Aeromedical Services WA Inquiry – Formal Hearing Transcription
Inquirer: Dr Marcus Kennedy
Organisation: PHI International Australia Pty Ltd – Mr T Hartley, Mr G Watt, Mr S Mager
Date: 15 February 2022, Time: 0830 – 0904

KENNEDY, DR: Good morning.

HARTLEY, MR: Good morning. How are you?

KENNEDY, DR: Good, thanks. 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'll begin by introducing myself, my name's Marcus Kennedy and I've been appointed by the Chief Health Officer to undertake the inquiry. And beside me is Mr Jonathan Clayson who's the Inquiry's Project Director.

We would ask that you aware that the use of mobile phones and other recording devices is not permitted in this room and that you would please ensure that your phone is on silent or switched off. Speaking of which - that would be embarrassing, wouldn't it?

The hearing is a formal procedure convened under part 15 of the Public Health Act 2016 and whilst 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. And 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've previously been provided with the inquiry's terms of reference, the inquiry's current State considerations paper, a focus list of relevant considerations and information on giving evidence to the inquiry. Before we begin do you have any questions about today's hearing or the process?

HARTLEY, MR: No, not at this stage.

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

HARTLEY, MR: Tim Hartley, General Manager of PHI International Australia.

MAGER, MR: Sean Mager, Service Delivery Manager for PHI Australia.

WATT, MR: Gordon Watt, Commercial Manager for PHI.

KENNEDY, DR: Thank you.

You'll now be invited to address the focus considerations list and the considerations document and other matters that you may wish to, and you may speak to those matters for 15 minutes. I'm happy for you to talk longer than that assuming that I don't have a lot of questions and things that I need to clarify as we get through the half hour that we've got allocated. But otherwise unless I don't understand something, I will allow you just to present the material that you wish to present first and we can take it from there.

HARTLEY, MR: Understood.

KENNEDY, DR: If you wish to remove your mask to be heard more easily or to speak, that's okay. The rest of us will keep our masks on.

HARTLEY, MR: Thank you. Thanks for the opportunity of coming in today. To give a better overview I'm probably better off handing to both Gordon and Sean who have joined me today.

KENNEDY, DR: Yes.

HARTLEY, MR: PHI are an aviation provider that's been in business for 72 years. The reason both Sean and Gordon have come today is Gordon's background is search and rescue medevac in air medical and predominantly helicopters also he is a qualified paramedic. And Sean has just on 29 years with the RFDS involved in this. So, it's probably best to hand over to them to outline PHI's response.

KENNEDY, DR: Absolutely.

HARTLEY, MR: - - - start off for us.

KENNEDY, DR: I'm happy for you to use the time as is - - -

HARTLEY, MR: Sure.

KENNEDY, DR: - - - most useful for you. Go ahead.

WATT, MR: Do you [Sean] want to lead off?

MAGER, MR: Yes. Good morning. Thanks for the opportunity. Before I do start I just, want to confirm did you receive the document that was sent last week?

KENNEDY, DR: It's right in front of me.

MAGER, MR: That document was referring as an oversight of the considerations document that was presented to us. Just to give a broad view, a broad response, it wasn't directly trying to answer the 190 points of consideration. PHI believes that providing an increased opportunity for medical services provision to those in the country by way of rotary response is a good idea and something that's been a long time coming. There's been a gap in the system for many, many years and my past life that was something I dealt with that every day.

PHI is represented, and Gordon will speak more to this, with a 24/7 all-weather search and rescue aircraft that's based in Broome and this is utilised regularly by AMSA and other stakeholders to, retrieve people or search and rescue opportunities offshore, onshore. Before I go further, I'll throw to Gordon just to throw in some more detail on that area, if that's all right.

WATT, MR: Yes, sure, thanks, Sean. So, we have a number of operational bases in the north of the State and we have primary clients for the resources sector both oil and gas and mining.

For all of those contracts or clients as such we provide an Aeromedical Service of varying degrees from simply a stretcher transfer vehicle for want of a better term supported by ground based medical teams who would look after the patient all the way through to a 24/7, highly

capable search and rescue aircraft based in Broome supporting predominantly the Ichthys and Prelude Projects for Inpex and Shell respectively.

All of our clients are supportive of State requirements whether it be AMSA, DFES or other stakeholders who request our support. In most circumstances that support is forthcoming and they're willing to release the asset as such to provide a service but there's no assurance in that service. There is also a lack of standardisation between ourselves and other providers' interaction with different medical services as to exactly what's being delivered. COVID is a good example of that, whereby we have adopted in conjunction with our medical providers a reasonably robust COVID transfer protocol in terms of donning doffing PPE these sorts of things.

With other medical providers that we've been working with from our other bases we've noted that the protocol, for example, isn't quite the same. It's not say that one is better than the other, but they're certainly different. So State-wide standardisation and coordination of that kind of response would be warranted. Also, our primary response is to support people mainly offshore but onshore as well and if we're engaged with the State in that requirement, then we obviously aren't then available to provide it to our primary client and vice versa. So, the volume of assets available doesn't really match the potential need I would suggest.

MAGER, MR: And referencing back to the document that was submitted last week there was a broader approach to the information provision. Obviously, PHI's focus is what it does it's a helicopter business. This response also addresses some of the issues that have been observed over a number of years in the system and the weaknesses. It recognises that a single approach State-wide coordination centre that has single prioritisation, single governance would be a good enabler to providing the right solution for the people. The present system has large gaps in those areas, it has large gaps in resource allocation, resource management.

In a couple of the earlier forums there was lots of conversations around neonatal transfers or repatriation flights. With neonatal transfers obviously NETS want to have their model to operate and do all the work from single source using the expertise that exists. Approaching that from a logistics perspective is a very difficult one and I don't know whether in their solution they have considered how logistically it will actually work, it has to be well, well-funded. It's going to be extremely expensive. It's a long way to go from Balgo to Perth. And those sort of things aren't regularly sort of looked at.

Repatriation flights there used to be a contract dedicated for repatriation flights, it doesn't exist at the moment. So, for patients it's an ad hoc when you can service, so that creates a backlog in the systems in town. Prioritisation is obviously something that is problematic at the moment with multiple different approaches to prioritisation for patients. Obviously RFDS have different to WACHS and WACHS have different to St John's and all that needs to be aligned to be successful.

KENNEDY, DR: And NETS have different to all of them.

MAGER, MR: Yes. Yes, there is always conversations about that. As part of the document I provided or PHI, sorry, provided an overview of current resources and locations with a recommendation for future consideration to meet the current and ongoing needs of the community. At the moment these bases are historical for - if you're thinking about aeromedical transfers. And for future benefit of the people there's a need to look towards a further

expansion of those positions for location of both fixed wing and rotary. But ultimately if you relocate rotary in further flung areas you're going to have one hour response to nearly most of the population throughout the whole State and just through a simple rejig what actually transpires at the moment.

I could probably talk more and more but that's probably just a brief overview of the document that was presented from our perspective. I just don't know where you want us to go in that regard, so - - -

KENNEDY, DR: That's up to you. I'm happy for you to highlight any kind of key strategic thoughts that you might have or to address the considerations document or any other matter and when you stop talking, I guarantee I've got some questions.

WATT, MR: I think an observation really in that the - if we're talking rotary specifically there are lots of helicopters in the north of the State and it's potentially an untapped resource in itself. Varying different other providers to ourselves who have helicopters with varying degrees of aeromedical kind of services. If there was a cohesive coordination of those and collaboration with other areas such as the resources sector, then perhaps there could be a more cost effective, response capability throughout those more remote areas.

KENNEDY, DR: So how do you turn that gaggle of capability into a system that's got consistent standards both from an aviation and a clinical governance and clinical capability perspective?

WATT, MR: I would suggest it's going to have to be centrally coordinated and managed. I think it's fair to say that to meet the safety case requirements of the various different resources' companies all found onshore they require a level of medical response, which in most circumstances would be, you know, helicopter provided. In Karratha, for example, I'm aware of I think - or between Karratha and Barrow Island at least four different helicopters that are on standby at any given time day or night. They're all crewed independently by different companies.

Surely there's some opportunity to bring that under a more State driven system so that the funding that's available to provide that can cater for all needs but also expand out into the community support.

KENNEDY, DR: So broadly there'd be potentially two ways to do that from my perspective. One would be that the State does a, you know, WACHS DFES type thing - - -

WATT, MR: Yes.

KENNEDY, DR: - - - times five or whatever.

WATT, MR: Yes.

KENNEDY, DR: You know, up the coast. Because it's already in that business, it's already got the standards established.

WATT, MR: Yes.

KENNEDY, DR: The aviation side of it's pretty well ticked. Or you look at other models of service providers who would need to comply with all of the standards et cetera and be prepared to work within the system bearing in mind that that would have an impact on their other obligations, commercial obligations, so there'd need to be redundancy in the system - - -

WATT, MR: Yes.

KENNEDY, DR: - - - allowed for both of those things to occur safely. I could have a guess which way you'd go with those two models in terms of your commercial interests. But for the purpose of the inquiry how do you see that working? Do you think it's a feasible option or opportunity for the State to look at?

HARTLEY, MR: I think one of the considerations there in normal circumstances it would be triaged as to who the resource would be tasked to first.

KENNEDY, DR: Yes.

HARTLEY, MR: However, -with a commercial consideration the commercial is always going to regardless of the triage system

KENNEDY, DR: But you could set up systems about how you do that as well.

HARTLEY, MR: You can. We face that now even with servicing our commercial clients against an AMSA tasking, for example - - -

KENNEDY, DR: Okay.

HARTLEY, MR: - - - regardless of the triage of that patient or the tasking that we're being tasked to, the commercial will always win over as such, they're paying for it, so they'll get it first. So, I think that's something that will need to be addressed.

I think to summarise some of what we've said today there are multiple providers out there, including a commercial sector, that if it was all to come in under one it would benefit not just the commercial sector but also the growing population that we see outside of Perth and the metro area. I think one of the important parts to all of this, and that's what's in the back of the document that we sent through, is there's strategic locations of where it's based. As Gordon mentioned, there's four assets currently sitting in Karratha and then there's vast areas at the moment with no assets. And if you look at the golden hour and response time to get a injured person back to primary care in some areas that's available providing that asset's not tasked to a commercial operation whereas other areas it's just not possible. Fixed wing is not always an option for obvious reasons.

So the consideration for us is first looking at the strategic locations where assets need to be based and then how that network would link up to the service, not only the general population, but if funding was a consideration in all this how it could then also benefit or be funded more by the commercial sector.

KENNEDY, DR: Yes, yes. Well, I mean presumably there'd end up being some kind of shared funding model, if it was an on fee for service basis, plus, you know, infrastructure and understanding the long term, you know, demands of the industry. There are other models, if you like, for particularly rotary networks that in the past have been, you know, clusters of

benevolently funded operations and things like that, particularly up the east coast and in other places. Are you aware of any similar kind of geographical scenarios that exist, you know, in the north of the State that would be comparable elsewhere? So, where there's clusters of, you know, industry plus population and there's a crossover in how that primary helicopter type responses are applied. Has anyone else done it somewhere else in the world? Canada, Alaska?

MAGER, MR: Canada have a very similar - at Ornge they have a very similar model with lots of sort of helicopters similar and PC-12 coverage and cover a vast area and do long hauls.

KENNEDY, DR: Ornge is all State run, isn't it?

MAGER, MR: It's State run, yes. Another consideration for a medical model would be to utilise the hospital workforce. So you can engage a company, a rotary company meeting the right standards but then, you know, you upskill your medical workforce, so if there's a requirement they come out of the ED particularly at the regional centres - - -

KENNEDY, DR: Yes.

MAGER, MR: - - - that would be a way to approach it.

KENNEDY, DR: Yes. And work in partnership between the various platform providers and the workforce availability, which is certainly something in the considerations that we've developed both in terms of, you know, existing RFDS bases and relationships with WACHS workforce and any, you know, future models that might emerge. So, no thoughts about existing models that are similar to this that would be interesting to examine?

WATT, MR: My backgrounds from the UK as in the UK military and the Royal Air Force and we provided a search and rescue service, but it also had an aeromedical transfer. We did lots of interhospital transfers in the poor weather, which is often experienced there. And as well as that, the Royal Navy provided it from geographically different locations, but they also provided a service with the same aircraft type and interestingly enough the same crew contingent but quite different procedures were used. Interlaced with that was a charity-based air ambulance network or EMS network, which still exists.

But with the transition from the military to a civilian provider of the search and rescue services they did exactly that, they went to one single point of coordination. There were originally two coordination centres. A single coordination centre, a single provider in terms of the rotary assets, single standardisation, single governance chain.

And from my experience is that it certainly improved probably the patient care that was delivered because everything was under one umbrella.

There was still independent of that the charity-based type network shall we say and where we saw issues - for example, the base I was at was beside a beach area, and someone had a near drowning event that we were asked to respond. And also, an air ambulance was asked to respond through a breakdown I guess in communication with 999. But the 000 call, if you like, that was made had gone one to the coast guard, we were called, and one to the ambulance service and air ambulance was called. So, disarray almost in terms of the response that was being brought to bear.

I'm a fan personally of a broader coordination single point with the assets. Whether or not you then choose to have a cost model that would allow industry to participate in the areas that have less populous in the north or mid-State as such where they're working and they need to have that service, you know, the back room costing of it could be - but I would like to see that the service provision is cohesive.

HARTLEY, MR: I think if we look at the east coast of Australia where there's multiple assets dotted all the way up and down the coastline you will quite often see competing organisations I guess being tasked. And although it's always good to have additional assets it's not the most cost effective or even the best way of doing it. State by State it's somewhat different.

KENNEDY, DR: Yes.

HARTLEY, MR: You know, Victoria's got the air ambulance there.

KENNEDY, DR: Yes.

HARTLEY, MR: That works quite well. And Queensland, for example, has helicopters all the way up and down their coast - - -

KENNEDY, DR: Yes.

HARTLEY, MR: - - - that are operated by three or four different providers.

KENNEDY, DR: Yes.

HARTLEY, MR: There's (indistinct 8.52.36) sort of dotted at the three locations.

KENNEDY, DR: There is some variation up there but, as we're saying, there are overarching standards, which are required to be complied with. There's an overarching activation, you know, and mobilisation system. So, it's coming back to your point about the single point of - - -

MAGER, MR: I think the (indistinct 8.52.59) works really well.

KENNEDY, DR: Yes.

MAGER, MR: You know, I think that's something - - -

KENNEDY, DR: And if, you know, know I guess if you get the military to play with civilians, then you could get industry to play with - - -

MAGER, MR: Yes.

KENNEDY, DR: - - - the State, that's for sure.

MAGER, MR: Yes.

WATT, MR: And if we look at AMSA in terms of their panel provision they have a standard, they provide equipment, they provide training to some degree and they have an acceptance process to gain, you know, a place on the panel as it were. So that model can and does work.

KENNEDY, DR: Okay. So, I mean the other concept that could be considered would be if there were a State based asset somewhere in the north, a base with all of the governance and things goes with that. If that were to be able to articulate with industry, so that you've got a kind of mix model then locally of - that has got a direct link, a permanent link to the State in terms of governance, oversight et cetera, and then a local network of related again contracted commercial providers thinking about redundancy and all those sorts of things, then - there's a few different ways that you could put together, you know, the public and private worlds.

HARTLEY, MR: That's a big thing, you need resilience in the organisation because assets will go unserviceable at times. There will be double taskings.

KENNEDY, DR: Of course.

HARTLEY, MR: There's a number of factors to consider - - -

KENNEDY, DR: Yes.

HARTLEY, MR: - - - if you do want to maintain that coverage.

KENNEDY, DR: And then something bigger than all of us will happen and - yes. Can I just you a question about the mapping work that you've done here or the illustrations? In the rotary and fixed wing solution that you've got I do believe that there's - other than the obvious new kind of suggestions but there's a fundamental suggestion here around the RFDS distribution with a removal of Meekatharra and positioning of the base at - and aircraft at Geraldton, is that correct?

MAGER, MR: Yes.

KENNEDY, DR: What's the rationale behind that suggestion? The rest of it, you know, kind of is pretty obvious but this is the first time that I've had someone propose a specific suggested change about the structure of the system and I'm interested in it.

MAGER, MR: Meekatharra itself is - way back in 1988 there was a report, the Cresap Report, which actually recommended the closing of Meekatharra as an operational base for the RFDS. The government moved towards closing Geraldton instead. There used to be a Carnarvon base until the mid90s as well.

The Geraldton option would better cover the Midwest itself and the smaller hospitals around the region that would feed back into Geraldton and provide improved access there. And you're still providing access to the larger sandstone magnet as a response for primary response within an hour. An hour-and-a-half you're on the other side of Meekatharra for your Wiluna retrieval.

And then also from - if you're looking at a Kalgoorlie provision you've still got that option - - -

KENNEDY, DR: Yes.

MAGER, MR: - - - to push north through there. So, if you were to relocate to the coast not only does it provide improved response to the areas around the greater Geraldton area and Three Springs regions you also - it's easier to recruit to staff. The model out of Meekatharra it's very difficult to staff for everyone, not only just RFDS but also WACHS, it's very hard to put

staff in there. I know it's a political time bomb, that's why it's been kept going for a long time, but for the future that's the reason why that was suggested.

KENNEDY, DR: Okay, all right. I guess I've got the advantage of being politically naive, so I don't have to worry about bombs despite your military past. But it is a question that I raised at some point. In your opinion is a kind of historical legacy of it partly related to the type of aircraft that were used at that time and need to, you know, refuel or something? I mean what was - - -

MAGER, MR: Look, it's a good way point but there's nothing stopping that still maintaining as a way point.

KENNEDY, DR: Yes.

MAGER, MR: You don't have to have a base there to have that structure there. Aircraft are changing, so the need to stop there is getting less and less.

KENNEDY, DR: Yes.

MAGER, MR: And obviously now if you want to talk fixed wing just for a second the advent of the 24 for the RFDS - - -

KENNEDY, DR: Yes.

MAGER, MR: - - - removes it totally. And in good weather PC-12s can - don't have to stop there at all.

KENNEDY, DR: Yes, and I think the approach that you've suggested in terms of the - in general terms, you know, the density and overlap between the rotary and fixed wing capability provides quite a neat coverage solution. Is this material publicly usable from the PHI perspective? Do you have any issue with it being reproduced in any way?

HARTLEY, MR: Unbranded I wouldn't have an issue with that.

KENNEDY, DR: Unbranded or you want it acknowledged?

HARTLEY, MR: If it's going to be put in the public, I'd take PHI off it for the time being.

KENNEDY, DR: Take the PHI off it.

HARTLEY, MR: Yes.

KENNEDY, DR: Okay, all right.

HARTLEY, MR: It depends on where it's going, I guess. If it is going into - - -

KENNEDY, DR: I mean we can just mock it up ourselves really - - -

HARTLEY, MR: Well, that's it.

KENNEDY, DR: - - - if we wanted to. You've done the work and - - -

HARTLEY, MR: Yes.

KENNEDY, DR: - - - it is elegant, I'll say it's nice work. And even if we, you know, use it as illustrative options, you know, ways to think about how the system could be rejigged it's an interesting exercise in terms of the report to suggest that that work is something that could be looked at in a more formal way in the future. So, we might come back to you and ask you for those images and attribute them, if you want them attributed, or just include them without labelling. We'll clarify that with you afterwards.

HARTLEY, MR: Sure.

KENNEDY, DR: Is there anything else that you wanted to raise today?

MAGER, MR: I was going to go back to the coordination piece as a - - -

KENNEDY, DR: Yes.

MAGER, MR: Obviously we've talked about the medical considerations but the State-wide coordination I know that WACHS have now got the advent of the APTC. I was engaged with that at the start, but that approach is critical to any success of anything currently. Both St John's and RFDS respective coordination centres operate well within themselves and the functionality of them is very, very good. The single point as far as RFDS are concerned the one stop thing works but I think it works in siloed way. The cross-communication doesn't work well enough and often enough and there are gaps there that mean that result in patient delays.

So this approach will - or a State-wide - and I think it needs to be bigger than WACHS, there needs to be a whole of health coordination response because there are areas in mental health, bed finding, bed allocation, that are outside of WACH's control. You know, north and south metro, all these things are out of their control and trying to bring everyone together to work together is very difficult, so a wider health coordination solution would actually be a better result.

KENNEDY, DR: Yes, I think that's a - you know, it's a very valid statement, it's something that we've heard repeated many times during the considerations and generation in the consultation period and, you know, I think it's well heard. I think between that and the concept of uniform standards, both aviation standards and clinical standards and clinical governance side of the equation, put those three things together, that's the renovation task.

And then how the system has grown to meet the current gaps that it clearly has is probably the next big item on the list. So you've identified all of those things, which I appreciate, and also as a - you know, as a commercial entity to engage in something like this is - yes, I think that's, you know, a big tick really from our point of view. It's good to see that kind of collaboration and hopefully it may amount to something in the future system, we'll see.

HARTLEY, MR: I think something you touched on there the aviation standard is a big part of this as well.

KENNEDY, DR: Yes.

HARTLEY, MR: Obviously for us clinical governance is - it's a well governed - - -

KENNEDY, DR: (Indistinct 9.02.11) space.

HARTLEY, MR: - - - industry but aviation standards do vary - - -

KENNEDY, DR: Yes.

HARTLEY, MR: - - - between - it is regulated obviously through CASA and the regulator but at varying levels of what was considered history has proven that there has been accidents and incidents from - - -

KENNEDY, DR: Well, that's - yes, I think - - -

HARTLEY, MR: - - - poor control through aviation.

KENNEDY, DR: The bigger your system is like this, if you've got particularly people moving between it, you know, you can't be expecting them to do a different thing every time they get into a different truck. Who does your medical - who provides your medical services? Do you have a - is that contracted or - - -

WATT, MR: Yes, it depends on which, you know, contract area. We have provisions subcontracted through the RFDS - - -

KENNEDY, DR: Yes.

WATT, MR: - - - for one of our bases and we work with WARAME *(West Australian Resources Aero-Medical Evacuation Service)*, which is provided by Aspen medical - - -

KENNEDY, DR: Yes.

WATT, MR: - - - in another - - -

KENNEDY, DR: So RFDS provide you with medical or nursing workforce from time to time.

WATT, MR: Yes.

KENNEDY, DR: Does that - --

HARTLEY, MR: Sorry, probably not so much time to time. So, we offer a 24/7 medevac where they're always on standby for us, so they're in our hangar available.

KENNEDY, DR: So that's a dedicated staff person that is - - -

WATT, MR: Yes.

KENNEDY, DR: - - - provided by RFDS.

HARTLEY, MR: Correct.

KENNEDY, DR: So, it's not pulled - - -

WATT, MR: With their normal network.

KENNEDY, DR: - - - not pulled from their - - -

WATT, MR: Correct.

KENNEDY, DR: - - - other operations.

WATT, MR: Yes. The commercial element, yes.

KENNEDY, DR: Okay. Anything else finally quickly? We better finish up then because we've gone a little bit over, which is fine. Thank you again for your attendance at the hearing today, it is appreciated. A transcript of the hearing will be sent to you, so you can correct any minor factual errors before it's placed on the public record and, as I mentioned, we will also formally ask you about those images. You will need to return the transcript to us within 10 working days of the date of the covering letter or email otherwise we'll assume that it's correct.

While you are not able to amend your evidence in that, if you would like to explain any particular points in more detail or present further information, you can provide that as an addition to your submission to the inquiry when you return the transcript. So again, thank your attendance and for your generous input.

HARTLEY, MR: Thank you.

KENNEDY, DR: Thanks.

MAGER, MR: Thanks very much.