Aeromedical Services WA Inquiry – Formal Hearing Transcription
Inquirer: Dr Marcus Kennedy
Organisation: Child and Adolescent Health Service – Dr S Wood, Ms D Chiffings
Date: 10 February 2022, Time: 1415 – 1450

KENNEDY, DR: I'd like to start by thanking you for your interest in the inquiry and for your appearance at today's hearing, which is no doubt falling in the middle of a very busy week for you.

WOOD, DR: Indeed.

KENNEDY, DR: Apologies. The purpose of the hearing is to assist me in gathering evidence into - for the inquiry into Aeromedical Services in Western Australia. I'll just start by introducing myself, my name's Marcus Kennedy. I have been appointed by the Chief Health Officer to undertake the inquiry. Beside me is Jonathan Clayson who's the Inquiry's Project Director.

We need to ask you to be aware that the use of mobile phones and other recording devices is not permitted in this room and we'd ask you to 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, so although you are not being asked to give your evidence under oath or affirmation it is important that you understand that you must answer all questions that asked and that there are penalties under the Act for knowingly providing a response or information that's false or misleading, which I'm sure you don't intend to do.

This is a public hearing and the transcript of your evidence will be made for the public record. If you wish to make a confidential statement during today's proceedings today, you should indicate that to me and 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 this afternoon's procedure?

CHIFFINGS, MS: No.

WOOD, DR: No, I don't think so.

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

WOOD, DR: I'm Simon Wood, I am the Executive Director of Medical Services, and I'm acting as a delegate for the Chief Executive of Child and Adolescent Health Service.

KENNEDY, DR: Thank you.

CHIFFINGS, MS: Debbie Chiffings, I'm a nursing co-director for the Neonatology Division of CAHS.

KENNEDY, DR: Thank you. So, you are now invited to address the focus considerations list that has been provided to you or any other part of the considerations paper that you wish to. We'd ask that you feel free to speak for up to 15 or 20 minutes after which I may have some additional questions for you. I will try not to interrupt you during that initial period of your presentation unless there's things that I don't understand. And, as I said, after you address I may ask you specific questions. So over to you.

WOOD, DR: Yes, so thanks for inviting us to come and participate in this review. We have read through the considerations and the focus considerations that you've presented for us to

comment on. And I guess our initial comment is that almost all of the considerations are consistent with our observations and thoughts (indistinct 2.18.32).

If I can just perhaps - I don't intend to go through and address each one but I would just like to perhaps just explain how we kind of fit into the aeromedical system. So, the Child and Adolescent Health Service is responsible under the Health Service Act for providing for managing and operating the Neonatal Emergency Transport Service for Western Australia. And this service is a highly specialised service and it is a state-wide service. So, we are a single HSP who has the remit to deliver this service on a state-wide basis.

As I've mentioned, the Neonatal Emergency Retrieval Service it is based at Perth Children's Hospital and it is comprised of, you know, a highly specialised team and that team provides a number of functions, including retrievals. So, sending a team to retrieve a patient and bring that patient back to the Perth Children's Hospital or to King Eddie's Neonatal Service but essentially to the Perth Children's Hospital.

But the service also provides advice as to the management of patients while they're awaiting retrieval. And also, an outreach education function in terms of upskilling regional - principally regional hospitals and services in neonatal management. So, the service retrieves about 1,200 babies a year and of that about 25 per cent are from regional sites outside of the metropolitan area whereby we need to retrieve via a fixed wing transfer - transport service. And I guess that's our interaction with the Aeromedical Services in Western Australia. We do rely on the existing services to provide our transport options for the regional retrievals that we have to do.

From the point of view of the challenges for us with that arrangement it really comes down - we have a quite significant challenge in terms of logistics and equipment. I guess they're the two big issues that, you know, are consequent to that interface. And the logistics issue really is the tasking of the availability of the transport, the aeroplanes to take our teams to the location and bring them back. It's a little more complicated than that, of course, because there are a number of other providers who are also associated with providing parts of that end to end transport service. So, for road-based elements it might be St John Ambulance. For the actual flight it will be Royal Flying Doctor Service or Medical Air.

And, you know, then there's often road-based transport at the other end as well and back. The fact that there are different organisations providing the different elements of the service is a particular challenge for us navigating the service because there's not an overarching sort of I guess corporate or clinical governance structure in place. And this can raise challenges, specific challenges in a couple of ways. One is the tasking of the transports and how they are prioritised. And in the current system the tasking of the transports are prioritised by the provider rather than an independent element.

And we often find that the priorities for newborns we feel are sometimes felt, you know, to be second to the priorities for adult patients in the regions. And I'll ask Debbie after I finish to elaborate further on anything that you'd like us to elaborate on.

The other challenge is the fact that the different services each act as a different corporate entity and so make their own decisions regarding their service delivery. And this can have an impact, particularly - you know, it can have an impact on the whole system but it has had a particular impact on the whole system but it has had a particular impact on our neonatal emergency transport service in a number of ways in the past.

One of these is, I'll give an example, for instance, is with our equipment there was a decision made by St John Ambulance who on whom we rely for the road-based elements of the transport to upgrade their ambulance equipment structures. And this was done without any consultation with our part of the service and we found that our equipment, in fact, was no longer compatible, so our cots couldn't be placed in the ambulance, which is a real risk for us meaning that while they might be able to do the metropolitan part of the service we might be able to get them to the aeroplane but we might not be able to actually fit out equipment into retrieve at the other end and back. So that's an example of a particular service decision that has had, you know, a potentially quite significant impact on us.

Another example of kind of corporate decisions being made by individual entities where it might have an impact is say the recent purchase to helicopters by RFDS without (indistinct 2.25.00) consultation or how they might fit in with the service. And I think you've mentioned that in the considerations, so you're aware of that.

I think one of the major concerns for us is the lack of an overarching clinical governance framework for aeromedical retrievals. I mean it is hard to have good visibility of the safety and quality of the care that is provided to a patient from the complete end to end patient journey when you have different elements of different organisations providing those but without an overarching kind of structural governance system to have visibility of that.

And we have been aware of this for some time, we've been trying to engage with other services to improve that in terms of recently we've initiated the interagency working group to try and look at this issue. And we have done that on an ad hoc basis, clinical incident reviews with other agencies but I think it's a very - the system needs to mature and needs to be better structured.

So, I mean I think they're kind of the key considerations from our perspective in terms of how NETSWA interacts with the aeromedical system, what our observations have been. I'll just ask Debbie to make any other comments.

CHIFFINGS, MS: Yes. Some of the other - - -

KENNEDY, DR: Perhaps before - - -

CHIFFINGS, MS: Sorry.

KENNEDY, DR: - - - we move on - - -

WOOD, DR: Yes.

KENNEDY, DR: - - - can I just ask you do you have thoughts in terms of the system developments that could address the issues that you've raised or the issues that I guess lack of visibility of some of the compatibility, things across the system, clearer visibility of your logistics challenges, tasking concerns et cetera.

WOOD, DR: Correct.

KENNEDY, DR: And then the overarching clinical governance question. What do you see as a potential solution to that?

WOOD, DR: Yes, a potential solution. Well, I think it has been mentioned in the paper that I think there is a need to sort of think about who owns that sort of responsibility for delivery of the aeromedical system.

KENNEDY, DR: System.

WOOD, DR: And at the moment there's not a clear overarching owner of that and I think that's probably a part - - -

KENNEDY, DR: So, something is needed to tie that - - -

WOOD, DR: Yes.

KENNEDY, DR: - - - together in - - -

WOOD, DR: Yes.

KENNEDY, DR: - - - some form.

WOOD, DR: Absolutely. I mean understanding that our system also or, you know, we - it's 25 per cent of the work that we do it's quite an important 25 per cent and it's the highest risk part of the work because of the delays that are associated with the long distance for travel.

KENNEDY, DR: Yes.

WOOD, DR: Yes.

KENNEDY, DR: Okay, thank you. Sorry to interrupt.

CHIFFINGS, MS: Sorry, yes.

So just going on from what Simon's already said, the issues around the logistics is actually also availability of aircraft. So there has been several occasions where there is no flight available or there's no crew available. That leads to some quite long delays in leaving Perth to get to the north west in particular. The south west is another issue. In the paper for adults it seems the north west is a bigger percentage of flights. For neonates it's the opposite, the south west forms probably about two thirds of our requirement for flights and so some of the ones to Bunbury there's never a flight available to go to Bunbury, so it's a road transport, which does make that quite a lot longer and delays in getting there.

So staffing, so RFDS like to have their own staff on the flights. For neonates it is a specialised area and we do like to send our own teams to pick up patients. Sometimes RFDS decide to bring the baby down and then we will meet them at the tarmac and Jandakot. And we have had some serious clinical incidents with some of those transport cases. So, they're probably the main things.

We have got our own contract, as you saw in the paper, with Medical Air because RFDS seem reluctant to ask Medical Air to help out, if they haven't got a flight, so we have our own separate contract that we can use a different provider for Medical Air. And also, to go interstate because we also do transports interstate a few times a year with some of our patients.

So, they're probably, yes, just to extend on what Simon said is the delays in leaving, lack of availability of flights. And also, RFDS sometimes seem to override the decision making around priority cases. So, what we would think would be a high priority it gets changed without you being part of the decision making.

KENNEDY, DR: What do you mean by "Part of the decision making"?

CHIFFINGS, MS: Well, we have a teleconferencing system, it would be nice to be in on the conversations, if RFDS is deciding that the baby should be - is downgraded to P2 or a P3 and we think it should be a P1, we should be part of that conversation and that a three-way conversation with the team at the hospital where we're treating from. RFDS and our staff having a say on what that looks like.

KENNEDY, DR: Okay. So, if I understand, you're describing a situation where you as a specialist service have interacted with a referring service and have a full clinical picture - - -

CHIFFINGS, MS: Yes.

KENNEDY, DR: - - - and probably provided care advice, maybe monitoring that, and have assigned an urgency to that scenario. That's communicated when you book your transport and then the transport agency reassigns that urgency.

CHIFFINGS, MS: Yes.

KENNEDY, DR: Based on a conversation between them and the referring hospital?

CHIFFINGS, MS: Yes.

KENNEDY, DR: So, we now have a triangle of non-communication.

CHIFFINGS, MS: Yes.

KENNEDY, DR: And you're not part of that?

CHIFFINGS, MS: Yes, that's exactly.

KENNEDY, DR: Has that issue been - I mean have you attempted to resolve that in terms of that's just not good practice?

CHIFFINGS, MS: We have and that's part of the reason why we've set up the interagency meetings in - - -

KENNEDY, DR: Okay.

CHIFFINGS, MS: - - - a bit more structured format.

KENNEDY, DR: Yes.

CHIFFINGS, MS: Because I think you lose track then of the clinical outcomes for the patients because they deliver, you know, help you deliver the patient to the hospital but they then don't know what happens after that and the impact of some of their decisions on that patient's outcome.

KENNEDY, DR: Okay. You also described a scenario where a baby may be brought down by air by RFDS and that's a surprise to you and the patient - - -

CHIFFINGS, MS: We normally know about it. We would prefer to send our team to collect the patient because we have had incidents where - an example that's going through Court is the baby was extubated but they didn't notice it and when our team went out to meet them at Jandakot the baby was in a really poor condition. So if you've got inexperienced medical staff bringing the patient down with an experienced RFDS nurse, the equipment's quite specific as well, it's very specialised for those babies, if you don't know the equipment and you don't know what you're looking for, then you're going to miss things.

KENNEDY, DR: Okay.

CHIFFINGS, MS: So, we've had - and even equipment failures. Knowing the equipment is half of the job - - -

KENNEDY, DR: Totally.

CHIFFINGS, MS: - - - of going to pick up the patient.

KENNEDY, DR: Absolutely. So that scenario that you're talking about hopefully would be quite rare. But would you be aware of the - I mean if your initial plan was that you would retrieve that baby and a decision made for it to be done by a crew from elsewhere how is that decision reached? The appropriateness of that level of care and that response how is that decided?

CHIFFINGS, MS: It's not decided by us, it would be decided normally by where they have a plane available. If the logistics of that is it's easier for them to bring the patient down than have a two-way flight because you've got to - - -

KENNEDY, DR: Yes.

CHIFFINGS, MS: - - - fly up there and then fly back whereas if there's a plane already up in Broome, for example, then they're just flying the patient down. So, it's not our preferred model and we prefer to send a team up.

And the other thing that's starting to happen a little bit more recently, and it's different for adults, you can bring the adults out to the tarmac and put them on the plane, for neonates you don't do that. We like to go and stabilise the baby and it will take longer to get the baby onto the plane because you go to the hospital and stabilise prior to transport. So, we have had that happen recently where we're saying, no, you cannot bring the baby to the tarmac and then swap it over, it actually is detrimental to the patient to do it that way.

KENNEDY, DR: So, does that happen?

CHIFFINGS, MS: They've tried to have it happen.

KENNEDY, DR: Because?

CHIFFINGS, MS: And to make it - it's quicker for them, they're not waiting for us then to stabilise the patient to bring it down. So especially if they're on, you know, hours of work or hours of flight times - - -

KENNEDY, DR: Yes.

CHIFFINGS, MS: - - - and then you're waiting for an extra four hours makes a bit of a difference. So that team fatigue I think - - -

KENNEDY, DR: That's a big - - -

CHIFFINGS, MS: - - - is a big factor.

KENNEDY, DR: It is a big issue.

CHIFFINGS, MS: Definitely.

KENNEDY, DR: And the logistics of pilot hours and - - -

CHIFFINGS, MS: Yes.

KENNEDY, DR: - - - so on is - - -

CHIFFINGS, MS: Yes.

KENNEDY, DR: - - - it's important.

Okay, I understand exactly what you're saying. I think you raised a question of the RFDS crewing. Do you mean crewing in conjunction with the NETS crew or instead of the crew?

CHIFFINGS, MS: For those ones we're not involved, it will be an RFDS nurse and then usually a doctor from the hospital that's transferring the patient because it will be a paediatrician. We would prefer for our team to go with the RFDS nurse.

KENNEDY, DR: So that would be a general paediatrician, not a neonatologist obviously - - -

CHIFFINGS, MS: Yes. Well, its whatever doctor is in that - - -

KENNEDY, DR: Is there.

CHIFFINGS, MS: - - - particular town at that time.

KENNEDY, DR: So, it may not be a paediatrician?

CHIFFINGS, MS: They usually are paediatricians, but it just depends on their level of experience whether they've had any neonatal experience. Or some of them where they've had an experience in WA a lot of - you get a lot of overseas doctors who - - -

KENNEDY, DR: Yes.

CHIFFINGS, MS: - - - don't understand the logistics and the whole size of WA and the hours involved in getting from one end to the other is quite different from a lot of other places.

KENNEDY, DR: In the other scenario where a NETS crew responds on a RFDS plane with an RFDS pilot and a nurse - - -

CHIFFINGS, MS: Yes.

KENNEDY, DR: - - - you're comfortable with that crewing arrangement?

CHIFFINGS, MS: Yes.

KENNEDY, DR: Okay. The independent contract with Medical Air - - -

CHIFFINGS, MS: Yes.

KENNEDY, DR: - - - seems to be something that has arisen out of necessity in terms of availability of resource, is that fair?

CHIFFINGS, MS: Yes, we've had that for quite a few years now, we just upgraded it two years ago. We used to use Medical Air more going interstate.

KENNEDY, DR: Yes.

CHIFFINGS, MS: So, if we had - but we have used them when RFDS are unavailable.

So, the contract with RFDS sits with WACHS, so we don't have a contract directly with RFDS. But Medical Air were available and have, you know, have a plane and have the crew, so we got our own contract just to stop those delays.

KENNEDY, DR: How is that budgeted for? It's probably a question for you.

CHIFFINGS, MS: It's in our budget, so - - -

WOOD, DR: It is in the budget.

CHIFFINGS, MS: - - - it's part of NETS.

KENNEDY, DR: It was added on in some way when you developed those contracts through government funding?

CHIFFINGS, MS: Yes.

KENNEDY, DR: You don't have to go out and rattle tins for it or - - -

CHIFFINGS, MS: Not normally. And it's just a pay as you go contract, so it's not - we don't have a contract where they're available 24 hours a day, which would have been our second preferred model where we could have had a contract. We were waiting for the outcome of this inquiry actually before we progress on that one. But we have looked at having a contract where Medical Air would be available 24 hours a day for NETS and then you would pay as you use it. At the moment it's just an open contract and so we're able to use them as required and if they're available. Whereas the other option there would be a different contract, they would be available on standby 24/7.

And then we could also sort out some of those equipment incompatibilities. So, the difference with the equipment is whatever size plane you're getting on as to what the interface is from the NETS equipment to the plane and securing it.

KENNEDY, DR: Okay. Can I just broaden the conversation a little beyond little children to bigger children? Are there issues of interface with the aeromedical system in terms of paediatrics more generally that you wish to speak to or - - -

WOOD, MR: Well, I think we don't have a paediatric retrieval - - -

CHIFFINGS, MS: Retrieval.

WOOD, DR: - - - service in Western Australia. We have the neonatal emergency transfer service and NETS will, you know, extend beyond the neonatal period in some instances where it's appropriate to do so depending on the size of the child and the condition and the location. But we don't have a paediatric retrieval system.

So, the way that children might arrive at Perth Children's Hospital at the tertiary service via an aeromedical system would be via Royal Flying Doctor Service or the DFES emergency response helicopter service. And in which case, look, it's a pretty simple transaction when it's a primary retrieval or an in hospital transfer from the point of view of the - I mean for a primary retrieval it's a simple interaction because it's usually the emergency department and/or our intensive care unit.

And the number of children that get flown down through - via the Royal Flying Doctor Service, look, it's - I'm not aware of any particular issues.

CHIFFINGS, MS: Not huge numbers. I think the biggest issue is that lack of visibility.

WOOD, DR: Yes.

CHIFFINGS, MS: Because I did speak to the team before we came. Knowing when people are going to arrive and having that sort of flight tracking, so you know where they are in the system, that was their main issue around that, not having that visibility or if there are delays you're not informed about it, especially if you're waiting for them to go to theatre. Or the organ transplants was the other part about having that visibility of flight tracking.

KENNEDY, DR: So, you would be aware in some State there are specialised paediatric emergency transfer services where their advocacy for the need for such services is loud and insistent.

WOOD, DR: Yes.

KENNEDY, DR: And there are other States and other jurisdictions where this is done in a more general way, for example, in New South Wales, which is a high-volume system and it's handled in a general set sort of scenario. Is there a group who - I mean is the view in Western Australia pretty solid in terms of the lack of need for development of a paediatric emergency transfer service?

WOOD, DR: I wouldn't say that that would be the view. I think there is a recognition that there is a need for a paediatric - at least for infants up to - - -

KENNEDY, DR: Yes.

WOOD, DR: - - - school aged children. I think, you know, that's the group I think that - and that's for metropolitan transfers as well as regional transfers, you know, I think - - -

KENNEDY, DR: Absolutely I mean that's where the volume is coming from - - -

WOOD, DR: Yes, most - - -

KENNEDY, DR: - - - your peripheral metro hospital into your - - -

WOOD, DR: Absolutely. And having worked as an emergency physician in a peripheral emergency department in Perth I know what it's like to hop in the back of an ambulance with a very sick child, infant, and transfer them down and how stressful that can be and how risky that can be for the transfer. So, I think there is a recognition that this - you know, that there is a gap in the service. There is a gap in that part of the transfer service in Perth.

KENNEDY, DR: So, any thoughts about how that gap could be narrowed either through outreach and coordination, telehealth through to obviously the provision of response teams?

And I'm thinking mainly aeromedical but obviously this gets translated to ground as well. But at the moment is there an established outreach approach where if someone's in Albany and got a problem with a child that's two years old they can talk to someone and get the support that they need, they can be in the room with telehealth?

WOOD, DR: So, there is that service that exists through WACHS, the WACHS sort of - - -

KENNEDY, DR: Sure, so - - -

WOOD, DR: - - - telehealth service but it does lack the - - -

KENNEDY, DR: It doesn't have the paediatrician attached to it.

WOOD, DR: It doesn't have the paediatrician. And, look, it was - you know, it was a topical discussion when COVID first commenced because we were, you know, thinking about we might - how CAHS might support the other - the rest of Western Australia and particularly the regional areas in terms of providing some support with paediatric expertise for consideration. The thought was, you know, this could be done via telehealth and that could be done. It would require, you know, an investment and, you know, to actually achieve that.

KENNEDY, DR: Sure.

WOOD, DR: With our current COVID response we have set up a virtual or remote paediatric service, which will provide telehealth at least, you know, telephone - - -

KENNEDY, DR: Yes.

WOOD, DR: - - - support with, you know - for vulnerable children who are COVID positive throughout Western Australia.

KENNEDY, DR: Okay.

WOOD, DR: So, I think there is - that could be done.

KENNEDY, DR: That concept is there.

WOOD, DR: Yes. And it is recognised that that would be a beneficial thing. I think in terms of providing a retrieval service and we have - you know, it would probably need to come out of the Perth Children's Hospital and it could happen as an extension of the NETS team as it is done in Victoria with the PIPER service or it could - you know, it could be developed separately. But again, it would require us to work up a model and a business case and submit that to the State. It will require the State to want us to provide that, that service I think is the - and so that brings us back to that overarching ownership of aeromedical and retrieval services within Western Australia and where that sits.

At the moment with the separate health service providers as the people who do the operational component of health service delivery there's - it's not clear where that, you know, who should be making those decisions in terms of activating these services, yes.

KENNEDY, DR: So, constructing something that does that work of coordination and brings - - -

WOOD, DR: Yes.

KENNEDY, DR: - - - the right people together in that collaborative setting - - -

WOOD, DR: Yes.

KENNEDY, DR: - - - is really part of - -

WOOD, DR: Yes, and understands fully the risks - - -

KENNEDY, DR: Yes.

WOOD, DR: - - - the safety issues, and the gaps in the services.

KENNEDY, DR: Yes. Do you see that kind of structure as interfacing with NETS in a particular way? I mean most of NETS or PETS type services sit at the Children's Hospital and there's an Aeromedical Service or a coordination point somewhere else and they're kind of special and different but also like the systems things which stops all of the issues that they have with compatibility and, you know, providers et cetera. So, I guess that doesn't need to be a co-located or inhouse type arrangement as long as the working relationships and processes are effective.

WOOD, DR: Yes.

CHIFFINGS, MS: It's the communication pathways really - - -

WOOD, DR: Yes.

CHIFFINGS, MS: - - - and that discussion around priorities and how cases get priorities and access like and the same - - -

KENNEDY, DR: And the governance principles can sit around all around from an aeromedical point of view - - -

CHIFFINGS, MS: Yes.

KENNEDY, DR: - - - without - - -

WOOD, DR: Absolutely.

KENNEDY, DR: - - - any discomfort.

WOOD, DR: Yes.

CHIFFINGS, MS: I think the other gap in the service is obstetrics, which obviously has a flow on effect for neonates. So, some of the - that is a big gap around transferring of pregnant women and especially people who are in labour. So, the preferred model in WA has always been to transfer the baby in utero, it gets a better outcome. That's causing more of an issue, we've had a very increase in out born very preterm babies in the last few years in WA, which is different to what we've ever had before. It's gone up sort of from five per cent to 13, 14 per cent, which is quite - - -

KENNEDY, DR: Do you know why?

CHIFFINGS, MS: No, not really. It's quite significant. I think some of it is a lack of education and lack of understanding.

KENNEDY, DR: These are all potentially aeromedical transfer type patients?

CHIFFINGS, MS: Yes. Some of them are metro as well, so that's a bit different but the difference with the aeromedical ones it's a long way to go and 24-week twins somewhere the outcomes are much, much worse than bringing the mother down. So, it's that interface with the obstetric divisions.

KENNEDY, DR: But aside from the aeromedical component of that do you have an obstetric outreach capability, a perinatal emergency type - - -

CHIFFINGS, MS: No.

KENNEDY, DR: No, okay. So that - - -

CHIFFINGS, MS: You can phone - - -

KENNEDY, DR: - - - is, therefore, done by clinician to clinician - - -

CHIFFINGS, MS: Yes.

KENNEDY, DR: - - - on an ad hoc basis.

CHIFFINGS, MS: Yes.

KENNEDY, DR: Provision of advice - - -

CHIFFINGS, MS: You can phone the tertiary hospital and speak to someone.

KENNEDY, DR: Yes.

CHIFFINGS, MS: But it's not very well established and even like that three-way conversation with NETS and obstetrics - - -

KENNEDY, DR: Okay.

CHIFFINGS, MS: - - - and the providing hospital.

KENNEDY, DR: All right.

So, I mean if they become an aeromedical transfer, which they probably are, the - what would apparently be missing from that scenario then would be like the governance around that initial conversation, how is that captured? Is there consistency advice?

CHIFFINGS, MS: Yes.

KENNEDY, DR: What's the governance around reviewing that process and practice and the interim care? And then the response is provided by RFDS presumably based at the time in the current setting.

CHIFFINGS, MS: Yes.

KENNEDY, DR: Okay. So, you would be suggesting that in some way that's more systemised?

CHIFFINGS, MS: Yes. I think especially as obstetric services start to increase out in other units, not just centralised in the King Edward tertiary hospital but with Fiona Stanley expanding their neonates, Joondalup expanding, and those hospitals also having adult ICU capacity because some of these mothers are also really sick.

KENNEDY, DR: Yes, sick.

CHIFFINGS, MS: So, it is an extra part of that real - - -

KENNEDY, DR: Okay. All right, well, thank you very much. Is there anything else that you wanted to raise finally?

WOOD, DR: No, I don't think so.

CHIFFINGS, MS: I don't think - everything's captured quite well in the considerations actually.

KENNEDY, DR: Thank you. This is the only session that's gone overtime, so - - -

CHIFFINGS, MS: We must be the most interesting.

KENNEDY, DR: - - - thank you for your - - -

WOOD, DR: Sorry, talking too much.

KENNEDY, DR: - - - stimulating content.

CHIFFINGS, MS: Thank you.

KENNEDY, DR: But I only let that happen because I know we've got a long break now, so we can recover. Thank you for your attendance at today's hearing. A transcript of the hearing will be sent to you, so that you can correct any minor factual errors, if there any, before it's placed on the public record. You will need to return the transcript to us within 10 work days of the date of the covering letter or email otherwise we'll assume that it's correct. While you cannot amend your evidence per se, if you would like to explain particular points in more detail or present further information around any of those topics you may do as an addition to your submission to the inquiry when you return the transcript. So that's it, thank you very much - - -

CHIFFINGS, MS: Thank you.

KENNEDY, DR: - - - and I thank very much for your input.

WOOD, DR: Thank you.

KENNEDY, DR: Thank you.