Aeromedical Services WA Inquiry – Formal Hearing Transcription
Inquirer: Dr Marcus Kennedy
Organisation: Aboriginal Health Council of WA – Ms K Gates, Dr M Wood
Date: 14 February 2022, Time: 1430 – 1459

KENNEDY, DR: Good afternoon. Thank you for your interest in the Inquiry and for your attendance this afternoon, it's appreciated.

The purpose of the hearing is to assist me in gathering evidence for the Inquiry to air and medical services in Western Australia. My name's Marcus Kennedy and I've been appointed to the Inquiry by the Chief Health Officer to undertake the Inquiry. Beside me is Jonathan Clayson as the Inquiry's project director.

I just need to remind you to be aware that the use of mobile phones and other recording devices is not permitted in this room. Please make sure that your phone is on silent or switched off. The hearing is a formal procedure convened under Part 15 of the Public Health Act 2016 and while you're not being asked to give your evidence under oath or affirmation it's important that you understand that you must answer all questions and that there are penalties under the Act for knowingly providing a response or information that's false or misleading.

This is a public hearing and a transcript of your evidence will be made for the public record. If you wish to make a confidential statement during today's proceedings, you should request that that part of your evidence be taken in private. You have previously been provided with the Inquiry's terms of reference and the Inquiry's current state considerations paper, focussed list of relevant considerations and information on giving evidence to the Inquiry. So, before we begin, do you have any questions about today's hearing or the process?

GATES, MS: No.

KENNEDY, DR: Thank you.

For the transcript, could I ask each of you to state your name and the capacity in which you are here today?

GATES, MS: My name is Kim Gates and I'm the public - sorry, the executive manager of Public Health and CQI at the Aboriginal Health Council WA. And my colleague.

WOOD, DR: And I'm Dr Marianne Wood and I'm the public health medical officer from the Aboriginal Health Council WA.

KENNEDY, DR: Nice to meet you. You will be invited to address the focus considerations list that you've been provided. You may speak to these matters for up to 15 or 20 minutes if that is required. Then after your address I may ask specific questions in the time that remains. I will try not to interrupt you during your presentation unless there's matters that I don't understand, in which case I will interject. If you wish to remove your mask it's okay from our perspective if you do that to see or speak clearly. Over to you.

GATES, MS: Okay. Thank you.

Okay. So, I'll probably leave my mask because my glasses are fogging up. So thank you very much. I'd like to begin by acknowledging that we are on Aboriginal land, we're meeting today on the land of the Whadjuk People of the Noongar nation and I pay my respects to elders' past, present and emerging.

We're here representing the Aboriginal Health Council WA and its 24 member services. AHCWA and its member services welcome this Inquiry if it serves to improve the care of Aboriginal and Torres Strait Islander people in Western Australia. The priority for our members

is to have a safe, efficient, timely and affordable air - sorry, aeromedical service and by safe services, we mean services that are both clinically and culturally safe.

To be fair, the current system, particularly with the RFDS has served our sector well and we receive very few complaints. This, however, is not to say that the system can't be improved. So, in relation to focus point 3, we agree that there would be some advantages in having a central coordinating authority - authoritative agency in terms of efficiency and consistency. However, there are many positive aspects of the current system with RFDS which the service of most - which is the service of most relevance to us, that we would hate to see loss through a centralised management system.

Specifically, the current system is highly valued and respected by local Aboriginal Community Control Health Services here in WA and the Aboriginal people living in those respective communities. This trust and respect has grown over many years of service and is not transferrable. It needs to be earned and at the coalface over time. Moreover, this long-established relationship between the RFDS and our Aboriginal Community Controlled Health Services (ACCHS) is at the heart of cultural safety and it is worth pointing out that cultural safety is not referred to in any of the documentation that we've seen with respect to this Inquiry.

You can have the most efficient, well-organised, state of the art service in the world but if it does not engage in a culturally safe manner with Aboriginal people, it's likely that some people refuse to use it and lives will be lost. We have also had a very positive feedback from our member services about the way in which the RFDS engages holistically as a healthcare provider and this has been particularly clear during the COVID pandemic with RFDS being the vaccination service of choice for many of our communities.

Continued - continuity of care and interagency engagement are also strong from our perspective. Just going forward, we've actually grouped certain numbers 18, 20 and 59 together in our response. This is an area where we can see some potential improvements. For many communities particularly in the east of WA, there are strong cultural connections with the Northern Territory or South Australia. Not only are Darwin and Alice Springs and Adelaide geographically closer, they are also culturally closer which may mean better family support or the person less hospitalised.

It's our understanding that arrangements for cross border transfers occur on a case by case basis and negotiations are sometimes lengthy and time-consuming for the staff or if the patient is left in limbo until a decision is made. One example provided was an expectant mother from the Kimberley who'd previously been airlifted to Derby then required urgent specialist care. Darwin was the preferred location as it was closest to her hometown where her family was. The negotiations for that cross border transfer took quite a long time, several hours. It was finally agreed that she would be transferred to the NT but after a seven-hour flight she required an emergency caesarean and a longer flight to Perth may have had consequences for that unborn child.

There are however, clear risks with cross border arrangements. As has been very apparent with the hard border due to COVID, AHCWA supports the border closure and quarantine restrictions but the negative effects on service provision have been very significant. Interstate staff have been able to travel - unable to travel. Medication supplies from Alice Springs for the Ngaanyatjarra Lands communities have been a challenge and even the processing of pathology items at hospital are. And currently transferring a patient to the NT or South

Australia from a remote community in WA would mean immense difficulties for that person when it comes time for them to return home.

Focus point 22, whilst this is generally agreed there have been some instances where the prioritisation of patients is problematic. Services in the Kimberley, Pilbara and Goldfield have all cited this as an issue to us. Concerns raised from a member service in the Pilbara about the limited RFDS availability for the State. An example was provided where a patient developed sepsis and was admitted to the Karratha Health Campus - sorry, there's some medical words here that I'm going to probably get confused about, and commenced on Ventolin on an - - -

WOOD, DR: (Indistinct 2.37.50).

KENNEDY, DR: Antibiotics.

GATES, MS: - - - on the advice of Infectious Diseases.

The hospital did not have the ability to perform the day required levels so whilst waiting 48 to 72 hours for test results to guide dose adjustments, they became more unwell and renal failure developed. Each day the patient was told they would be transferred to Perth but it took actually three days for them to be prioritised and sent to Perth so obviously their condition worsened in that time. The journey was additionally taxing for someone who had sepsis but also had to fly onto Meekatharra to actually pick up another patient and so it took a considerable amount of time before finally arriving in Perth.

It was noted that there was considerable inequities as mining companies in the Pilbara are often able to transfer their workers very - who are seriously unwell in a timely fashion while the Department of Health cannot. Repatriation of patients is a big issue in itself for some patients. They do not have the health or the mobility to climb into light aircraft. In the Goldfields, the RFDS has assisted with repatriation on occasion but it is a very low priority and sometimes it’s too late, particularly if the patient is to return home to country for palliative care. There’s been a number of patients who passed away wanting to be repatriated back to their home country.

Another issue raised from the Goldfields region was the breakdown in communications within the patient transport system. The clinic will send a referral letter and notes but this often does not arrive at the final destination with the patient. The patient is moved from the clinic to an ambulance, to a plane, to an ambulance to a hospital and somewhere along the line the paperwork seems to go missing. So maybe some process around that would be encouraged.

There was concern about the availability of the RFDS to manage the coming surge in COVID cases and likely increased need for aeromedical transfer. At a recent Pilbara COVID planning meeting, agencies were advised that mining companies could be approached to provide this service in the event the RFDS did not have capacity. However, a senior Rio Tinto employee advised that this was not the case and in the event of serious illness the RFDS should be used.

There appears to be a lot of mixed messages about the capacity and who is going to assist in remote WA in the coming months. Services have also expressed concern that priority is given to patients from single nurse clinics over those with greater level of staffing. Whilst it is understandable the flow on effects for the bigger remote clinics of managing a very ill patient for many hours at a stretch does not always seem to be recognised. Okay.

Focus point 67. Airport maintenance has been raised as an issue by some of our member services, particularly night-time access. The need for helicopters as backup when fixed wing planes cannot land due to ground conditions has also been raised. One service asked why helicopters could not be used on a contract basis. Number 70. We actually support this notion. We have nothing further to add.

And 147, this is an interesting suggestion, but we have concerns about making very precarious rural workforce situations even worse through fragmentation. One of the things that our sector values most highly is the respect to the RFDS is their stable workforce and their continuity of care. The (indistinct 2.41.36) clinicians and managers greatly value their longstanding and trusted relationships.

Finally, we come - we welcome change that is beneficial, but we do not want to see the valuable aspects of the current system lost in this process.

Thank you.

KENNEDY, DR: Thank you.

Did you have anything that you would like to add to this material at this point?

WOOD, DR: Yes, just one thing and that's about cost. Obviously, you know, not only do services need to be safe culturally and clinically but it also needs to be affordable and it's probably not perhaps within the scope of this Inquiry but the costs of the road ambulance transfer from the hangar when the plane lands in Jandakot or in Kalgoorlie for that matter, to the hospital is a big burden and barrier for our Aboriginal Community Controlled Health Services and their clients and it is hundreds of dollars just to get from the Jandakot to the hospital and people will actually sometimes not get in the plane because they've had bills for this before. So just to put that as - in the mix there.

KENNEDY, DR: Bills to the patient or bills to - - -

WOOD, DR: Yes, to the patient. Yes. So if the RFDS is called by a WACHS service and often it's the hospital but also for say, Nullagine Clinic or one of the remote clinics run by WACHS then there is no cost from the Jandakot to - - -

KENNEDY, DR: So it's from a - - -

WOOD, DR: - - - Fiona Stanley but - - -

KENNEDY, DR: - - - WACHS facility.

WOOD, DR: - - - but if it's called by Puntukurnu Aboriginal Health Service (indistinct 2.43.10) Health or one of the Kimberley Aboriginal Medical Service (KAMS) clinics, there's a cost.

KENNEDY, DR: To that clinic or to the patient?

WOOD, DR: To the patient and then what often happens is that some clinics pay it. Sometimes the patient just gets - they get bills, they get - actually get debt collector bills, you know. Yes, there's two - this isn't, for some reason Wiluna has got some contract with

WACHS, so it doesn't have that issue but pretty much all the others do. It's a barrier to actual service access.

KENNEDY, DR: Is there a known list of relevant clinics or places where this occurs?

WOOD, DR: Yes. I could - well I could - - -

GATES, MS: We can provide that.

KENNEDY, DR: Or is it possible to provide that to the Inquiry - - -

WOOD, DR: Yes, we certainly can, yes.

KENNEDY, DR: - - - so that'd save us go hunting - - -

WOOD, DR: Absolutely.

KENNEDY, DR: - - - for it.

WOOD, DR: Yes. This was raised at the ambulance inquiry - - -

KENNEDY, DR: Okay.

WOOD, DR: - - - a few weeks ago but nonetheless, I think you should know about it as well - - -

KENNEDY, DR: Yes, yes, yes.

WOOD, DR: - - - because - yes.

KENNEDY, DR: if it's a - I mean, it's a disincentive for people to use - - -

WOOD, DR: Absolutely. Yes.

KENNEDY, DR: - - - a necessary service which then - - -

WOOD, DR: Yes.

KENNEDY, DR: - - - (indistinct 2.44.16).

WOOD, DR: Yes.

KENNEDY, DR: Thank you. If you could send that information to us. Is there anything else?

WOOD, DR: No. No.

KENNEDY, DR: Okay. So I've got a question, it's fairly clear at a State level that one of the things that the aeromedical service requires is improvement to the central structures which are about, you know, receipt of calls or referrals interagency collaboration about what's the best solution for that destination planning, et cetera, and then the activation of, you know, whatever response normally through RFDS, if there's going to be some - an increase to the degree of centralisation of some of that coordination, are there measures that need to be taken

or advice that you can provide in terms of your concerns about loss of cultural safety which is clearly a feature of the service that you're receiving at the moment so are there things in the design of, you know, a new service or modifications to the central service that should specifically be kept in mind?

GATES, MS: I think what we were talking about this morning.

WOOD, DR: Yes. Yes. So, it- I think the reason why the RFDS is so much trusted and respected (indistinct 2.45.44) it's just that they've been there for such a long time and they really know the communities they know the communities - - -

KENNEDY, DR: So, there's a confidence - - -

WOOD, DR: There's a confidence, yes, and that - - -

KENNEDY, DR: - - - component to that.

WOOD, DR: - - - knowledge it's actually really hard to get that knowledge without actually being there, so on the ground knowledge is hard to learn. Yes, so you want to maintain that knowledge base of all those small remote communities, the cultural side, the social side and the geographical side all together. Yes, and the - yes so, it's a complicated space. Yes, and we'd hate that knowledge base to be lost. Yes. Can I also - - -

KENNEDY, DR: So just - - -

WOOD, DR: Sorry, well, when we finish this bit there's something related to this, yes.

KENNEDY, DR: So I'm not really aware that through the consultation process up until now there's been any proposal which has suggested that the basic kind of operational process for RFDS changes in any particular way so, but, you know, the crewing, the staffing, the historical approach to the bulk of, you know, the response, et cetera, is not something that has really been put on the table in terms of the interaction with clients and carers in remote locations. Is there a concern that that could be fiddled with or disrupted in some way through the Inquiry or through - - -

WOOD, DR: Possibly. The other thing that the RFDS does for our sector is that they actually provide an afterhours service, you know, so particularly in that - - -

KENNEDY, DR: Sure.

WOOD, DR: - - - Tjintjunjarra and the Ngaanyatjarra Lands and the Puntukurnu (indistinct 2.47.24) communities, so and whereas that service is provided differently in WACHS. You know, you have your ETS service, you know, whereas our services rely very much on the RFDS and I don't know, that's sort of either been sort of very well demonstrated in the documentation we've seen.

KENNEDY, DR: So is that a component of what you would understand to be the RFDS, Commonwealth funded clinics and outreach and primary work or is - - -

WOOD, DR: It's an - well, that is a good question. It's not primary care outreach it's actually the afterhours service. So, it's - so the nurse will ring up the RFDS and say, "I've got a patient here. I'm not sure, you know, what's going on," and they'll have a chat over the phone.

KENNEDY, DR: Talking to whom at - - -

WOOD, DR: The nurse.

KENNEDY, DR: - - - at RFDS?

WOOD, DR: The - whoever they ring up at RFDS, I'm not exactly sure who they ring up but it's an RFDS phone call that they make and then - but it may not need aeromedical evacuation for that particular clinical situation but they need that advice so they provide that advice which I think is given by the ETS for WACHS. So, we have one service in Bidyadanga part of KAMS which does use their ETS but none of our other services use the ETS. They're not connected. So, the equivalent is they use the RFDS and to be honest, I don't know where the funding comes from for that but it's a very integral part of how those remote primary care services function 24/7.

KENNEDY, DR: Okay. All right. So that's noted. Presumably there will be a need for the ETS and the WACHS central service to interact with various clinics and other places of a similar nature over time. So what other success factors in terms of the relationship with the RFDS provider that - and what is the hesitancy in using the ETS or the WACHS service?

WOOD, DR: There's - we just have never been invited to be part of that service.

KENNEDY, DR: Okay.

WOOD, DR: In fact, it was myself actually that suggested that we actually do this - - -

KENNEDY, DR: Yes.

WOOD, DR: - - - join up with the ETS and - - -

KENNEDY, DR: Yes.

WOOD, DR: - - - and that was - that trial clinic was actually in Bidyadanga.

KENNEDY, DR: Okay.

WOOD, DR: Yes and it's - - -

KENNEDY, DR: So it's - - -

WOOD, DR: - - - going - it works well but it does make - there's just sort of an extra layer as well because they also use the RFDS as well so it does get a - that can actually get a bit more complicated as well.

KENNEDY, DR: Yes.

WOOD, DR: Yes. As well as (indistinct 2.49.56). It's a - the particular benefits of it is as a - videos involved and there's cameras whereas the - - -

KENNEDY, DR: Yes.

WOOD, DR: - - - it's a phone call to the RFDS - - -

KENNEDY, DR: Yes, yes.

WOOD, DR: - - - as I understand it from one of other clinics, yes.

KENNEDY, DR: I think that that whole telehealth environment creates a whole different dimension to the interaction in terms of at a clinical level, in particular how well a clinician can interact with the provider by more or less being in the same room as opposed - - -

WOOD, DR: Absolutely.

KENNEDY, DR: - - - to being down the line - - -

WOOD, DR: Yes.

KENNEDY, DR: - - - on the telephone.

WOOD, DR: And I'd say that two years ago there probably wasn't the capacity to do that - those - - -

KENNEDY, DR: Yes.

WOOD, DR: - - - video consultations but an awful lot has happened in this space since COVID - - -

KENNEDY, DR: All right.

WOOD, DR: - - - and since the technology is there.

KENNEDY, DR: Okay. So that's kind of noted as a potential changed space and that, you know, as is the case with anything that you change there's no point in throwing out what's good just - - -

WOOD, DR: No.

KENNEDY, DR: - - - to have something that's new, it needs to be new and better and acceptable. Do you feel confident that you know, through the interactions with the WACHS coordination centre, that the level of cultural awareness and safety that you mentioned earlier in your presentation is satisfactorily addressed or is there work to be done in that space?

GATES, MS: Personally, I think there's work to be done in that space (indistinct 2.51.24) but I haven't been - sorry, I haven't been in Western Australia very long so I'm not but I've worked in remote space in NT and South Australia but certainly I think that - - -

WOOD, DR: Yes.

GATES, MS: - - - space can be improved somewhat in the - - -

WOOD, DR: Yes, it depends - yes, absolutely. I mean, generally speaking, for people living in Perth and running that centre really have got no idea about what it's really like in a place

like Warakurna, frankly, you know, you have to have been to Warakurna to understand what Warakurna is so I think that's an issue.

KENNEDY, DR: Yes.

WOOD, DR: Yes.

KENNEDY, DR: It's a difficulty. It's a challenge - - -

WOOD, DR: Yes.

KENNEDY, DR: - - - for any system which delivers healthcare remotely and you know, the larger the space, the bigger the gap - - -

WOOD, DR: Yes.

KENNEDY, DR: - - - the harder the appreciation of the issues at the other end but it's not unique and as much as people talk about the unique challenge that's involved in the WA setting, you know, whether it's a thousand kilometres in Queensland or 15,000 kilometres somewhere else, it - it's not 15,000 I know, it's - - -

WOOD, DR: No.

KENNEDY, DR: - - - way too many, or - - -

WOOD, DR: Yes.

KENNEDY, DR: - - - 1,500 kilometres - - -

WOOD, DR: Yes.

KENNEDY, DR: - - - here the principle's the same, isn't it? You're removed from that setting and it's behoven on you if you're providing a service like that to narrow that gap in terms of your awareness and knowledge and connection but, yes, even now, much of the RFDS work obviously is done from Perth so although the basis, you know, obviously interact and have a local presence as well. However, that's - it's noted that challenge, thank you for raising it for us.

WOOD, DR: And language difficulties too.

KENNEDY, DR: Yes.

WOOD, DR: "Difficulty," is probably not the right word but, you know - - -

GATES, MS: Barriers.

WOOD, DR: - - - challenges, yes. Language challenges, yes. I mean there - lots of people - well, older people and now remote communities, you know, English is their sixth language, you know - - -

KENNEDY, DR: Yes.

WOOD, DR: - - - so, yes.

KENNEDY, DR: The issue of, you know, cultural connection between the northern populations and NT whilst acknowledged through the consultation period, we had quite a number of people refer to that. We had the system described at different levels how it's tried to explore that in the past but from a number of respondents to the consideration of the service, there was acknowledgement that there's more that could be done in that space and that - I mean, from a purely aeromedical kind of system perspective, it makes a whole lot more sense just from the transport arrangements, let alone the cultural arrangements - - -

WOOD, DR: Yes.

KENNEDY, DR: - - - or cultural drivers which are obviously an important factor, you know, to be looking at that kind of horizontal movement in the north as opposed to bringing people down to Perth all the time - - -

WOOD, DR: Yes.

KENNEDY, DR: - - - which - the other issue that you raised around repatriation has also been raised in many of the submissions and discussions and from a lot of perspectives but the sort of issues that you raised in terms of the leaving people for longer than necessary in, you know, tertiary or other hospital settings in a metropolitan environment when that's the last place that they want to be really - - -

WOOD, DR: Yes.

KENNEDY, DR: - - - and that's not a positive contributor to their health or their recuperation at all, apart from which it's a hell of a waste of beds.

WOOD, DR: Yes, (indistinct 2.55.18).

KENNEDY, DR: And so finding better mechanisms and more efficient mechanisms for appropriate repatriation is certainly on the radar from our point of view.

WOOD, DR: Can I just say one more thing about - - -

KENNEDY, DR: Yes.

WOOD, DR: - - - the cross border thing?

KENNEDY, DR: Yes.

WOOD, DR: So one thing that would need to be considered is just to be sure that the communication back is good. , You know within WA communication is really good with its discharge summaries and letters and people who work in primary care in this State, you know, have a familiarity around - - -

KENNEDY, DR: Need good information.

WOOD, DR: - - - that, yes.

And so we just want to make sure that the same good process of discharge letters and proper identification of the primary care provider exists in those Northern Territory or South Australian hospitals where people might go to, that's really important.

KENNEDY, DR: Yes. That makes a lot of sense. And just to conclude the issue that you raised around prioritisation, again that's something that has been raised through the sessions where I guess, secondary issues can sometimes influence prioritisation, issues that are n to fundamentally about the patients' urgency or need for intervention, whether they're in a place that's perceived to have capability or they're in - you know, have a clinical problem type such as mental health issues which some people in the system perceive as being automatically rated at a different level of urgency with subsequent, you know, compounding of morbidity and threatening of outcomes really, I think, when unnecessary delays occur in that situation. So urgency from our perspective is a combination of considerations and obviously the patient is the - the patient's need is the main consideration. There's also the impact of that patient's presence in a resource depleted site - - -

WOOD, DR: Yes.

KENNEDY, DR: -- - - on other patients who are there and - - -

WOOD, DR: Certainly.

KENNEDY, DR: - - - the need for the clinician to be doing other work. So they might be looking after one sick patient with asthma but they need to look after the lady that's giving birth and the - - -

WOOD, DR: Absolutely.

KENNEDY, DR: - - - old guy that's got chest pain and the - everything else that needs to go on there. So, it's often a hell of a balancing act but, again, that's where this concept that we're promoting of central coordination and having amore holistic view of what the system is doing as well as what the patients' needs are, it's important.

WOOD, DR: And that was our point about the bigger clinics with the - maybe a couple - - -

KENNEDY, DR: Yes.

WOOD, DR: - - - of nurses is that they can take them out for the whole next day because they've just been up all night.

KENNEDY, DR: Yes.

WOOD, DR: Yes.

KENNEDY, DR: Yes, and while they're dealing with that then, what are they not able to deal with.

WOOD, DR: Certainly.

KENNEDY, DR: Yes. All right. Is there anything else that you wanted to raise?

WOOD, DR: Not that I can think of.

KENNEDY, DR: No. Okay. Then that leaves me - - -

WOOD, DR: Just don't throw the baby out with the bath water.

KENNEDY, DR: Yes. Well, change for change sake is - - -

WOOD, DR: Yes.

KENNEDY, DR: - - - pretty silly and changing for improvement is the only change worth doing really, isn't it? So, thank you for your attendance at today's hearing. A transcript of this hearing will be sent to you so that you can correct any minor factual errors in that before it's placed on the public record. You need to return the transcript to us within 10 working days of the date of the covering letter or email otherwise we will deem it to be correct.

While you cannot amend your evidence if you would like to explain any particular points in more detail or present further information you can provide this as an addition to your submission to the Inquiry when you return the transcript. So once again, thank you very much for your evidence and for your attention today. Thank you.

WOOD, DR: Thank you very much.

KENNEDY, DR: Thank you.