Aeromedical Services WA Inquiry – Formal Hearing Transcription
Inquirer: Dr Marcus Kennedy
Organisation: Department of Fire and Emergency Services – Mr C Waters, Mr G Gifford, Mr S Sartain
Date: 11 February 2022, Time: 1030 – 1150

KENNEDY, DR Good morning.

WATERS, MR: Good morning.

KENNEDY, DR I'd like to thank you for your interest in the Inquiry and the appearance at today's hearing. The purpose of the hearing is to assist me in gathering evidence in the Inquiry into our medical services in Western Australia. I'll start by introducing myself. My name is Marcus Kennedy. I've been appointed to the Inquiry by the Chief Health Officer to undertake the process. Beside me is Jonathan Clayson who's the Inquiry project director.

I just need to remind you that you may not use mobile phones or other recording devices in this room to record. 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 is important that you understand that you must answer all questions and that the penalties - 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 record and therefore 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 when giving evidence to the Inquiry. So, before we begin, do you have any questions about today's process or the hearing?

WATERS, MR: No. No, thanks.

KENNEDY, DR Okay. For the transcript could I just ask that each of you state your name and the capacity in which you're here today?

WATERS, MR: Craig Waters representing DFES as the Deputy Commissioner of Operations.

KENNEDY, DR Okay.

GIFFORD, MR: My name's Gary Gifford, I'm the Assistant Commissioner of Operations Capability and have the Aviation Portfolio.

SARTAIN, MR: My name's Steve Sartain, I'm the DFES Manager for the Emergency Rescue Helicopter Service.

KENNEDY, DR Thank you.

You'll now be invited to address the focus consideration list that's been provided to you and other material from the paper as you wish. The way that you present that is up to you, we've got 60 minutes or so, perhaps a bit longer, allocated for you to make that presentation, however, at the end of that time I'll have some questions, I'm sure and then in any time remaining we would - are able to discuss other matters. I'll try not to interrupt you during your presentation unless there's areas of - that you're talking to that I don't understand you're, but I'll ask that you speak through and then when you're - - -

WATERS, MR: Yes.

KENNEDY, DR - - - completed, then we'll come back and discuss some relevant components. I'm comfortable, if you are comfortable, if you wish to take your mask off while you're speaking, if you find that easier to either see through your glasses or speak clearly and while - - -

WATERS, MR: Yes, it's fogging up.

KENNEDY, DR - - - we're not speaking the rest of us will put our masks back on. Thank you.

WATERS, MR: Okay. So, I'll give you a broad overview of the Department's historical involvement and current involvement with the ERHS and then I'll pass to Steve Sartain, he's the manager of ERHS on behalf of the Department. Obviously, we've gone through the themes of the considerations so Steve will provide some summary and commentary upon that and also we'll provide additional information in writing post the sitting. In relation to operations portfolio, I look after the metro operations, country operations and also ops capability and as Mr Gifford alluded, part of that consists of air operations which - and also the Emergency Rescue Helicopter Service reporting to Mr Gifford.

Historically, discussions commenced around 2000 - sorry, 1999 about the introduction of aircraft in relation to - for DFES, coinciding around the time that the Department became the Fire and Emergency Services Authority, FESA. In 2002 the Emergency Rescue Helicopter Service commenced and at the same time DFES was going through a significant procurement program in relation to aerial firefighting fleet and assets. Coinciding with that was one of the FTEs that came across, Mr Mike Waters came across from the Department of Health and he managed at that time both our Marine Rescue groups and also our air operations section and was heavily involved in the procurement. In 2015 the second ERHS funding was secured, and the Southwest Bunbury Project was highlighted. In 2016 the Southwest ERHS came online.

Primary tasking in relation to the trauma response- St John Ambulance has been contracted to manage the clinical governance of those arrangements and the Department of Health, managed the secondary tasking with inter-hospital transfers. DFES contract manage the service which includes the aircraft, crew, critical care paramedics and also St John Ambulance in relation to tasking. There is 100 per cent transparency in relation to the funding and accountability for the expenditure of the State funds, that's reported quarterly to the Minister and also an annual review of the expenditures.

I suppose from a Department's perspective, everything we do in relation to emergency management is done in the collaborative framework. We wouldn't be able to coordinate our response to significant events if we don't have that collaborative approach and as I said before, the considerations in relation to the themes. DFES is currently finalising the awarding of the current aircraft and crew contracts.

However, the critical care paramedic and the clinician contract is on hold on advice from the Treasury awaiting the outcome of these reviews.

However, in the planning phase for the critical care paramedic and clinician contract, it's being planned that the tasking contract is separated from the critical care paramedic and clinician contract. From our perspective, in an area of improvement in service delivery and to increase the collaboration in tasking, DFES has a State Operations Air Desk which manages our

firefighting fleet and we feel that increasing collaboration, coordination could be achieved in operating the State Operation Air Desk model.

So we have a State model that includes a collaborative interagency joint tasking mechanism where we not only use our own aircraft but also aircraft from the Department of Biodiversity, Conservation and Attractions and the National Aerial Firefighting Centre to coordinate and manage our fixed wing, rotary wing aircraft that we use for our firefighting operations. More recently we've used these processes in coordinating and managing response in relation to National Large Air Tankers, lead aircraft, line scanners, aerial suppression aircraft, both fixed and rotary wing and we have also had initiated contracts and negotiated contracts in relation to having transport companies and contractors on standby if required.

So, I'll leave it there, I'll now pass over to Steve just to talk on the themes that came out of the considerations in relation to what we want to deliver.

Thanks, Steve.

SARTAIN, MR: Thank you, Deputy Commissioner.

Thank you, Dr Kennedy.

So a couple of the main themes that we've identified out of all the considerations is contract management being one, clinical governance is the second, strategic planning is the third, centralised coordination as a fourth and just a couple of additional inputs that we've identified in the report that were not directly addressed to DFES initially.

Under contract management as the Deputy Commissioner indicated, DFES has contracted out the service operations of both the helicopter and crew contract and the clinician contract, and we've been very fortunate in that the incumbents have been successful respondents since day 1 of the service. One of the reasons and considerations of the clinicians - initially, St Johns were just appointed because they were the only provider of paramedics in the State at that time. Since then, they've been providing excellent service and have been very competitive in subsequent tendering of the clinician service.

As part of that, we ensure accountability for all service contracts with the specification and monitoring our specific KPIs, reporting requirements – quarterly and annually operational reporting which again we, as DFES provide to the DFES Commissioner and the Minister directly. The rescue helicopter crew can be, as per one of those KPIs - which is a highlight of the service - the aircraft can be airborne in less than 15 minutes and they actually average about 12 minutes to get airborne.

But because of the strict requirements that we manage, we're also able to maintain a 95 per cent online status which highlights a high rate as compared to other providers within the State if not nationally.

We also are able to contract manage and created surge capacity with access to our technical backup aircraft. And as recently demonstrated through both Cyclone Seroja and the Carnarvon floods, are able to mobilise that aircraft in order to support additional emergency services operations and/or mass casualty operations.

Along the lines of clinical governance, we contract St John Ambulance to provide not only the provision of the critical care paramedics on board the helicopters, but also the management of all medical consumables, equipment, as well as most recently as experienced with the pandemic of decontamination and infection, prevention and control procedures of the service. Along with the current contract, we do include the tasking of the rescue helicopter and all the clinical governance decision-making around tasking through the 000 network, as provided through St John Ambulance.

The levels of standards and skills experience of the clinicians on board the helicopter have basically evolved since 2003 in direct consultation with the Department of Health, specifically the Royal Perth Hospital Trauma Centre, as well as input directly from the St John Ambulance clinical director or medical director. As directed under our contract, we do require St John Ambulance to conduct monthly clinical reviews of all ERHS missions as well as quarterly reviews in direct collaborations with the DOH representatives for any cases that may need to be escalated through the clinical review process. We as DFES receive executive summaries of those reports, but of course we don't want it to impinge on patient confidentiality. This is the way that we as State Government can ensure that those reviews are occurring.

The missions are reviewed in conjunction with and to the same standards of SJA's clinical governance frameworks as established under the Department of Health, State 000 dispatch, and road ambulance contracts. The State trauma centre also advised that there has not been deficiencies, stating - we have not identified any clinical deficit with regards to the safety and quality outcomes for the patients that are carried on board the rescue helicopter or the Royal Flying Doctor Service. Additionally, we do hold quarterly tasking meetings as part of the review process in which St Johns chair that review, but we do include members from both WACHS, RFDS, additional DOH personnel as well as our helicopter and crew contractor to participate as part of those quarterly tasking meetings.

During those meetings, we review all taskings to include missed and/or rejected tasks. So ideally, we clearly focus on those opportunities where there are demand opportunities either within the current capture area, but also as part of the annual review of the rescue helicopter network. We take that data and then look at additional areas within the State that may benefit from rescue helicopter services. Back in 2019, we as DFES engaged the DOH clinical excellence committee to seek additional strategic planning with regards to the service and its procurement. At that time, they indicated they wanted no change to the area of clinical governance, and it wants the patients to remain within a common clinical governance framework from incident to definitive care.

So the benefit of us contracting St Johns is that we're included as part of that ready ambulance network, so that if we are going to pre-hospital incidents, trauma incidents, it's the same clinical governance framework all the way to delivery to the tertiary hospital.

Next under the theme of strategic planning – this is one of the areas I feel that DFES has strongly excelled in. We have sought numerous consultations throughout the history of the service, as well as established memorandums of understanding with both WA police and the Australian Maritime Safety Authority. Now, my understanding of the current MOUs established were strictly around search and rescue capability of the aircraft, but we have also sought MOUs with the Department of Health as well as continued consultation with numerous areas within the Department.

We basically ensure, as Deputy Commissioner Waters indicated, that the ERHS provides a whole State responsibility with the service. Although we only have the two helicopters currently based at Jandakot and Bunbury, we are able to capture 89 per cent of the State's population within the operational range of those two aircraft. In the strategic planning for the next generation of contract services, we have done numerous consultations with both inter-jurisdictional agencies as well as within the Department of Health, and the commercial aviation industry that also operate aeromedical capabilities to identify what that next model could look like. Everything from the clinical aspects, to tasking, to central coordination, strategic outlook, because again, we are looking at 20 years down the road.

As part of that indication, we have sought 10-year contracts as an indication with the next generation of helicopters, and all of this was led initially through our Southwest Emergency Rescue Helicopter Service project. So, with the establishment of the Bunbury service, it was a deliverable in that project to develop a midyear review or Midterm Review of the service. Carrying that consultation process, we hired consultants to come in as well as conduct face-to-face meetings with all parts of State Government to indicate where the direction of the service needs to go. So as part of that, we looked at everything from clinical capability, to better collaboration between agencies, as well as what capabilities and basically did a needs analysis / capability needs analysis for the State. So, this capability needs analysis shaped what the next helicopter and next generation of clinical services would look like as part of that midyear review or Midterm Review.

KENNEDY, DR Sorry, what date was that performed?

SARTAIN, MR: That was performed in November 2018 as part of the Southwest ERHS project deliverables, and I believe we've provided you a copy of that document, in the initial consultation. We can send you another one if it happens to be left out, but I'm pretty sure we sent you a copy of that document. Along those lines, we looked at the unmet need as part of that Midterm review, so we looked at potential areas of the State that could benefit from the same type of service with overlapping coverage, to provide that additional redundancy and capability within the State. Such areas that were identified included the Midwest Gascoyne and Goldfields similar to what was identified in the draft review.

Along those lines, the Midterm Review also highlighted a need for the centralised command, (a lot of the same things that we've then identified in the report), also better coordination, and a need for a capability needs analysis, not just for rotor wing but for fixed wing throughout the State.

Along those lines, we have also consulted and conducted numerous meetings with both local emergency management committees and district emergency management committees to see what needs are out there within the regions, so areas that are not currently serviced through our general operations area or standard operations area, to see what areas and needs we could provide to support all of emergency services.

The next theme we go onto is centralised coordination. I think we've kind of mentioned that already. Like Deputy Commissioner Waters mentioned, we within DFES do have a centralised command and control with regards to aerial firefighting and have agreed that there is a need for that within aeromedical. As we currently utilise the 000-phone network or 000 emergency services network to task the rescue helicopter, there needs to be, again, better visibility across the State for that patient beginning to end journey of - and to include repatriation at the end.

As part of that, DFES currently use TracPlus - I know this is getting a little technical in the detail - but we currently use TracPlus as our aviation system, so we can clearly see in a live stream environment of where all of our aircraft are at any given time. Something like that could greatly be benefitted to the State with regards to aeromedical assets. We've also supported the initiative of this centralised control which will not only ensure clear visibility but also be able to better coordinate - so if there's a what we use to call in defence - a trans-load capability of moving a patient from a rotor wing directly onto a fixed wing and then have that fixed wing come back to the metro area. That is well lacking within this State.

We have a successful mission of such which occurred back in 2018 which was off of the coast of Esperance in Israelite Bay where an incident that occurred - but that was something that was led by the crew that were flying the mission that day - where a fisherman basically had his foot severed. Not to get into too much detail, if it wasn't for the capabilities of both the rescue helicopter and the partnering with RFDS to quickly transport that patient back to the metro area, the patient wouldn't have survived.

Now, on the flipside, we can show the demonstrated capability of where that coordination is lacking. Back in 2016, there was an incident on Rottnest Island where a gentleman basically took a dive into the coral reef and smashed the whole side of his face. The helicopter was initially tasked because the phone call came in through 000n but there was confusion whether it was a primary incident versus an inter-hospital or an IHPT because the patient was then subsequently moved to the nursing post on Rottnest Island.

So, whilst the helicopter was sitting on the ground there ready to take the patient, there was a de-confliction of whether it was a fixed wing job versus a rotor wing job. And whereas the helicopter could have gotten the patient to Fiona Stanley in less than 10 minutes, the patient's journey actually took about two and a half hours to get to the trauma centre. So again, we can demonstrate a positive aspect and a negative aspect of the collaboration that's required.

Lastly, just a couple of points around the differing input and additional considerations. We've provided through the service that aviation expertise because again, DFES has been in aviation for numerous years.

Especially around emergency services and aeromedical, DFES has helped the Department of Health and WA Country Health Service with any sort of consultation that we can provide. A most recent example is around the helicopter landing sites that were established at both Narrogin and Jurien Bay hospitals. Myself and our CHC Base Manager, who you met him the other day, were heavily involved with those projects and helping to get them established at both regional hospitals. Unfortunately, again, those are WA Country Health infrastructure asset projects, not DFES', so we can't mandate that building of HLS to occur. But again, we're more than happy to provide that expertise and consultation to help establish these type of infrastructure projects in the regions.

Additionally, we have also consulted heavily with the new Royal Perth Heliport which is established on the rooftop, not only because we're the primary user of that location but it's also future proofing the facility for any sort of aircraft that may be landing on there. One of the things that we were able to provide as an input for that helicopter landing site on the roof, was not just for patient delivery but potential insertion of capability into the CBD area. In some sort of mass casualty situation where the CBD becomes gridlocked or the arterial roads coming into the city are inaccessible, it was DFES' consultation to provide that input of allowing the

RPH Heliport to be used for insertion of either DFES firefighters, AFP personnel, WA Police personnel, or even medical personnel to bring additional clinicians into the CBD.

I just wanted to mention that - one of the concerns that we have within DFES - due to the limitations of only one helicopter landing site located at each of the tertiary hospitals - is around the coordination of helicopters landing at those facilities. With additional operators now looking to land there, we cannot afford to ramp helicopters on the roof and delaying the delivery of a patient into that facility. And I know this has been raised through East Metro Health's concerns as well. If patients are not requiring immediate landing at one of these tertiary heliports, (and we do it within the rescue helicopter service) if it's not a critical patient, they can easily land the helicopter at the airport and then be roaded in to one of the tertiary hospitals. That eliminates numerous safety aspects from an aviation safety standpoint, because again, landing on rooftops is not your standard practice for landing helicopters, so that will help risk mitigate for that as well.

And then lastly worth highlighting is all of the additional strategic planning that DFES has done with Department of Health. So, everything from infrastructure requirements to also (as Dr Davis mentioned this morning), we've been consulting heavily with regards to NETS transport capability. It's always been in the scope of the service, as I mentioned to you the other day, Dr Kennedy, but we've only been able to do one such mission in the history of the service due to the logistics issues that we incurred to date. Those should be resolved very quickly, and we have the capability of using the technical backup helicopter to better support those types of missions, and it's something that we are looking to progress and have included with the next generation of the rescue helicopter.

Are there any questions? No? Do you want to add anything? *(referring to Assistant Commissioner Gifford)*

GIFFORD, MR: No, I'm fine, thanks for that.

KENNEDY, DR Okay. Thank you.

I guess maybe if I just start by asking in regard to the considerations made by which you say, to a degree unfiltered kind of a paper, it's a lot of opinion and a lot of input from many different sources obviously so is there primarily to generate discussion and to assist us through this kind of a process. The components of that - are there any components of that which you wish to talk to where you may have strong disagreement?

SARTAIN, MR: Yes, I think AC Gifford had picked up a couple of points that he wanted to flag around probably strategic planning.

KENNEDY, DR Well, go ahead.

GIFFORD, MR: I'd like to rebut the claim of a lack of strategic planning. Steve's already referred to the midterm review of the Southwest Emergency Rescue Helicopter Service and if I was to draw your attention, with regards to the recommendations of that midterm review, a lot of what's been said in your considerations paper were actually captured in that midterm review. So, the Department hasn't been without strategic planning or strategic thinking on how it can progress the Emergency Rescue Helicopter Service in Western Australia.

KENNEDY, DR Thank you.

SARTAIN, MR: If I could as well, Dr Kennedy, so along those lines, we as DFES, have taken a proactive stance. We consistently engage or try to engage our stakeholders as part of managing the service. One such includes when we were looking at the - *(cough)* excuse me, looking at the other requirements with regards to the journey itself. So, we've actively sought to get the Department of Health's involvement with regards to all of our clinical review that St Johns conducts on our behalf and include them in as many regular meetings that we conduct.

So, a couple of examples of those is that we actually led the establishment and creation of the tertiary heliport working group. When I first started with DFES back in 2016, I noted each hospital had differing procedures, had different radio frequencies, had different operational personnel of who could come on and off the Helicopter Landing Site, different procedures with hot offloads and hot on-loads. So, we were able to help collaborate this group with all three hospitals talking together, and we were able to help standardise those helicopter procedures.

Now, once the patient goes through the doors and down through the elevators, obviously that's up to each of the tertiary hospitals' procedures, but that was a successful working group that even to this day, still meet and we have now since gotten additional input from both WAPOL and the ADF as participation of this group. That was a lesson learned, especially with the ADF, because one day that goes back to 2019, a Black Hawk Helicopter just landed on top of Fiona Stanley. It was because a real-world accident occurred, and they just had to take their people - one of their soldiers - to the hospital.

Again, they were not aware of the established procedures that were in place, so we have now included additional Commonwealth and other State Departments as part of that working group.

Subsequently, with the creation of both Narrogin's and Jurien Bay's helicopter landing sites next to the hospital, DFES – also established the regional hospital HLS working group, and obviously now with video conferencing, it makes that working group a lot easier to meet. But again, we currently lead that group to help each one of the regional hospitals establish a common practice, and also are able to provide that expertise with aviation compliance.

So everything from how the pads are built, to operational procedures, to aviation regulatory and operational compliance out of that, we as DFES established a HLS guideline which will ensure that it would not only just meet our operational procedures but again, future proofing it to potentially larger aircraft that may land at those regional sites. As part of that regional HLS group, we've actually included both Karratha and Hedland Hospitals, even though we don't fly directly to there, but obviously there was a lack of that commonality in aviation expertise that was required as part of those working groups.

Additionally, along those lines, we actively participate with the WA SAR Advisory Group - the Search and Rescue Committee that is led by WA Police. I know both RFDS as well as St Johns and Department of Fisheries with their surf lifesaving helicopter, we all participate as part of that working group. Again, we continue that engagement and consultation where, again, we actively seek input with regards to how to better the service.

WATERS, MR: So there's just one further comment in relation to an area of potential improvement, were amongst the comments to move the clinical governance of responsibilities of the DFES ERHS to WA Health and it's got a comment there that it appears to be the only State aeromedical asset in Australia where operations are not overseen by Health or an Ambulance Department . DFES clearly contracts the Clinical Governance responsibility to St

John Ambulance which is obviously an ambulance department so that's on page 8, the last dot point. -It might be worth noting that commentary in relation to that is incorrect. Notwithstanding, there is probably potential improvements in the area of a more collaborative, cooperative coordination and especially of the tasking but that's probably an area of improvement along with the collaborative governance body with the Department of Health and St John.

KENNEDY, DR Thank you.

I will just restate that the material in here is in part quoted obviously from people who are well-informed, through to operating on rumour.

WATERS, MR: Yes, yes.

KENNEDY, DR So we've listened to everybody in that consultation so please don't be offended by - - -

WATERS, MR: No, no. I just wanted to highlight the statement

KENNEDY, DR - - - anything that's not accurate.

WATERS, MR: Yes, yes.

KENNEDY, DR However having, I mean, just to follow through on that point in terms of governance, the concept of contracting out clinical governance is an interesting one from a health system's perspective and it comes with challenges, have you thought about it in any other setting other than clinical care if it were any other form of governance contracting it out, you would possibly feel nervous about to the point that in any system where you contract governance it's incumbent upon you as the owner of the contract to have appropriate assurance and verification mechanisms. Are you comfortable with the systems and - or can you speak to them that would ensure the quality of those governance systems?

WATERS, MR: Sure.

SARTAIN, MR: Honestly, we have actively sought additional involvement through the Department of Health as part of that assurance process. Again, we are reliant and do contract St John Ambulance to manage the clinical governance and the training framework of our personnel and/or tasking of the aircraft and that patient journey as they are also, like I mentioned, the State ambulance provider. We do receive reporting through St John Ambulance but as an executive summary with information redacted to maintain patient confidentiality.

KENNEDY, DR Can I just challenge you at this point - - -

SARTAIN, MR: Sure.

KENNEDY, DR - - - because you're asking the State road ambulance system to provide a - to look at the aeromedical ambulance system which is not the same. I mean, yes, there's lots and lots of overlap but there's also lots of potential for concern in the space that the expertise is not established.

SARTAIN, MR: So, I'm very confident that the expertise is established. Dr Gayle Christie oversees the aeromedical aspects within St Johns, and she is well-established with both RFDS experience, as well as having flown on HEMS in Scotland, so she's got the expertise. And put it this way, ever since she has come onboard with St John Ambulance, we've seen massive improvements to not just how the ERHS mission reviews are conducted but also within the training framework and upskilling of our paramedics that are onboard the aircraft.

KENNEDY, DR And she is a DFES employee or a St John - - -

SARTAIN, MR: She's a St Johns and Department of Health employee.

KENNEDY, DR Okay.

SARTAIN, MR: She also serves as ED doctor in addition to Deputy Clinical Director at St Johns.- - -

KENNEDY, DR So - - -

SARTAIN, MR: She works as an ED doctor within Charlie Gairdner's.

KENNEDY, DR So the clinical governance process is contracted, and the verification process is contracted out. No? Am I - - -

SARTAIN, MR: No, no. She's a St John's employee as well.

KENNEDY, DR Is she a DFES employee?

GIFFORD, MR: No. No, sir. You're on the money and you're talking about enterprise risk and certainly can appreciate that from an Inquiry's point of view that basically we have one contract with St Johns to provide the critical care paramedics and the clinical governance and the employee which Steve's referring to is a St John's employee. - - -

KENNEDY, DR Correct.

KENNEDY, DR Absolutely, expertise which is not questioned obviously but - okay.

GIFFORD, MR: And that's where we've tried to make, again, those midterm review recommendations and it will be addressed in the next tender where Health's involvement will be required directly as part of that clinical review process.

KENNEDY, DR I mean, given the difficulties that you have engaged in health in that process as you've presented to me to the hearing, do you see other opportunities or options in terms of engaging a verification or assurance - I mean, think finance, think auditors, is there some other way that that could be approached that may help you as well?

GIFFORD, MR: Yes. Sir, if I reference back to the midterm review again, I don't know whether it's actually documented in the midterm review but in the - we actually established a - what I'd refer to as a senior officer group, to help the implementation of that project and the delivery to the Southwest Emergency Rescue Helicopter Service. The intent was to use that senior officer group to then be a collaborative forum, if you like, to look at improving the service going forward so that clearly would be one of the mechanisms which could have been used

but alternatively, I think, I'm looking towards Mr Waters here because I'm not in a position to comment on behalf of the Department, he is.

But I would certainly suggest that there would be no disagreement that there needs to be a collaborative approach amongst stakeholders to ensure that clinical governance and that mission determination has actually been achieved.

KENNEDY, DR And certainly one of the common consideration points that many people raise during this is this, the need for that overarching mantle of clinical governance which could bring together in a collaborative sense, all of the arms of the service provision to help do this. What I was heading towards is the potential for you to access external providers of audit services - - -

SARTAIN, MR: So, if I could address that specific point, Deputy Commissioner?

KENNEDY, DR Yes.

SARTAIN, MR: So, we are, as DFES, in the process of establishing an aviation consultancy panel of contractors and one of those is aeromedical. So that was one of the things that I identified about two years ago of trying to get an external provider to conduct that clinical audit of our services. We do it quite frequently with our aviation service provider. The panel will contain consultants to be used for DFES' providers of the helicopter services to include not only auditing services across all DFES Aviation Services, but also aviation expertise consultants, to include Aeromedical.

KENNEDY, DR Yes.

SARTAIN, MR: With our aviation safety and CASA compliance audit with our air operations, that's done yearly but again, yes, we are in the process of implementing it as a separate contractor.

WATERS, MR: So I think it goes back to my initial commentary around our role in emergency management, just by nature in emergency response and emergency management is the collaborative response, whether it's air operations or whether it's managing motor vehicle incidents, it's around engaging, collaborating with other agencies, other hazard management agencies as well that support the overarching operations. So, I think that underpins all of our emergency management operations.

KENNEDY, DR Absolutely.

KENNEDY, DR Yes, understood. Just let me go back to the 2018 midterm review.

Are there particular aspects of that which you may wish to bring to this particular venue? I appreciate that we've received that but in terms of this public setting, are there aspects of that which you feel may be worth bringing to the hearing's attention?

GIFFORD, MR: Sir, if I may?

KENNEDY, DR Yes.

GIFFORD, MR: Basically again, as I say, if I draw the Inquiry's attention to the recommendations at the back and there's a Figure there which I can't read without my glasses on which I (indistinct 11.09.47) but I'm confident that - - -

KENNEDY, DR Is it a big figure or a little figure or - - -

GIFFORD, MR: It's Figure 39 Urgency of Recommendations.

KENNEDY, DR Okay.

GIFFORD, MR: I'm confident that basically when you talk about enhancing capability, future type of the aircraft, whether it's with regards to increasing contract periods or being collaborative with other agencies or whether it's the funding streams going forward, all of those issues and the written aspects which support capability are within those recommendations which supports that, from both a service and specifically from a rotary wing but even more strategically from a aeromedical point of view, that those recommendations I think, you will find will address some of the points which you're raising.

KENNEDY, DR Can I ask you then specifically, you refer to the potential to - in terms of unmet need that had been recognised through that review process, there was potential to extend the existing type of service I think same service was the word you used, to Midwest Gascoyne, Goldfields. Was there consideration of a different type of service?

GIFFORD, MR: So, if I may, were you referring specific to rotary wing?

KENNEDY, DR Yes.

GIFFORD, MR: So certainly there was acknowledgement that the service could be expanded rotary wing in the Southwest of the State, but that another model recognised kind of the public, private partnerships into the Pilbara and the Kimberley was perhaps a different operating model for the northwest of the State.

KENNEDY, DR So exploring that a little bit in terms of the case type, at the moment a strong feature of your service is the provision of pre-hospital care and primary response and I guess if you were to look on - at the average rotary wing system around the country, there would be a difference between the amount of secondary or inter-hospital transfer that your service provides compared to many others despite an obvious catchment which is appropriate. In that review, did you identify the opportunity to alter the spectrum of work to increase through increasing resource or capability to increase the presence of the service in the inter-hospital space?

SARTAIN, MR: Put it this way, sir, I'm not sure if it's - because it's been a while since I've reviewed the document, but I'm not sure if that's specifically mentioned in the Midterm Review. However, we have identified that as part of our annual review that if the fleet were to grow, specific helicopters used for inter-hospital would be possible then we could look at specialising those – such as one dedicated NETS helicopter or one dedicated inter-hospital patient IHPT helicopter versus all aircraft being configured the same - or specialise in just one search and rescue helicopter, and allowing the rest of the fleet to do more of that IHPT work. Based upon current ERHS tasking protocols, there are opportunities in other regional parts of the State for additional rescue helicopters.

KENNEDY, DR Yes.

KENNEDY, DR So whatever the shape of the reconfiguration of the hardware might be, there is a recognition that there may have been an opportunity in terms of unmet need.

SARTAIN, MR: 100 per cent. In our tender documentation and contract that we're about – hopefully award very shortly, allows for that flexibility and allows for that increased unmet need.

KENNEDY, DR If there were funding available to pursue that.

SARTAIN, MR: If there was funding and government approval, correct.

KENNEDY, DR And so at this stage would it be fair to say that the current case load of the platforms that you've got in place is close-ish to maximum or do you see that there's additional capability there?

SARTAIN, MR: As I mentioned this morning with regards to NETS, we are able to utilise the technical backup helicopter and we do have contract options to bring in a call-up crew to man that helicopter where we can't meet some of that unmet need now.

KENNEDY, DR Okay.

SARTAIN, MR: We, within the contract options - were able to mobilise that backup to help specifically with the Carnarvon floods, had 35 rescues on the first day that it was up there, and not impact the primary response of the two primary rescue helicopters main bases.

KENNEDY, DR Okay.

So has there been a process along the way, say since 2018, where there may have been a proposal to increase the resource - resourcing in terms of numbers of helicopters such that the known unmet need in inter-hospital transfer could have been met?

GIFFORD, MR: So, if I may, sir, that basically the Midwest has been an identified option.

And we've been monitoring that very closely with regards to road trauma and search and rescue requirements into that area. Certainly, there's been a highlighted demand in the region, and it could be fair to say that we are monitoring and reviewing that, and have been doing so since 2018, or 2019.

But you know, basically of course the service is dependent on budget and at this point in time, requires state government support and funding.

KENNEDY, DR Yes. Well, budget flows as a result of a business case in a bid for additional budget obviously so I guess, where I'm heading is that there hasn't been any formal process to try and expand the resources of the - of your service to meet that unmet need.

GIFFORD, MR: It would be fair to say, sir, that it has been reported onto government.

KENNEDY, DR Yes. Okay.

WATERS, MR: The interest has been reported to government.

SARTAIN, MR: Correct.

WATERS, MR: And there hasn't been government support at this stage.

KENNEDY, DR Okay. So let me pose a hypothetical that you have an unmet need in an inter-hospital transfer space of, let's say 250 to 350 cases per annum within an appropriate radius of - your operating radius in terms of the current base setups, if you were in a position to expand the DFES approach to its work, how would you view that in terms of potential system design or changes to your resource, platform numbers, et cetera, if you were to immediately seek to try and meet that need?

WATERS, MR: I think it would be a staged approach to increasing obviously the capability of the ERHS into the Midwest Gascoyne and the Goldfields area to have a bigger capture of things but again, I'll go back to Steve in relation to what's been considered previously.

SARTAIN, MR: Thank you, Deputy Commissioner. So, yes, Dr Kennedy, we have looked at that with the creation of the Southwest ERHS. The helicopters operate as a network so they're able to either be sent both to one incident, or if one is out, the other can still backfill and meet that need of, say two incidents occurring simultaneously in the southwest.

So once we were looking at additional areas and again, this is part of our annual review process, we were looking at the potential unmet need, like in the Midwest, and then which airport would best suit that unmet need to ensure (1) that there's suitable aviation - jet aviation infrastructure established, as well as (2) continuing to create that network overlap so we can then provide the additional redundancy with either the metro based helicopter and/or the southwest based helicopter.

So out of that review if you're just looking in the southern portion of the State the primary airports that have that jet aviation infrastructure include Geraldton, Kalgoorlie and Esperance and Albany because again, that's probably one of the - what we were discussing the other day - one of the major limiting favours in Western Australia, is access to jet fuel.

Now to offset that, DFES have established regional fuel caches located at regional airports which house aviation jet fuel and pump stop for our use. We partner with both WAPOL as well as our aerial firefighting fleet to access that fuel which again obviously extends our range. But again, if we were to look at establishing another base out in the Midwest or in Goldfields, then we would look to expand those fuel caches to again provide us the best overlapping coverage for the service.

KENNEDY, DR Okay. So, the scenario that I painted which is a 250 to 350 additional inter-hospital transfers you feel that you would be able to manage with fuel caches.

SARTAIN, MR: With the fuel caches and the number of fleet because obviously as the fleet grows you could potentially configure the aircraft so that one could be used specifically for IHPT, another for SAR, another for transport, and so on.

KENNEDY, DR So what would be required in terms of the number of fleet?- - -

SARTAIN, MR: Yes. If we were to expand to an additional base - and this is in order to maintain our current 95 per cent online stats as well as adhere to our 15-minute response for primary and SAR - a new base would require a primary and its own backup and provide redundancy. Which then we would have two technical backup helicopters that could be moved across the network to help offset any sort of unplanned maintenance or even surge capacity as well.

KENNEDY, DR So what have you considered the scenario of the same bases but aircraft with different range, would that meet the challenge of that scenario?

SARTAIN, MR: It would. However, we would need to consider a fleet of at least 6-7 helicopters to consider different aircraft models within the network. Through our consultation with eastern states providers as well as international providers, the instant you start looking at multiple platforms with different aircraft licencing types for the pilots, the costs for the State goes up significantly because now you're having to hire a pilot and aircraft maintenance engineers to maintain currencies and licensing requirements on multiple aircraft. By utilising the same model aircraft fleet, just taking the SAR capability off of it, we are able to then maximise cost efficiency within the operations for the fleet. But like you said, we could tailor the same make and model aircraft, but with just a different mission type configuration.

KENNEDY, DR Okay. Just in terms of your view as a provider and I appreciate that this is kind of a clinical question, however I'm sure you'll have a view, in regard to inter-hospital transfer, utilising rotary wing platforms there's a general approach within the aeromedical space that rotary platforms are best suited to missions which are either time critical or skillset specific to what the helicopter can provide or have some level of time criticality. Time criticality is an interesting concept but there's a component of that is - is that a concept that you apply or would support in general terms?

WATERS, MR: Yes, I think that's more a clinician medical interpretation. I don't think we would make comment and would consider this to be a Department of Health consideration.

GIFFORD, MR: I think, sir, if I may, even going back to your last question, basically DFES from the outset is contract managed and our contract management is largely based on what the State's requirements are or that the Department of Health's requirements ideally are communicated to us. So I think, yes, kind of in that space, our expertise is with aviation and with contract management. So, depending on what the requirements are of the customer, in this case Department of Health, I think we could create - we could establish a service to meet those requirements. - - -

KENNEDY, DR Yes.

Thank you. Part of the reason that I ask that question is the reference to the statement you made in regard to having better ramping as a potential risk attached to the implementation of new services. In that and correct me if I'm wrong but I felt that there was an implicit assumption that the use of rooftop helipads on health infrastructure was reserved for time critical patients.

KENNEDY, DR Yes.

WATERS, MR: Yes, I was just going to say - - -

SARTAIN, MR: That's, if I may, Deputy Commissioner, so that's as per each of the tertiary hospitals' operational procedures, and obviously we as DFES coordinate that through the St John Ambulance State operations centre. And that's one of the great things about going through that is that they're able to do that coordination for us. So even when we've got both rescue helicopters trying to land at RPH, the St John State Operations Centre is able to de-conflict with those helicopters - so either, the first bird just leaves the paramedic at the site flies to Jandakot, so the second one can land, and/or re-diverting the second helicopter to either QEII Heliport platform or Fiona Stanley. So that coordination happens internally for our network. But again, it's our concern that there is no central coordination as of yet for potential helicopter ramping. Ramping does not occur with how we currently operate because again, St Johns does that de-confliction for us as part of the SOP, yes.

KENNEDY, DR So who is responsible for managing potential conflicts of access to the CBD or other city rooftop helipads?

WATERS, MR: Good question.

SARTAIN, MR: So that this deconfliction is addressed, I know that's one of the discussions that Kylie Bosich, who is chairing the committee, I think she just spoke before us part of the coordination centre. We're trying to resolve that now, as we speak. But as of today, there is no established process as of yet. But again, as I mentioned, that that's one of the benefits of your recommendations - to actually have that centralised coordination. So, it's not just about tasking the aircraft, but it's also the de-confliction at the landing site and that could potentially be for Bunbury Hospital as well. Because again, if a patient does not require being transported to a trauma centre, they could be transport there. We currently do that now with the Bunbury-based helicopter.

If the patient is not critical or time urgent and doesn't require the trauma centres, they'll bring the patients back to the Bunbury Rescue Helicopter Base where an ambulance will be waiting for the transport to Bunbury Hospital. In fact, that just occurred this past weekend out of the Bridgewater incident.

KENNEDY, DR I mean, from your perspectives as aviation experts and managers do you have a view on the utilisation of CBD placed hospital roof helipads for routine inter-hospital transfers in terms of safety and risk exposure?

WATERS, MR: I think that's always risk assessed on the positioning of the helipad and there's procedures put in place to manage those risks on inbounding aircraft. So, I think that's up to the determination of the clinicians in relation to the timeliness of getting a patient transferred to a tertiary hospital.

KENNEDY, DR I think that's straightforward when there's a time critical issue - - -

WATERS, MR: Yes.

KENNEDY, DR - - - when there's not a time critical issue I think that - and this is my commentary, I think it's unreasonable to expect clinicians to understand the risk scenarios that are here, a medical system.

SARTAIN, MR: I mean, that is a risk even from an engineering perspective with these rooftop helipads. I know when we first started looking at neonatal transport for QEII, there was a

concern of the additional workload that that QEII pad would undertake and the hospital had to consult Risk Cover, just from an insurance perspective. And again, if we have additional helicopters landing on these sites, from an aviation safety perspective, that is something that we need to consider.

Everything from the safety aspects of landing on these infrastructures, to the flight corridors that need to be established - which have yet to be finalised through State Government - to protect the departure and approach paths going into these pads, so we don't have an incident what happened down in Melbourne. But again, we've been able to provide that consultation and we are actively participating in those discussions even now with the rooftop helipad at Royal Perth, and we've been able to provide that consultation to the City of Perth to protect those flight corridors.

KENNEDY, DR Thank you. Do you, as an organisation, have a view in regard to the development of rooftop helipads at health campuses which may reasonably expect to have significant emergency load and be within the overall mantle of helicopter operations?

WATERS, MR: Yes. We'd support obviously the inclusion of additional helipads to enhance the service delivery, absolutely.

KENNEDY, DR Yes.

SARTAIN, MR: It eliminates that additional road ambulance transfer on the front end as well as multi-handling of patients., Also you're going from one clinical governance to another, then potentially to a third, then back to the road ambulance and finally to tertiary hospital. So, yes, the establishment of helipads, obviously benefits all rotary wing assets for the State.

KENNEDY, DR So the question obviously then extends into a solution and that is why is there such a glaringly obvious deficiency of helipads in WAs health campuses? Have you got thoughts on that or thoughts on how that may be able to be resolved because clearly, you're in agreement that this would be a system improvement?

GIFFORD, MR: So, if I may, sir, I think history might become part of that reasoning. I mean, many of the health campuses were opened prior to the introduction of the Emergency Rescue Helicopter Service. - -

KENNEDY, DR History is the documentation of what happened.

GIFFORD, MR: So, if I look at e- - -

KENNEDY, DR Help me understand what that is.

GIFFORD, MR: I'll look at the introduction of the Emergency Rescue Helicopter Service which was only established in 2002-2003, Quite - many of our hospitals were existing at the time. Certainly as Steve's alluded to, in the information which he's provided, that both DFES in consultation with the contract provider have visited a number of sites - let me say "A few sites", rather than a number of sites and provided that input for which I understand that a number of those - well a couple of those hospitals have actually established helicopter landing sites on the recommendations provided by DFES and the contractor.

KENNEDY, DR: Okay. I guess in terms of looking at what's come through the considerations paper I think there's a view amongst some that's been expressed that DFES has a perspective which is more fundamentally pre-hospital in its focus, which makes a lot of sense in many respects but it also doesn't recognise the sometimes invisible urgency of people who are in hospitals and who need to move from one place to another.

And so I guess as the main system provider your awareness of the need for those helipads on a - is less than if you were doing 25 or 30 per cent of your work as interhospital transfer and every one of those involved a road transfer to the airport and additional time for your crews and things. So, but the spectrum of the work is such that I can understand to a level that that hasn't been a driver. What defendant you see as a way forward in terms of changing the perspective on that, if there were an opportunity?

WATERS, MR: I think it's probably increased collaboration between all involved. It's, as I keep going back to collaboration.

KENNEDY, DR: Go back to that strategic plan.

WATERS, MR: Collaboration is the key to developing strategies in moving forward, enhancing the service that needs to be provided for the wellbeing of the whole community. And you can't do it in isolation, one agency can't do it in isolation. We're really good at managing aircraft and contracts, arrangements around procurement of aircraft. Obviously, the Department of Health and St John are good around clinicians and critical care paramedical services. So, I think it's a collaborative approach in bringing everyone together on what the service delivery might all look like going forward and how we achieve that and what the funding and support is required to actually get to that outcome.

SARTAIN, MR: So if I could as well, Deputy Commissioner, we are able to track and we've got historical data, which we have passed onto WA Country Health, with regards to where the rescue helicopter service goes now with regards to IHPT specifically. So, we've clearly identified which hospitals would be best served with an HLS and we've passed that information on. I think Narrogin and Jurien Bay just kind of happened, because it was a budgetary benefit that was available at the time. But, as I mentioned, we can demonstrate and provide that information, which we have provided back to the Department of Health or WACHS to say, yes, these hospitals could definitely benefit and not just for the ERHS but any other rotary wing aeromedical provider in the State.

And like you mentioned Dr. Kennedy, it would eliminate that additional road transfer. But again, it goes back to the collaborative working and/or having a central controlling / command and control body that would be able to help that communication and dissemination of that information. Because obviously we as DFES can't mandate Department of Health infrastructure requirements.

KENNEDY, DR: Okay.

KENNEDY, DR: Okay. There are several considerations that have been placed in the paper, which I had anticipated that you would speak to directly and I guess maybe if we just go back and look at those. Perhaps it is they're in the group of - I mean there's a lot in there. There's a ridiculous lot in there, I understand that, and perhaps you just agree with them. But there a number of considerations and opinions stated about crewing of aircraft and the most obvious

one in regard to rotary is the two-clinician model. Is there any comment that you wish to make at this stage on any aspect of that?

WATERS, MR: I don't think so, I think the requirements for clinicians to respond and do that safely and effectively should be something that the Department of Health and St John collectively come to agreement on would be our position.

SARTAIN, MR: And again, we cite that input and even in our current draft of our request document for the next clinician contract, we've provided options for the second clinician in that contract. However, if the WA Health Department, states that we must have two onboard and it must look like this, then obviously we can go to market for the State to meet that requirement.

KENNEDY, DR: Or implement whatever model is decided. - - -

SARTAIN, MR: 100 per cent. Yes.

KENNEDY, DR: Yes. Secondarily, there is mention in the considerations of the movement of the ERHS home from DFES to something within health. Did you have a view about that, which you wish to talk to?

WATERS, MR: I think where it sits is where it sits. I think we've shown we can clearly manage contractual arrangements in relation to the ERHS, we've got a history of doing that. We've got a significant fleet of aircraft in relation to our firefighting operations.

So, yes, I don't think we have a formal position- it sits where it sits, that would be our take. The only caveat I would put on that is if there's a degradation in services that we are responsible for as a hazard managing agency in relation to response. There's a fairly complex funding arrangement in place. There used to be Royalty for Regions funding, it's now gone to consolidated account with Road Trauma Trust funds as well. And I think 2.7, 2.8 million of ESL funding and if the service was degraded to the point where it didn't cover any of our hazards, then there would need to be a review of whether ESL expenditure is appropriate in funding the ERHS.

GIFFORD, MR: If I could maybe add to that too, it's not only about the financial resources but there's human resources in the background as well. So, our finance section, our procurement section, our media section, our aviation section. Whilst it's an emergency rescue helicopter service managed by DFES and sponsored by RAC, certainly there's human resource commitment by DFES in the background as well.

KENNEDY, DR: Yes. No, I understand that. I mean there are obviously collaborative models where those things can work between departments and across governments - - -

WATERS, MR: Yes.

KENNEDY, DR: - - - so I'm sure that - - -

WATERS, MR: Yes, I'm just saying it needs to be reviewed and probably considered going forward. Yes. - - -

KENNEDY, DR: I mean my understanding from the various input that we've had is the rationale around that is that the core business of your service is a health service, it's an ambulance service really.

WATERS, MR: Yes.

KENNEDY, DR: And when you look at other jurisdictions it would be uncommon for that to sit outside a health environment, particularly for those clinical governance an oversight reasons that we've spoken about earlier. And also, potentially to articulate with the other parts of the health aeromedical system, including fixed wing in a more kind of holistic way. But I can understand where that opinion is coming from.

WATERS, MR: Yes, yes.

KENNEDY, DR: But it's also obvious to me the level of expertise and professionalism that your organisation has provided in terms of both establishing and developing the helicopter service as it is, and it is an impressive service. And once you get some new machines it'll be even more impressive.

Finally, well, maybe not finally but finally on my short list do you have a view about the current or pending trial of two helicopters in the interhospital space, the RFDS trial that's commencing shortly? Is there any component of that in terms of its strategic alignment or its place in the world?

WATERS, MR: I think it came to us as a bit of a surprise. I don't think that we've been consulted.

SARTAIN, MR: A little bit.

WATERS, MR: A little bit?

SARTAIN, MR: Deputy Commissioner, yes.

WATERS, MR: But probably not a lot of detail, especially around the coordination, how that's going to be a coordinated response and the tasking of that. And again, you need a collaborative approach as to how we're going to manage that going forward, if there's additional aircraft being operated from the Royal Flying Doctor Service.

KENNEDY, DR: So, can I just confirm there as the sole State provider of aeromedical rotary services that that trial has occurred without consultation?

SARTAIN, MR: I wouldn't say that, Dr Kennedy. Like I stated before, I've been involved with some consultation through WACHS so through Kylie Bosich's area, as part of that collaborative process. She's been seeking our advice especially around rotary wing governance aspects, especially where CASA's concerned and licensing requirements and auditing services that we currently utilise, so we've been part of that process. We've been part of the current process with trying to get them online as well, so that there's a correct process to coordinate the use of the tertiary heliports - - -

KENNEDY, DR: Yes.

So just allow me to separate out the pre and post of that conversation. So, you're talking about the detail of a trial? - - -

SARTAIN, MR: Correct.

KENNEDY, DR: And you've assisted in that which is obviously important given your expertise. In the decision prior to conduct a trial was there consultation with purchasing the aircraft? - - -

SARTAIN, MR: I would say there wasn't consultation in the procurement of those aircraft. I did receive some questions from their Director of Aviation, Mr Anthony Green, on what we currently utilise onboard our rescue helicopters. So, everything from the types of radios we use to communicate with the hospitals to the types of night vision goggles that we operate with and those types of aspects. And we actually invited them over to the rescue base to have a thorough look at our rescue helicopters. But, no, after that we, DFES weren't really consulted.

WATERS, MR: I think in particular probably about the integration of how they would integrate with the current services as opposed to a new service coming in, that consultation obviously didn't occur.

KENNEDY, DR: Okay. You may choose not to answer this question. As an expert in, well, as an expert service in terms of delivery of aeromedical rotary services that's got experience on I guess what I would call a past generation platform and you're now in the process of moving to current and future, what's your assessment of the choice of platform for the proposed trial?

WATERS, MR: We're happy to comment on it. Steve's done a fair bit of a work in relation to the future service.

KENNEDY, DR: From its perspective to deliver the services required in terms of meeting all of usual terms. And in terms of its potential for integration into the broader aeromedical system.

SARTAIN, MR: Having been in the aeromedical industry now for over 24 years and flown and managed both fixed wing and rotary wing, I think a true capability needs analysis could have been conducted to better inform the decision of what additional assets could be beneficial to the State especially when you're looking at - if you're only looking at interhospital patient transport. There's platforms out there that would provide increased capability and capacity. - - -

KENNEDY, DR: Can I suggest that you don't postulate about what may or may not have been done?

SARTAIN, MR: Sure.

KENNEDY, DR: And confine your answer to the question and that is what is the suitability of that platform in your assessment - - -

SARTAIN, MR: Yes, if we're looking at strictly interhospital patient transport there are better platforms out there that would have covered a greater range and needs for the State. We've

got the Bunbury base, which gives us that better coverage of the southwest, but to just be based out of Jandakot and limit to a 250 kilometre range, we're missing out on the bigger capture or needs for the State, especially in the southwest. Without having a helicopter to stop and refuel then, yes, there could be better platforms with a larger cabin capacity, longer range, faster speed, that would meet the IHPT needs better.

KENNEDY, DR: And would that type of helicopter provide a greater flexibility potentially to the system in terms of how it could be incorporated in other areas?

SARTAIN, MR: Absolutely. Even with NETS. NETS is probably one of the key ones, as Dr Davis mentioned this morning. The fact that the current cots won't fit on the RFDS's new helicopters is a concern. NETS is IHPT and if there is that high demand regardless of the other issues, he *(Dr. Davis)* mentioned, both Bunbury and Busselton, as he identified, are in dire need of a rotary wing NETS platform. And hence why we've been collaborating with the NETS team to see how we can utilise the technical backup, which can hold the capacity for the NETS cots.

That's just one example. Let alone the amount of available seats that are onboard that helicopter. So, with ours, we can stretcher two patients and even potentially carry Little Johnny and his mum with the additional seats onboard our rescue helicopters. If you're flying with the two-clinician crew in the back of that cabin, there is no additional space in the EC145s.

KENNEDY, DR: Do you have an opinion on the crewing of the EC145 in terms of air crew versus clinical crew?

SARTAIN, MR: So again, with my experience with aviation, I believe there are some safety aspects that you really have to consider with single pilot operations. So even with our rescue birds and the birds out east, the fact that Australia operates with single pilot aeromedical is not the norm for the rest of the world. In the US, Canada, even the UK, most aeromedical platforms, rotary wing and fixed wing, are dual pilot.

GIFFORD, MR: Is there a CASA regulation on it?

SARTAIN, MR: No, not yet. So that is something CASA is looking at as we talked about the other day. But there is obviously a lot of debate around the dual pilot requirements for aeromedical in Australia. But the fact that CASA has now integrated all aeromedical into ATPL or Airline Transport Pilot Licensing requirements, it's pretty cut and clear that you need two pilots. It's no different than flying passengers on a Qantas 737. Dual pilots is the norm and the usual standard. We as DFES offset some of that safety risk with the incorporation of an air crewman.

So the fact that air crewman not only operates the sensors onboard the aircraft and controls the winching of our paramedic - who also doubles as a rescue crewman down the wire - but they *(aircrewman)* are there for the safety aspects of the aircraft. So, they're helping and you've got a second set of eyes that is clearing for traffic whilst en route. They're also that second set of eyes to help clearing landing sites on unimproved locations such as a footy oval, a paddock or a roadside or on a beach. And those are all aviation safety concerns whilst operating in austere conditions when you're looking at your flight crew contingent.

KENNEDY, DR: Yes. Do you see that those safety concerns and the role of the crewman as they in the absence of a second pilot are relevant in the interhospital setting as well from a safety OH&S, loading unloading, general procedures approach?

SARTAIN, MR: If the helicopter is appropriate configured, if you're operating single pilot, and you're operating in and out of either airports or established HLS then, no, there's minimum risk and a single pilot operator can do that safely. Because, again with the building of an HLS, you're ensuring clear safety areas in the construction of that. You're ensuring clear pathways in and out of HLS. Airports obviously have multiple safety zones and clearways for helicopters to operate in and out of. So, a single pilot has no problems operating in and out of those areas.

Now, once you start talking in unimproved locations, which CASA defines as basic HLS - i.e. footy ovals, paddocks, landing on a road, landing on the beach - then there are significant safety issues that must be considered by the operator in these locations. Even to the fact where I've seen both within the FAA system and the CASA system that that is a limitation of the AOC or Air Operator Certificate for that operator to land in those unimproved locations.

KENNEDY, DR: Okay. We're moving towards the end of this session in as much as I'm running out of questions and you've run out of things to say. I do have a few more but I guess perhaps before moving onto a final discussion, there was - you did make comment in regard to unmet need in terms of zones outside the Perth space in terms of rotary work. And I understand it's clearly not your current remit to be necessarily looking at that, but you have awareness of it and you have done some strategic work. What would your advice to the inquiry be in terms of where that need is and what the potential solutions may be?

WATERS, MR: A collaborative approach by all parties involved to get together to look at a strategy going forward, horizon scanning and looking at a strategy on what the outcomes need to occur to deliver the best service to the community of Western Australia.

KENNEDY, DR: Yes.

WATERS, MR: It's just a collaborative approach coordinated together. And, yes, I keep harping on about collaboration but I think it's extremely important in all these initiatives, which has multiagency, multijurisdictional elements attached to it.

KENNEDY, DR: Yes. And I think - and that reinforces the - I guess the discussions that there's been about the need for strategic planning and getting that established at an aeromedical systems strategic plan at least.

Taking that one step further though beyond that collaborative approach, do you have views in regard to specific areas? So, for instance, I guess if I preface it by saying that in the - in some of the work that we've done since the considerations paper at a reasonably conservative analysis level it would appear to us that there is primary response and secondary response unmet need in a number of places, specifically out from Kalgoorlie in that area. Potentially further in the southwest and then in the north through the major centres in the Pilbara and Kimberley. Do you have a sense that that matches your own perceptions of the service systems and case mix that's there at the moment?

WATERS, MR: Yes, I think there's probably different levels of engagement in the involvement within the different departments. We're obviously very experienced in aircraft management.

St John Ambulance in that traumatic or the trauma response and the initial emergency response to their critical incidents they respond to. And obviously Department of Health in relation to the transfer, inter-transfer of patients between hospitals. So obviously there's no one expert that has oversight of everyone's part of the business and I think what is probably lacking is a collaborative group that actually looks at it holistically. And it probably gets back to your commentary around good strategic planning and going forward on what the model looks like and how it's delivered.

SARTAIN, MR: I believe, Dr Kennedy, the regions you've identified are in align with a lot of the historical review and strategic planning and annual review of the service. And that's data that we receive from both St John Ambulance as well as AMSA.

KENNEDY, DR: Yes. And so, at the moment in some of those areas there are quite diverse approaches to Aeromedical Service delivery, which I guess from the extent to which they are uncontrolled or - not exactly uncontrolled. Not working within an agreed set of clinical standards although I'm sure they work within the aviation standards. I would hope so.

WATERS, MR: Yes.

KENNEDY, DR: Particularly for the sake of the clinicians and patients that are involved in that. Do you see an issue with that lack of application of uniform clinical standards across the State's aeromedical providers?

WATERS, MR: Yes, obviously but I think that's a thing that should be promulgated by the experts in those fields, so Department of Health and St John's who are the clinicians should be providing that oversight on what should be delivered and how it should be delivered as well.

KENNEDY, DR: So, at the moment it would be fair to say that neither of those organisations necessarily feel that they have a remit to do that or perhaps the expertise of have had the strategic approach to do it. One of the solutions that has been proposed through the considerations is that some - is that the overarching the collaborative mantle, if you like, that system in whatever shape it is has a role to develop and require those clinical standards.

If people are to work in an aeromedical setting within the health environment, then health will have a statement about - the same way as it does about ambulance services, for instance about what the clinical standards should be. And obviously if they're purchasing them the aviation standards as well. - - -

WATERS, MR: Yes. I think it gets back to the introduction of the service in 2002 and as it matures and develops and expands. I would expect and hope that Department of Health would come up with those requirements as it escalated and the integration between services was required.

SARTAIN, MR: And I think that's one of the biggest comments, sorry, Deputy Commissioner, that it's the accessibility of those assets as well. So we as DFES, we do have call when needed contracts established for aerial firefighting, air transport as well just general intelligence gathering, which I think the State could benefit with similar arrangements on a call when needed arrangements., We do regular audits of all of those contractors to ensure they're meeting our standards and safety compliances. But obviously, like you mentioned,

Dr Kennedy, we need to have those standards established, so that those call when needed contracts are held accountable to those levels or those capabilities.

KENNEDY, DR: Thank you. Is there anything further that you would like to raise either in relation to the considerations or any other matter of import to the inquiry?

WATERS, MR: No, I think that's it, thanks, Dr Kennedy.

KENNEDY, DR: I'll just check my list of sticky questions. I think we're well covered. Well, I would just like to thank you then for your attendance and for the input that you've provided both in terms of the documentation, material, briefings, conversations, visits that we've had through the inquiry up until now, they've been extremely useful and valuable. And, as I said earlier, highly professional and clearly expert, so I appreciate it, that's made this component of the work easier.

There will be a transcript of this hearing, that'll be sent to you, and you correct any minor factual errors before that is placed on the public record.

WATERS, MR: Yes.

KENNEDY, DR: Unfortunately, if you've said anything that you now regret it's going to be on the record. But I think I mean to speak to that, and I'm off script here, I think - I appreciate your frank discussion and your construction discussion. Because that's what this is about, it's all fundamentally about how we can improve the system, not just how we can change the system, there's no point in changing if you're not improving, so I do appreciate that. - - -

You will need to return the transcript within 10 working days of the date of the covering letter or email otherwise we'll deem it to be correct.

WATERS, MR: Yes.

KENNEDY, DR: While you cannot amend your evidence, if you would like to explain particular points, if you feel a need to do that, 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, thanks very much for your evidence and for your attendance and taking the time out of your busy lives. - - -

WATERS, MR: Thank you.

WATERS, MR: No, thank you. Thanks very much.