Aeromedical Services WA Inquiry – Formal Hearing Transcription
Inquirer: Dr Marcus Kennedy
Organisation: CHC Helicopters Australia Pty Ltd – Mr L Vanson,
Mr R von Heerden, Mr J Barrington
Date: 15 February 2022, Time: 1130– 1203

KENNEDY, DR: Good morning. Thank you for your interest in the inquiry and for your appearance today, coming again.

The purpose of the hearing is to assist me in gathering evidence for the Inquiry into Aeromedical Services in Western Australia. So I begin by introducing myself and I'm Marcus Kennedy and I've been appointed by the Chief Health Officer to undertake the inquiry. Beside is Jonathan Clayson who is the Inquiry's project director. We would 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 under the - convened under Part 15 of the Public Health Act 2016 (WA). 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 the questions and that there are penalties under the Act for knowingly providing a response or information that's false or misleading.

So this is a public hearing and a transcript of your evidence will be made a 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, the current State considerations paper and information on giving evidence to the Inquiry.

So before we begin do you have any questions about the process for today?

VANSON, MR: No, we're all educated on the process, thank you.

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?

VANSON, MR: Certainly Luke Vanson, sales and commercial manager for CHC Helicopter for the Asia Pacific region.

VAN HEERDEN, MR: My name is Ronald van Heerden. I'm the manager, flight operations, chief pilot for CHC Helicopters Asia Pacific.

BARRINGTON, MR: And my name is John Barrington. I'm the flight operations manager for CHC Helicopters, Asia Pacific.

KENNEDY, DR: Thank you. So, you're now invited to address the focused or the considerations paper and/or any other material that you wish to bring before the Inquiry. I'll aim to let you speak through a presentation that can take up to 15 or 20 minutes if you require that time after which I may have questions for you obviously. I'll try not to interrupt you as we go along unless there's material in your presentation that I don't understand or I need clarification on the context. I'm happy for you to present that in any way that you and your team would like to present and - - -

VANSON, MR: Sure.

KENNEDY, DR: So it's over to you.

VANSON, MR: Thank you, Dr Kennedy. From CHC's perspective we're encouraged by the length and depth of the Inquiry thus far. We've been an active participant in all of the regional

reviews which you're well aware. CHC as a service provider to the state by the emergency rescue helicopter service under contract with DFES puts us in an interesting position noting that that contract currently under renegotiation and potential award in coming weeks if not months has placed us in a difficult position. That said we're invested in the best possible outcome for this review as Western Australian residents, aviation enthusiasts with family and friends that live here. Ultimately the state of Western Australia can do much better than we are and we welcome the opportunity to provide our expertise to support that.

So in summary I've got four points that pertain to helicopter services. There's been a lot of discussion around things that are outside of our area of expertise. Whilst we work closely with medical service providers, clinicians et cetera, the team assembled, we're aviation experts. We're not doctors or clinicians. So, in that light based against our experience both here in Australia and in other jurisdictions across the world, some of the areas for improvement we see here for Western Australia is in the - in setting up and formalising a state-wide aeromedical framework. That framework needs to incorporate a state-run and centralised tasking and coordination capability which includes and has the appropriate mandate for the triage and tasking of road, fixed and rotary wing assets across the state.

We find ourselves in an interesting place where there's a number of nuances that require approval and people that need to be engaged prior to our helicopter that is currently on contract being able to depart to do what it is that it's arguably there to do. The second point we had is that the aeromedical controllers that have the approval to task our aircraft, it would be advised that they have an increased operational understanding and experience in an aeromedical environment. An air ambulance is not just like another ambulance. It has many, many different layers of complexities. And we see other states do that much better than we do here in Western Australia.

The third one I've got is a quite an urgent need of a capability needs analysis. We're seeing some resources become available for the state that from our perspective are not fit for purpose, including the modelling, the aircraft itself, the specific platform. The standard of associated aircraft performance and the crew's experience have all been of concern to us as aviation experts in our field.

So we find it problematic that resources are made available on the market to departments such as the Department of Health that we believe are not fit for purpose and we're concerned at that. Within the politically sensitive environment with which this is may see something that is suboptimal and not in the best interest of the people of Western Australia.

And then lastly, we've seen some great improvements in the crew harmonisation, safety and performance outcomes by ensuring appropriate levels of crew integration, that this is a team sport effectively. If anyone of us could do it on our own, we would. But we need aviation experts. We need pilots. We need crewmen. We need engineers. We need managers. We need clinicians. We need aeromedical controllers. And together when we're all on the same page we can do wonderful things. So, the integration that we ensure is in place is in a formal capacity through CASA-regulated and mandated classification through *(section)* 20.11 type endorsements and providing ESCs to medical staff so they have a legal function as a member of the crew. They're not just someone that gets in the back to deal with the patient. They're treated as a member of the crew and that's been pivotal in our successes in other states and jurisdictions.

Gentlemen, I don't know whether there's anything else that I've missed in our briefing?

BARRINGTON, MR: Summarised that pretty well actually.

VAN HEERDEN, MR: Yes, no.

VANSON, MR: Yes.

VAN HEERDEN, MR: Pretty good sum up, I think.

VANSON, MR: So Dr Kennedy, I welcome any questions you may have.

KENNEDY, DR: Okay, just going in reverse, from the last point you made in relation to clinical staff crew status is that a universal approach?

VANSON, MR: It is in CHC operations, yes.

KENNEDY, DR: Yes. You spoke of concerns in regard to the - I guess the modelling, the platform fit and the crew capability in regard to services that are new or being introduced or have been proposed. I wasn't clear exactly what you were talking about there. Can you - do you wish to be any more explicit?

VANSON, MR: Yes, certainly. I'm aware that there's two EC-145s that have been made available to the state that will be operational in January of this year to provide inter-hospital capability.

KENNEDY, DR: Yes.

VANSON, MR: And the makeup of that platform, the crew configuration, the crew experience, the engineering requirements, all of those particulars are of concern.

KENNEDY, DR: Okay, so that's an opinion that CHC has formed as an expert organisation and provider of aeromedical services.

VANSON, MR: The concern is based upon the marked difference between what we know as industry best practice and what we're seeing in the field.

KENNEDY, DR: Okay. Can you think of anywhere, any other jurisdiction where the particular model that you're referring to has been applied successfully?

VANSON, MR: No.

KENNEDY, DR: Do you have a view on what the state could or may have been able to consider as an alternate if the goal in terms of the you know the target audience if you like, the patient cohort that it's aimed is inter-hospital transfers, do you have a view on what could have been an ultimate approach to that?

VANSON, MR: A tendering process out to market that the market responds accordingly. I think that the state of Western Australia is better than build-it-and-they-will-come type modelling. This is a resource that's much more important than that. The commercial world needs to apply appropriate competition to provide the best service to the people of Western Australia.

KENNEDY, DR: So other than from a commercial probity perspective which is not insignificant - - -

VANSON, MR: Yes

KENNEDY, DR: - - - are there other aspects of the introduction of additional rotary platforms in a system that need to be considered?

VANSON, MR: We've seen in other states around Australia and overseas of the build-it-and-they-will-come type model, it's potentially appropriate in third world countries trying to circumvent issues, red tape, funding, a myriad of challenges that might be appropriate. But here in Western Australia like I said we're better than that. And we're not going to get best outcome because the industry at large hasn't been given the opportunity to put its best foot forward to enable the appropriate procurement practices rather than have something that politically can't not be used.

KENNEDY, DR: Have you given any thought to the concept that those platforms are being introduced on a trial basis and how such a trial may be evaluated and to what end that may progress?

VANSON, MR: Yes, I think this isn't a new space. A trial in the interests of finding new information is a great idea but this isn't new.

There are a number of documented and thorough articles, research papers, et cetera, not only here in Australia but around the world that provide the required data and evidence to help educate someone as to which is the best way to go here.

KENNEDY, DR: So if I paraphrase what you're saying the system determined through a needs analysis that there was a requirement for an inter-hospital or rotary-wing transfer service. The evidence about the efficacy of such services over known geography and articulating with other types of systems is well researched and well published.

VANSON, MR: And readily available.

KENNEDY, DR: Thank you. You talk about the skill set and capability of aeromedical controllers. It's actually the first time that anyone has raised this in the Inquiry to date and takes me back to systems where I worked and seen I guess seen what I would consider to be highly educated and savvy controllers, dispatchers who have got capability to assess both the clinical demand and the aviation components of a response in terms of everything from safety to you know to urgency et cetera.

VANSON, MR: Yes.

KENNEDY, DR: Obviously within the framework of much of that response then being pilot response (indistinct)11.44.07 of course.

VANSON, MR: Yes

KENNEDY, DR: What brings you to raise that as an issue? Is this related to other systems where you've seen this working better than it is locally and so therefore there's an opportunity for improvement or as a - well, as a company, I meant?

VANSON, MR: Yes, correct, I was an air crew member of the Ambulance New South Wales rescue helicopters for some 14 years. Also base manager and then finished that contract through in contract management position. And through my tenure as - not only as an operator on board the aircraft but also as a manager and then a contract manager we implemented an educational program for the highly experienced controllers that are experts at doing the associated dispatching and understanding all of the nuances.

But like I said before if any one of us could do it on our own we would. We saw great increases in efficiencies and mutual understanding. We saw reduction in aircraft stand down and we saw an increase in the rate of flying. So when we interrogated that data what it showed is that we were getting called off less but we were flying more. So it meant that we were having more touch points with more patients and wasting less hours in - - -

KENNEDY, DR: So - - -

VANSON, MR: - - - unnecessary tasking.

KENNEDY, DR: So the appropriateness of the tasking improved?

VANSON, MR: Correct, yes.

So we found ourselves in a spot where with multiple service providers in a close proximity that we were able to eliminate helicopter shopping because they understood why a helicopter in this particular region might say, "No, we can't because of the weather" but one only just a little bit further up the road says, "Yes, we can" is - it was providing a greater level of education as to what is aeromedical retrieval to someone who is not a traditional aviator. And it paid dividends for the crews. It brought everyone as a team closer together because more people understood the decisions that broke down the silos. It was an amazing opportunity to rebuild a strong team.

KENNEDY, DR: So in terms of the current WA approach what would you see as the - you know as a potential pathway for improvement in that space?

VANSON, MR: The format that we used was actually having the dispatchers conduct sessions at the helicopter base with the helicopter crew to participate and sit in the crew room to understand and observe flight planning. With an appropriate air frame we were able to - and an appropriate job we were able to have them on what was referred to as ride-along mission so they could see what it was actually like from the aviator and clinician perspective and trying to operate in the back of the aircraft.

KENNEDY, DR: In some settings I'm aware of specific training programs that people that would move into that kind of role would need to go through in terms of you know a degree of formal education, both from the perspective of understanding the clinical side of the response and patient care - - -

VANSON, MR: Yes

KENNEDY, DR: - - - in the primary or secondary retrieval setting but then also from the aviation perspective. And then effectively to have a period of supervised practice where certain standards are met for - if they fly solo.

VANSON, MR: Correct. And that should happen prior to being released if you like.

KENNEDY, DR: Yes.

VANSON, MR: Prior to flying solo.

KENNEDY, DR: Yes.

VANSON, MR: That exposure, that training, that induction, that supervision should happen.

KENNEDY, DR: Are you aware of systems like that existing locally?

VANSON, MR: No, I'm not aware.

KENNEDY, DR: Okay.

VANSON, MR: That doesn't mean they don't exist but I'm not aware, no to answer your question.

KENNEDY, DR: Okay. So, in this context that would then sit with St John's obviously

VANSON, MR: In the current - - -

KENNEDY, DR: Current environment.

VANSON, MR: - - - environment in Western Australia, yes.

KENNEDY, DR: What about the from the perspective of secondary tasking which would come from RFDS through St John's? Do you see the same concept and the same issues in that space?

VANSON, MR: Yes, under the same preface as what my opening statement that we're not a clinical organisation.

KENNEDY, DR: Yes.

VANSON, MR: But we do see enormous challenges with a single non-government organisation providing the triage, the transport, the coordination that - that's a challenging environment to ensure the best outcome for the patient.

KENNEDY, DR: Yes. As a - you know as an aviation provider in this kind of setting and others obviously, but you talked to the issue of the framework around coordination and tasking.

VANSON, MR: Yes

KENNEDY, DR: The way that that is at the moment is a bit mixed, you could say mixed up. But there are different ways that a case may present itself either through WACHS, potentially through the - - -

VANSON, MR: Yes.

KENNEDY, DR: - - - you know the coordination centre or directly to RFDS through their clinician, through the call taking process which then goes to a tasking person - - -

VANSON, MR: Yes.

KENNEDY, DR: - - - that works adjacent to or is not connected to if it's the WACHS issue although there is now a liaison - RFDS liaison person in - - -

VANSON, MR: I understand.

KENNEDY, DR: - - - in the WACHS centre. What's your feeling about that sort of chain of communication as it is at the moment? Do you have any comment on that?

VANSON, MR: Again under the same preface of not being a clinical triage expert but from our experience in other states around Australia and other jurisdictions around the world it's very disjointed.

KENNEDY, DR: What are the main issues in there that cause that disconnection?

VANSON, MR: The tasking, the demand signal if you like for a requirement of a helicopter it doesn't change. It might be a police tasking. It could be an inter-hospital requirement. It could be a road crash. It could be a police search. All of those things are the same everywhere else. Having a single point of contact into the helicopter place that is the single point of contact when the helicopter is away from base to enable - to ensure that all of the information is funnelled through a single channel. When a number of - there appears to be a number of layers that are adding to the complexity of the tasking and therefore the associated authority as to who is in fact in control.

KENNEDY, DR: So if you were to - I might go the other way around. The Inquiry has looked comparatively at different state systems.

VANSON, MR: Yes.

KENNEDY, DR: From the point of view of firstly you know commonality of the system need in relation to geography, population distribution, clinical care, capability outside major centres, all that sort of stuff. And there's a fairly good match between South Australia and Queensland and WA. Or like the sizes are different you can look at in modelling and actually the demand or the system demand is fairly similar. New South Wales are slightly different, largely because of population distribution - - -

VANSON, MR: Yes.

KENNEDY, DR: - - - in a smaller space and the distribution of critical care capability outside Sydney is quite different to the other states. If you were to look at one of those and you can

include any other setting and say from a coms perspective and a coordination perspective and a tasking perspective, which to me kind a bit like a continuum anyway - - -

VANSON, MR: Yes.

KENNEDY, DR: - - - which of those systems do you see as potentially the most applicable to Western Australia's setting?

VANSON, MR: The bulk of my experience in this area in a practical sense is in New South Wales. I have intimate knowledge of the way the medical retrieval unit functions in New South Wales. I've worked in Queensland, Victoria, Northern Territory, Western Australia and South Australia. I haven't flown in Tasmania. It's the only state I don't have an aviation footprint in. But both the New South Wales and the Victorian models are from an aviation perspective by far most effective and efficient enabling the same person who calls the base, it's the same person you talk to on the radio when you depart, same person, you let them know what your ETA is to the receiving hospital. It's the same person, you let them know that you're back on base. It's the same person you tell that you've now turned the aircraft around and it's ready to go again.

KENNEDY, DR: Okay. You just blew your credibility because - I'm joking. But I would argue the point with you because the Victorian system actually - and you probably - you may not be aware of it, separates the primary response tasking and the secondary inter-hospital even critical care inter-hospital separate, quite separate. And then they have to come together and talk and decide about who can fight for what platform et cetera.

So, it's a slight weirdness. I would agree with you in terms of New South Wales. I think if you were to look at a system which has a single in point, to an environment where all of the right decision-making can occur and then a single communication point out of it in terms of the aeromedical response, it's very nicely set up. And although there are some differences in Queensland, it's very similar.

There's just a slight difference in terms of who takes that initial contact point depending on type of case that it is. I would actually - I think I would agree that the New South Wales probably in many respects one of the most balanced models and also the most functional at an inter-disciplinary level.

VANSON, MR: yes.

KENNEDY, DR: It's very team-focused and works well.

VANSON, MR: yes.

KENNEDY, DR: And I'm meant to ask questions and not give commentary but I can't help myself. It's better if it becomes a conversation. That actually covered off on the items that I had noted through your presentation. Is there anything else that you wanted to talk to or other members of your team would like to address?

VANSON, MR: To the team? Anyone?

VAN HEERDEN, MR: I think Luke has covered it pretty well. I think the one common theme is the central point gives the ability for the government, a government entity to have multiple

contractors working with different platforms in different ways in different parts of the state but still have that single oversight - - -

KENNEDY, DR: Yes.

VAN HEERDEN, MR: - - - which we don't have at the moment.

KENNEDY, DR: If you think about it from a you know developing system perspective in that central place in the Western Australian setting you're going to have WACHS and their responsibilities and work with referrers into the aeromedical system. They also (indistinct)11.55.54 region support obviously. You're going to have RFDS as a major provider, a contractor. You're going to have St John's Ambulance with the emergency side of the conversation. And then there's also road which is not so much of your interest although you know from an aviation point of view it's fixed-wing, incredibly important.

So you've got a lot of players sitting in that space. From your point of view do you have any thoughts about what the relationship that those people in that room should be or organisations in that room and how can that be made to work given that they all come from different organisations, all have their own perspectives and drivers, priorities. How do you make something like that work?

VANSON, MR: It's very difficult here in Western Australia with the lack of direct government agency and with multiple critical components provided by a commercial entity. It makes it very, very difficult to get them to all play nicely.

I think it's a testament to those that are involved in their current capacities. The fact that it works at all is remarkable and clearly they're doing a lot of things right because otherwise it would be in a much worse place than it is currently, notwithstanding a large amount of room for improvement. Getting that together is critical for the success of the future state of aeromedical retrieval.

To get there it's a single tasking authority that has the required authority to be able to make decisions from end to end. Can't have a hospital with a bed that's available that's going to decline the transfer of a patient when - it just turns into a mess. And I step carefully in that area because again it's not our area of expertise. But as an outsider looking in it's very disjointed right the way through the tasking - - -

KENNEDY, DR: Yes.

VANSON, MR: - - - and command control space.

KENNEDY, DR: Yes. So I understand you don't have you know clinical expertise but you do have systems expertise.

VANSON, MR: Yes.

KENNEDY, DR: And that's what we're talking about. So can you envisage an environment like that, space like that where there is a federated arrangement such that - and the characteristics of a federated arrangement are that each of the players in that system are completely autonomous and have the right to manage their own resources in the way that they

see fit. Does that fit with the concept that you raised of the need for authority and point direction, point responsibility?

VANSON, MR: I think it's at odds with it. I think it is unrealistic to expect multiple organisations with varying professional and commercial endeavours to be able to do that effectively.

KENNEDY, DR: So there needs to be some form of control over that system - - -

VANSON, MR: Yes.

KENNEDY, DR: - - - that isn't just good will and we're kind of on the same team guys.

VANSON, MR: Yes.

KENNEDY, DR: It needs to be more structured than that?

VANSON, MR: Agree, yes.

KENNEDY, DR: Okay. All right, is there anything else that you would like to add?

VANSON, MR: The only one that we haven't touched on is a funding model as a - - -

KENNEDY, DR: That's kind of important.

VANSON, MR: Yes, very much so.

As a commercial entity any service provider needs to be able to make a reasonable profit to ensure sustainability. When the funding model is such that there are motivations to operate in a particular way in the environment that is aeromedical retrieval I think we thinly veil our motivations are in the best interest of the patient. I think it's a slippery slope when the model allows or in fact encourages perhaps an operator to conduct themselves in a particular way to generate revenue where the funding model should be such that the helicopter or the fixed-wing makes or the road ambulance makes adequate money regardless of whether there's someone in the back of it or not. It's perhaps an idealistic way of looking at a commercial relationship with an operator. But when we're - we all claim to be patient-focused, safety always, the commercial reality of the funding model will influence the way a commercial entity operates.

KENNEDY, DR: So how much profit is too much profit?

VANSON, MR: Well, that’s a great question. A labour-intensive, high-capital investment, highly regulated government contract through the procurement papers that are available on the public record, it's suggested that a minimum of 8 per cent to 15 per cent is a reasonable profit to ensure sustainability and investment in the future. That's not a figure that I've come up with. That's one that's been researched and published by various government procurement agencies around the world.

KENNEDY, DR: Okay, thank you. That's been very helpful, very well thought through presentation and raised some important issues which will be of value to the Inquiry going forward. Thank you for your attendance at today's hearing. Transcript for the 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 it otherwise it will be deemed to be correct. 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 for your attendance and for your input. Thanks very much.

VANSON, MR: Thank you.

KENNEDY, DR: Yes.