. In many cases the area health service will choose to use their in-house transport service to save costs – but the patient is not given this choice.

Unless it is time critical, if the patient it is not justified to leave the community devoid of an emergency response ambulance – nor can it be justified to pass to the patient a significant cost that ought carried by the area health service.

Improper Abandonment of Legitimately Developed Policy
These concerns revolve around the abandonment of Advance Life Support training. Some may see this as an old issue but it must be remembered that legitimately developed policy set an aim to train every operational officer to the level of Advanced Life Support – similar to a policy since adopted in Victoria Ambulance.

This policy took its rise from the findings of numerous past reviews including the Gleeson Inquiry, whose findings and recommendations are still relevant today as well as the Paramedic Review. Gleeson recognized inadequacies with the Intensive Care Paramedic system as he saw it then – and as it still exists today whereby a central station is designated a paramedic station and it backs up the satellite stations surrounding it when a patient needs a higher level of clinical care than available from the satellite station.

Gleeson questioned the worth of a two tier system suggesting that patients would be better served if all officers were trained to a similar higher level. He made a formal recommendation that a review of the Intensive Care Paramedic be undertaken. This was subsequently attended a few years later. The Intensive Car Paramedic review noted that no advanced skilled officers were available in country NSW and lead to recommendations that a tier approach be adopted towards training ambulance officers with the final point being Intensive Care Paramedic.

This saw the introduction of what was previously referred to as Intermediate Life Support Officers to Country NSW. This was a level between the basic road officer of the day and Intensive Care Paramedic. This was later enhanced in line with the concept advanced in the Paramedic Review and saw the level raised to what is today, Advanced Life Support Paramedic (Level IV).

After a Public Accounts Committee of Inquiry identified continued weaknesses in ambulance management, it recommended a board be comprised to direct the affairs of the Service. One of the first tasks this new board undertook was to review all policies and it released a report entitled – *Future Directions.* Amongst other things

this report set as policy the stated aim to train all operational officers to the Advanced Life Support level.

The Board also introduced employment contract which made it a condition of employment that newly employed officers to would reach the Advanced Life Support level within I think 3 years (but it may have been 4)

By the time Ambulance had trained nearly 50% of officers to this level another review was conducted. This "review" entitled Review of Clinical Services was conducted in-house, behind closed doors and only a select few were offered the opportunity to make submissions. It called for the abandonment of Advanced Life Support (ALS) training – it went as far as to demand those trained to ALS be pulled back to the lower level. It justified this saying the advent of ALS was unplanned and just happened without proper consideration and was never supposed to reach the level it did.

This claim was quite untrue because its evolution was clearly forecast in the Inquires previously mentioned and addressed the many issues raised in those inquiries.

Nevertheless, while it was asserted that ALS training was merely on hold, this flawed review saw the Future Directions policy abandoned and ALS training ceased. Those officers employed under those contracts, who were later, denied access to training commenced civil proceedings against the Service for breach of contract and were subsequently offered the opportunity to train up and presumably obtained some sort of monetary settlement.

The process used to see this properly developed policy abandoned was brought to the attention of the NSW Ombudsman. In response to inquiries by that Office, Ambulance asserted that the document entitled Review of Clinical Services was merely a discussion document and had not been formally adopted. The Ombudsman rejected that claim after sufficient evidence was provided that showed clearly that it was being used as a policy document.

The matter culminated with the Ombudsman challenging the veracity of information the Service had provided to support that claim and concluded that the document was indeed being used to change policy and was not a discussion document at all. The Chief Executive suddenly chose to resign around that time saying in the Sydney Morning Herald that he could no longer tolerate his integrity being challenged constantly.

Mr G Rochford subsequently replaced him and assured the Ombudsman that a full review on clinical direction would be undertaken. This was done in a fashion, however, it remains, this policy, which was developed as a result of a number of formal inquires remains overturned – and for no valid reason. Moreover, the community have still been denied the high level of care that policy would have delivered with the first arriving ambulance.

The aim to train each operational officer to this advanced level would have led to a system in which the critical needs of any patient responded to would be met by the first arriving ambulance. Because country officers had priority of training position (because there was and still is minimal Advanced Life Support officers out there), the flow on effect was that officers were keen to serve in smaller regional and more remote locations because it meant they had priority of training. Being dedicated as ambulance officers are – they were and still are keen to gain higher-level clinical skills so it was worth the trade off to go bush for a few years to get the skills.

Unfortunately, I know of at least one Regional Superintendent who commented that he did not like training these officers because no sooner he paid to train them they moved out! While it is acknowledged this probably did occur, at least it encouraged staff to move to those otherwise hard to fill locations. Whereas once this training was ceased, there was no incentive for officers to take up those positions. As I understand it, the Service still finds difficulty filling those positions today. Officers with minimal experience now tend to fill many of those positions because they are "shanghaied" into the position immediately after training - no matter how unwilling they may be. Instead of complaining about the cost of training these fellows, a more imaginative management would have introduced a scheme whereby in exchange for the opportunity to train to the ALS level, the officer would give a commitment to remain at the same location for say two years after training– but this was never explored.

A past Medical Director of the Service has described the distinction between Advanced Life Support Paramedic and Intensive Care Paramedic as an artificial distinction. Some would disagree vigorously however; I would suggest while a little too simplistic, it is closer to the mark than saying there is a huge difference. If this policy were allowed to run to completion, it would result in most calls being handled with just a single car response, which would again lead to reduced demand on resources. It would not remove the need for a higher-level back up service but it would mean these back up units could be trained to fill a higher role.

There has really not been that many more advanced skills introduced to Intensive Care level that have not also flowed down to lower levels than there was when they were first introduced. Technological advances have allowed many of the skills and procedures practiced by Intensive Care to flow down to lower levels over time. Surely similar technological advances along with the self sustaining body of knowledge developed collectively since introduction should provide the opportunity for the Intensive Care officers to move forward to even higher levels so that by the time they arrive they bring with them the more complex skills the patient needs but can wait a period of time for.

An ideal service would be one in which, the first arriving ambulance carried officers with Advanced Life Support training (with a few additions) and these officers could then meet all the time critical needs a patient can reasonably expect to be met in this day and age. Then, if higher level care was needed, Intensive Care paramedics (trained to an even higher level than they are now) would arrive around the time the ALS officers were reaching their limits of treatment and they would bring with them the new and additional skills the patient needs – but on most occasions, the skills carried by Advanced Life Support officers would be all that is required.

In essence, the policy that aimed to train all operational officers to ALS would have set the groundwork for such a system and we would truly have an ambulance service of clinical excellence. Moreover, it would have resulted in a system in which if a case involved just one patient – the clinical needs of that patient would in all but the most exceptional circumstances be met by the first car to arrive and therefore reduce the need for back up by higher qualified officers. In essence, most calls with single patients would be one job – one car!

Unfortunately, in many regional and rural areas higher-level back up is simply not available in a timely manner yet these officers are no longer permitted to train to this highly functional Advanced Life Support level. This means a cardiac arrest in Sydney

or Newcastle gets a far higher level of care than one in many smaller communities. In fact with the new base skill level the patient in cardiac arrest won't even get a drug as basic as adrenaline for God's sake.

The review Mr Rochford conducted failed to address why the previously legitimately developed policy that stood to serve NSW so well was ever over turned in the first place. A new lower base skill level has since been introduced but has many crack in it. Many patients slip through those cracks and fail to receive the time critical drugs and advanced care they so desperately need. At other times, the Intensive Care Paramedic is able to back that car up and deliver the additional care but it is often too little and too late.

I believe the committee would do well to review why this policy was abandoned and am willing to speak to these issues in greater detail if required. In particular, I would appreciate the opportunity to test any defence management offer in this matter as I have no doubt I will be in a position to show it to be a lie – just as I did in the past.

Regards

Christopher Cousins

25/6/08