Aeromedical Services WA Inquiry – Formal Hearing Transcription
Inquirer: Dr Marcus Kennedy
Organisation: Australian Maritime Safety Authority – Mr J Fryday, Mr P Kelly
Date: 14 February 2022, Time: 1100 – 1135

KENNEDY, DR: Okay. Good morning. My name's Marcus Kennedy, I've been appointed by the Chief Health Officer to undertake this Inquiry, and beside me is Jonathan Clayson, who is the Inquiry's Project Director.

Welcome, and I'd like to thank you for your interest in the Inquiry and for your appearance at today's hearing. The purpose of the hearing is to assist me in gathering evidence for the Inquiry into Aeromedical Services in Western Australia. I would assume that you are not recording this meeting, because we have a general requirement at this end that we don't allow recording devices of any sort in the room. And at this end, again, we have got phones switched off or silent. And I'll just check - - -

FRYDAY, MR: I can confirm, there's no recording from our end and our phones are also on silent.

KENNEDY, DR: Thank you very much.

The hearing is a formal procedure convened under part 15 of the Public Health Act 2016 WA, and while you are not being asked to give evidence under oath or affirmation, it is 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 is 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. I believe that you've previously been provided with the Inquiry's terms of reference, the Inquiry's current state considerations paper, a focused list of relevant considerations and information on giving evidence to the Inquiry. So, before we begin, do you have any questions about the hearing process today?

FRYDAY, MR: No, we are fine with the process, and we've also spoken to AMSA Legal, who are also fine with the process.

KENNEDY, DR: Thank you.

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

FRYDAY, MR: My name's Jim Fryday, I am a Duty Manager for the AMSA Response Centre here in Canberra, which deals, mainly, with search and rescue.

KENNEDY, DR: Jim, would you mind raising your hand, so that I can be sure which is you? Thank you.

FRYDAY, MR: White shirt.

KENNEDY, DR: Well, they both look pretty white from here.

KELLY, MR: Peter Kelly, I am a Senior Search and Rescue Officer here in the AMSA Response Centre. My involvement has been that I normally coordinate and engage with Western Australian authorities and the State's authorities for conduct of similar incidents.

KENNEDY, DR: Thank you very much.

At this stage, I'll invite you to address the focused considerations list or other matters that you may wish to in the considerations paper that's been provided to you, and you can speak to these matters for 15 to 20 minutes or so. After that, I may ask you specific questions and then, in any remaining time available, we're free to address any other matters of relevance to the Inquiry or discuss other points. So over to you.

FRYDAY, MR: Thank you.

We have the three consideration points here, there's not going to be a lot of discussion about them, but I'll go through them one at a time, and welcome your questions in relation to the same. Item 3, "The health service governance, including aeromedical services, must be closely monitored and managed by a central coordinating authority - health authority", at page - that's on document page 7. AMSA agrees with this statement.

KENNEDY, DR: Thank you.

FRYDAY, MR: Item 21, "Lack of formal strategic planning or agreements for most offshore for response and transfers limits the development of efficient patient-focused response systems". AMSA agrees with this observation.

AMSA has established an open panel of fixed wing and helicopter operators that are able to provide opportunity services of the three board types described herein:

a) Rescue capable helicopters
b) Helicopters capable of performing search functions
and
c) Fixed wing aircraft capable of performing search functions.

When AMSA is requested by a ship to medivac a crew member/passenger, we are required to identify an appropriate helicopter operator to conduct the mission and seek release from their primary customers, which is mainly the resource industry.

A separate release is also required from the customer for the medical team that accompany the helicopter. In the Perth and surrounding areas, AMSA is able to directly request the release of the Department of Fire and Emergency Service helicopters. That's it for number 21.

KENNEDY, DR: Thank you.

FRYDAY, MR: Number 62 consideration, "There is a lack of coordinated rotary wing aeromedical capability in the northern part of the State, despite clearly unmet need both over land and offshore.

There may be potential to develop local capability in clinical workforce in collaboration between WA CHS, SJA and RFDS around existing hospital and aeromedical services in Broome and Hedland, which could include additional rotary wing capacity". AMSA agrees with this statement.

KENNEDY, DR: Thank you.

FRYDAY, MR: We welcome any questions or any other inquiry that you may have.

KENNEDY, DR: In relationship to the first of those considerations, number 3, and understanding the broad interactions with aeromedical services, which AMSA has at a national level, can you speak to the jurisdictional differences, in terms of the presence or not of coordinated health service responses? What I am heading towards there is that, clearly, there is a suggestion, in this consideration, that there's a need for greater monitoring and managing and central coordination of the - by an authoritative agency, can you talk about jurisdictions where this may be visible to a greater or lesser extent in your experience of working with them - pros and cons?

KELLY, MR: So, I'm just going to find - frame your question response. I'll be generic, initially, and I suppose, we have a tele medical advisory service, which is, when a ship contacts us and requests medical assistance, we have that service contact that ship and provide medical advice to the master and to the injured or sick crew member. Once they've done that, and they make a recommendation back to us that the person should come off and they give us a priority as to how quickly that should occur. We then take that for action, and then we will go and engage with the State authorities to help remove the crew member off the ship.

In other states, we normally have one point of contact, who - our medical officer, that the team has service contacts with, and essentially, does a clinical transfer, and has an agreement with that State, that, yes, the State agrees that the person should come off, and that the person should be accepted into that State's system, and provides us advice as to where that should occur.

At the same time, those authorities that we engage with are normally the primary tasking authorities for their State assets. For example, in New South Wales, we talk to the RLTC, Rapid Launch Trauma, and they control the Toll and the Surf Lifesaving helicopters throughout the State. In Queensland, again, we have a similar arrangement, and that other states. So the first call is that we talk to the State about the clinical transfer of the person, and the need to get them into the State. And after that, we will then either ask for release of their helicopter from the State. If they have a suitable helicopter, we will then go and try and locate another one, which may be a military helicopter as well.

Once we get that release of the helicopter, we generally ask that we can engage with the helicopter crew directly, and then we can - we will go through a tasking process or risk assessment process and set up the job. Because sometimes, these transfers will take place over three days - or two days, and we need to - in a case of Western Australia, it may require us to move the helicopter a hundred miles off the coast, then move it 200 miles off the coast out to Willis Island and then go another 80 miles on from that, so there's a degree of coordination.

And at the same time, we have our fixed wing aircraft that we will put out to support that operation and provide safety to the helicopter at the same time, which is our risk process. So once we get that release, we'll engage with the helicopter crew, and then, we'll task them to the role, we'll continue to engage with the State aeromedical system, and particularly, when the crew get on scene and they make an assessment about where we bring the person back and into what hospital or whatever like that.

The differences we have with West Australia to the other states, that we do not have that central point of contact. If it's around the Perth area, we can go to St John's, we get release of the two aircraft - helicopters down there, and we use them, and our clinical transfer can normally be done in that same conversation with St John's. When we move out of the State, is where we get to the scenario where we don't have a central point of contact to communicate

with, so we'll sometimes talk to the Port Hedland Hospital, or sometimes, we'll talk to the different hospitals at Cocos Island or Keeling Islands as well, which we - come under the sort of WA scenario.

We'll also then engage, if we need to, with RFDS, the regional operators - regional operations group, because we may be bringing the person back to an airfield, and then, we'll arrange a fixed wing transfer from there.

So the key differences are that in every other State in Australia, we do have an arrangement with the one point of clinical transfer, and then, we do, generally, have arrangements to utilise the State assets or State contractor assets, whereas, in Western Australia, particularly up in the Pilbara region, where we do a lot - I think - what we - we've got the figures here on what that - how many we've done over four years. I'll give you a couple of figures over a four-year period: 59 medical evacuations off the coast, we've also got medical advice to 46 ships and 119 injury reports as well. 98 per cent of those evacuations were of foreign registered merchant vessels, bulk carriers, a lot of them into Port Hedland.

So (indistinct) 11.12.50 to up there is that we'll then have to go and seek release from one of the panel operators that we discussed before, and then, get release of their medical crews, such as Aspen or whoever is in the back of there, and then, conduct that and then, we'll bring them back and try and get them into the WA health system.

The cost recovery sort of side of that as well is that we have pretty standard arrangements around the country, and West Australia is the same, we will cost recover all transfers of crew members, of international and large shipping, for the helicopter, for the - where I've talked about we use a fixed wing aircraft to provide that support, that's our risk assessment, and we bear that cost for that action. And out of our community service obligation funding, we now utilise that to recover the money for all passenger and State - passengers of any ship, and for crew members of domestic vessels. Is there any questions about that, or - - -

KENNEDY, DR: Thank you. Can you just clarify who do you contract, currently, for your medical assessment service?

KELLY, MR: At the moment, our tele medical advisory service provider is LifeFlight up in Queensland. We've - that contract's probably been around now for probably about eight years, I think. Prior to that, we used RFDS.

FRYDAY, MR: It's just been renewed for another two years, last October.

KELLY, MR: And that's a two-part service for us, the first part is that they provide a service to any ship anywhere in the world, can contact us, and then we'll patch them through and the ship will be provided medical advice. And there's a couple of other services such as that, one in Italy, and one in the US, that provide that similar service. And then, when the ship is in the Australian region, they then provide us with assistance with conducting our medivac transfer and advice and the clinical transfer into the State.

KENNEDY, DR: So just to clarify that latter part, I was just going to ask you who provides your fixed wing service? I'm assuming LifeFlight is the answer to that?

KELLY, MR: No, our fixed wing service is - the aircraft is a search and rescue aircraft, it's a separate contract that we have.

We've got three jets, one of which is in Perth, and they're fitted with a range of sensors that we use for search and rescue. They have a - they basically fly for around eight hours, and we use them, primarily, for search and rescue, but in a case of the medivac, we use them to go out and to get ahead, normally, of the helicopter, to start setting things up, to reduce the amount of time the helicopter is not - or they're required to be in that area, they'll establish communications and then they'll be providing a safety service for the helicopter, so that in a case of a ditching or something, that they can then drop life rafts and stay at the top and then assist the crew until we can rescue them.

But they, themselves - our aircraft have no aeromedical capability. The only time - it's very rare that we would use a fixed wing for that aeromedical evacuation, because normally, we're taking people off ships. There have been a couple of times up in the Northern Territory, where we've used the Mallard, which is operated by the - Paspaley, to go and pick up a patient from the lagoon there, or we've arranged to have an RFDS jet meet the helicopter on arrival.

And that all depends on whether - and we had this little - there's a peculiarity there, where if we get the patient into the hospital, it's then up to the West Australian health system to make arrangements with RFDS to move that patient. If it's occurring before they're accepted into a hospital, we will liaise with RFDS to have that aircraft meet them, and then we do the cost recovery there as well.

KENNEDY, DR: Okay. So, the fixed wing medevac component, as opposed to the SAR component, would be either RFDS or one of the other State providers, depending on where you were, if a person's - - -

KELLY, MR: Yes.

KENNEDY, DR: - - - brought to shore, you know, in a place that's not got appropriate health facilities?

KELLY, MR: That's correct, yes.

KENNEDY, DR: Okay.

So in terms of the various State authorities that you interface with after the medical assessment, you mentioned New South Wales - I missed part of that, but were you referring to the aeromedical desk coordination point at New South Wales Ambulance?

KELLY, MR: Yes, that's correct, RLTC.

KENNEDY, DR: Yes.

KELLY, MR: There's around three or four organisations in that room there.

KENNEDY, DR: Yes, I understand. It's - - -

KELLY, MR: We talk - our point of contact is the RTLC, the Rapid Launch Trauma Coordinator.

KENNEDY, DR: And Queensland would be through RSQ?

KELLY, MR: RSQ, that's correct.

KENNEDY, DR: Ambulance Victoria - air wing?

KELLY, MR: Is - Air Ambulance Victoria.

KENNEDY, DR: Yes. Tasmania would be - - -

KELLY, MR: We go direct to the - I have to think of who their operator is with the helicopter down there, yes. *(Clarified on review of transcript: Ambulance Tasmania – State Operations Centre)*

KENNEDY, DR: Okay, for the ambulance aeromedical service?

KELLY, MR: Yes.

KENNEDY, DR: And in South Australia, is that through MedSTAR, or - - -

KELLY, MR: Yes, MedSTAR.

KENNEDY, DR: Thank you.

KELLY, MR: And NT is CareFlight, and then we utilise the - they've got the one CareFlight helicopter, or if required, we'll utilise - - -

KENNEDY, DR: RFDS?

KELLY, MR: Yes. And then, if there's no capability, particularly up in Darwin, we'll go seeking the defence helicopter that's in Katherine.

KENNEDY, DR: What do you - just a slightly different question, what do you see as the importance of standards - and by that, I mean aeromedical clinical standards and aviation standards, in terms of the organisations that you interface with? I presume that you would have a position, in terms of - I guess you don't get a lot of choice, in terms of who you interface at a State level.

But do you have a view about the importance of aeromedical and aviation standards that are met by the various organisations that you interface with?

KELLY, MR: So if - for the aircraft, and if they're a panel - an aircraft that is a panel, we have an auditing process as part of that contract, and - whereas we have (indistinct) 11.20.50 and we go through and we check to make sure that they meet the CASA standards, and particularly, at the moment, with the shift to CASR Parts 138 and 133. So - and with respect to the medical side of that, generally, on a State based, it'll be the air ambulance people - sorry, it'll be the members of the ambulance - the State Ambulance Service.

With WA, I - we don't have a contract, say - as an example, for Aspen. We don't have a contract with Aspen for the provision of medical people in the back of our helicopter. And we don't have an auditory process and we don't have a checklist to make sure that they're a certified medical provider for West Australian Health. But I think we fall upon the fact that they're part of an agreed package that's been provided to the resource industry or to the State, in the case of RFDS. So - yes, so we have a formal process that we go through for the aircraft, we don't have a formal process for the medical team on board.

KENNEDY, DR: So is that - that's the situation in any of the contractors that you have, so in any State, you don't have specific visibility of their clinical governance and patient care capabilities - it's assumed, because they are an ambulance service or a retrieval service?

KELLY, MR: That is correct, yes. Over the last 12 to 24 months, we ourselves, have gone through a process where we're more structured and we're tighter with the aircraft that we utilise now, and we only use our - unless it's an exceptional circumstance, we only have approval to use our panelled aircraft, and then, we have to go through a formal process if that's not available and we need to use something else. And the same again with defence, if we call upon a defence contracted aircraft to assist, because we don't have a civilian capability, we have a contract with the aircraft, but we are reliant upon their assessment of their medical team. What we do ask, with our medical service, our doctor is - does the patient need a doctor, a paramedic, or a medical attendant, and then, we'll drive out our process on that.

KENNEDY, DR: But you've got no particular way of knowing about the competency capability or historical performance of that doctor, paramedic or clinical attendant?

FRYDAY, MR: Yes, it's fairly broad - yes, we'll take that on notice, and we probably can speak to (indistinct) 11.24.12 in relation to that for you and get some clarification.

KENNEDY, DR: I guess, where I'm heading is, if you're dealing with a State service or military, then it seems a reasonable assumption that, you know, the State ambulance service would have appropriate clinical governance in place, in terms of guidelines, practices, a scope of practice, credentialing - all those sorts of things. When you're dealing with a contractor, which happens from time to time, does that sign of the equation have the same visibility or comfort, if you're dealing with, you know, company X, who provides you with an aircraft and a doctor and a paramedic?

KELLY, MR: I think - I'm going to say that in most cases in any other State, we're reliant upon the fact that it is a State ambulance service being provided under contract to that State - - -

KENNEDY, DR: Yes.

KELLY, MR: - - - so the standards, we would expect that they have in place there. With defence, we're reliant upon the fact that they have gone through a process and are providing - and we're familiar with the different State operator - sorry, the different defence operated helicopters. We are very familiar with their capabilities and their crewing of those contractors. Within respect to Western Australia, I - we don't have a process - and we don't have a formal process to say, yes, we believe that Aspen or, for example, that third party, are qualified and certified to do this role. At the same time though, if we are conducting a medivac, the only reason we're conducting a medivac in that sort of scenario is that it is life-threatening.

So, I think that we're reliant upon the guidance being provided by TMAS and by the State authority. And again, in Pilbara, whilst we say we don't have a State - a whole of State coordinating authority with WA, generally, we'll end up in a conversation with Port Hedland Hospital or their - and we would look at their expertise, if they believe that the third party in their helicopter is sufficient.

KENNEDY, DR: Okay. So I think I understand the perspective and those challenges there, which could be addressed by - as you've agreed, a more closely monitored and managed central coordination authoritative agency that would have governance oversight and perhaps be responsible, at a State level, for ensuring the aviation standards and the clinical governance standards of the response team, as is the case in other cases in other States, where you're dealing with a State ambulance service, mainly.

A question I have, just to finish, is how would you rate the level of organisational risk if that were not proceeded with? So, it's a recognised risk, obviously. It's - do you have any thoughts, either from your organisation's perspective, in terms of any risk that you may carry, or just in general terms?

KELLY, MR: We'll just talk - you know, just talk here for a second.

(KELLY, MR and FRYDAY, MR – have private discussion between themselves)

KELLY, MR: So, the risks do vary in relation to using a contractor and knowing what they're supplying. In relation to and regarding to what the New South Wales ambulance would, as an example - just because they're due governance as well, we have a process that we've brought into play here, with a risk process over every facet of using the aircraft on the panel, and that includes who they carry as well.

So, under CASR Part 138, they - the operator and the pilot have the regulatory standards to actually make sure the paperwork's up to date. Those people are observers or medical or whatever the case may be. So that's probably what I would tell you at this point of time. We regulate what we can, minimise the risk through the operator, and the way we task the asset.

KENNEDY, DR: Thank you.

Do you see that your risk exposure in interfacing with Western Australia systems is different to other jurisdictions?

KELLY, MR: Our risk assessment is different, yes, because we're using - other than the two machines down in Perth area - the St John's Ambulance, is we are using contracted aircraft that are not dedicated State ambulance aircraft. So - yes, we - and it also increases as well, because of the nature of the aircraft that are up in that operator area, is that pretty much every medivac we do must be a winch operation, which has its increased risk as well, because of the size of the helicopters and the deck limit on the aircraft.

So, a high percentage there involves winching, which therefore means, we're reliant upon that operator having a medical team that are qualified to be winched into that scenario as well. In fact, the other case there is, is that the lower level, where you don't have a life-threatening scenario, where we have somebody who's broken an arm or is ill and needs to, you know, would normally have to be taken to a hospital in an ambulance is, particularly, in Western - Port Hedland and that area, where the ships are 20 to 30 miles off the coast, we have also had that trouble of getting a qualified medical attendant onto the helicopter or a boat, even.

So, we - over the last few years, say, in Port Hedland, there has not been anybody that we could stick onto a boat that we know is qualified and able to be taken out in the pilot helicopter or on a boat. So that, for us, makes it very hard, whereas if we and the port knew that there was a qualified medical person to either paramedic - or as a medical attendant, a paramedic

or a medical officer available and qualified, that would reduce our risk assessment and increase the response for the seafarer quite significantly.

KENNEDY, DR: Okay. And Port Hedland is the epicentre of your activities in WA, or - that's other than Perth?

FRYDAY, MR: Karratha, (indistinct) 11.32.26.

KELLY, MR: The Pilbara region, but - yes, so that Port Hedland, Karratha, Dampier, yes, if we have - if we do a medivac down on the southern area, we've normally got to operate to - access to the two helicopters down there, of which we can make suitable arrangements, and we - but north of - really, north of Geraldton becomes a challenge for us.

KENNEDY, DR: Thank you. That's the end of the questioning from this end. Is there anything else that you wish to add that may be of value to the Inquiry at this stage?

KELLY, MR: No, nothing else further to our - I think your questions covered - well, hopefully, our answers covered what you wanted out of the questions, anyway. So, thank you for asking them. We're happy to assist.

KENNEDY, DR: Okay. Thank you very much for your attendance today at the hearing.

A transcript of this hearing will be sent to you, so that you can correct any minor factual errors before it's placed on the public record. You need to return the transcript within 10 days of the date of the covering letter or email, otherwise, it'll be deemed to be correct. And while you cannot amend your evidence, if you would like to explain 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 time, and for your contribution today, and to the consultation process that's led up to this as well, thank you for your input there.

KELLY, MR: Thank you very much.

FRYDAY, MR: Thank you.

KELLY, MR: Thank you, talk to you again, bye.

KENNEDY, DR: Thank you.