STATEMENT OF MARK STEWART ELCOCK

I, Mark Stewart Elcock, State Medical Director, for Retrieval Services Queensland, Division of the Chief Health Officer, QH, 2nd Floor Medilink Building, The Townsville Hospital, Townsville, say as follows:

I was directly involved in the Queensland summer flood disaster response from 26/12/10 through to 28/02/11.

1. I am a registered Medical Practitioner with the Medical Board of Australia. I have unconditional General Registration and Specialist Registration in Emergency Medicine. I received my Medical Degree in Glasgow, Scotland in 1988 (MBChB). I am an Australian trained Emergency Physician, obtaining a Fellowship of the Australasian College of Emergency Medicine (FACEM) in 1998. I also have a Fellowship of the College for Emergency Medicine in the United Kingdom (FCEM), conferred in 2002.

2. I hold the position of Associate Professor (Adjunct) with the School of Medicine and School of Public Health, Tropical Medicine and Rehabilitation Sciences, James Cook University. This appointment is due to my past experience and knowledge in pre-hospital patient care and disaster management.

3. I have been involved in pre-hospital care and aeromedical transport in Queensland since 1991. This has involved significant exposure to aeromedical clinical coordination and retrieval in Queensland. This specifically includes >4000 clinical coordination tasks and >800 primary and inter-hospital retrievals (road, rotary and fixed wing).

4. During this time I have developed close professional working relationships within Queensland Health (**QH**), Queensland Ambulance Service (**QAS**), Emergency Management Queensland Helicopter Rescue (**EMQHR**), the Community Helicopter Providers (**CHP**), Australian Helicopters Pty Ltd (**AHPL**), Royal Flying Doctor Service (**RFDS**), Careflight Medical Services (**CMS**), Careflight Group Queensland

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and the various clinical networks and professional bodies involved with retrieval and aeromedical transport services in Queensland, other States and Territories and internationally.

5. I am employed by QH as a clinician at the level of Eminent Staff Specialist. My position is that of State Medical Director, Retrieval Services Queensland. My role encompasses direct clinical work as a Retrieval Physician performing retrievals with QAS Flight Paramedics by QAS Ambulance or Emergency Helicopter Network (**EHN**) Helicopter and RFDS Flight Nurses via RFDS aircraft as tasked by the Queensland Emergency Medical System Coordination Centre (**QEMSCC**). I also perform QEMSCC Medical Coordination shifts.

6. My non clinical role is primarily to provide clinical governance and operational oversight of QH contracted retrieval and aeromedical service providers. I also provide specialist clinician advice in assisting the development of standards and policy to QH relating to aeromedical and retrieval issues. My role description assigns me to the position of State Controller of Aeromedical Assets for QH.

7. Retrieval Services Queensland (**RSQ**) was intricately involved in the acute flood disaster response from 26/12/10 through to 28/02/11.

8. I was State Medical Director during this period, performing clinical and operational roles as well as medical leadership across RSQ and QEMSCC. In particular, I maintained direct liaison with the QH State Health Incident Controller, State Health Emergency Coordination Centre (**SHECC**), QAS Deputy Commissioner and Medical Director, EMQ-HR General Manager and Base Managers, CHP Chief Executive Officers, Careflight Medical Services Chief Executive Officer and senior clinicians, RFDS senior clinicians and operational staff and Health Service Districts to direct the strategic positioning and integration of Emergency Medical System (**EMS**) aeromedical assets (Rotary and Fixed Wing) and Retrieval Teams to those regions affected. Additional EMS Helicopters were provided by the CHP.

9. This statement is being provided as a result of my direct involvement in the Queensland Summer Flood disaster response from 26/12/2010 to 28/02/2011 and in response to the letter dated 10 May 2011 I received from the Independent Commission of Inquiry into the 2011 Queensland Flood Disaster (the **Commission of Inquiry**).

10. In response to the specific matters requested, I now respond as follows:

A. Overarching structure for the provision and tasking of emergency helicopters in Queensland, including helicopters owned by Emergency Management Queensland and community helicopter (such as the Sunshine Coast Helicopter Rescue Service)

11. The EHN is comprised of four CHP, the Contract Provider in the Torres Strait and EMQHR. Together they provide a network of 10 helicopters along the east coast regions of Queensland.

a. The four CHP have a Funding Deed with State Government to assist with emergency helicopter service delivery to their community. The four approved CHP are:
   i. CareFlight (Qld) with bases at the Gold Coast and Toowoomba Airports;
   ii. Sunshine Coast Helicopter Rescue Service with bases at the Sunshine Coast and Bundaberg Airports;
   iii. Capricorn Helicopter Rescue Service based at Rockhampton Airport; and
   iv. Central Queensland Helicopter Rescue Service based at Mackay Airport.

b. The Contract Provider is AHPL and is based at Horn Island to service the Torres Strait area. The Contract Provider has a commercial contract with State Government to provide emergency helicopter services in the Torres Strait area.

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c. EMQHR has 3 bases at Archerfield Airport (Brisbane), Townsville Airport and Cairns Airport.

12. On 1 July 2010 the administration and funding for the four CHP and the Contract Provider in the Torres Strait were transferred from the Department of Community Safety to QH under a Machinery of Government change.

13. EMQHR remains with the Department of Community Safety. However, QH is developing a Memorandum of Understanding with Department of Community Safety for the use of helicopters for interfacility transfers.

14. Under the Funding Deed and Contract with the CHP, authorised services (or tasks) include aeromedical operations (including primary tasks, interfacility transfers, and transport of medical teams and equipment (nil patients) for large scale aeromedical operations), fire and rescue operations, urgent Queensland Police Service (**QPS**) responsibilities (including Search and Rescue operations and law enforcement), emergency management operations (including evacuations, re-supply, personnel and equipment transfer, reconnaissance and damage assessment and official transport) and training of tasking agency personnel.

15. Tasking agencies that task all the helicopters in the EHN are QH, QAS, Queensland Police Service (**QPS**), Queensland Fire and Rescue, District Disaster Coordination Centres (**DDCC**), State Disaster Coordination Centre (**SDCC**) and the Australian and Maritime Safety Authority (**AMSA**).

16. Tasking by QH and QAS is through the QEMSCC which is a joint initiative between QH (Retrieval Services Queensland) and the QAS.

17. The QEMSCC was established as a Statewide service in January 2006. This was as a direct result of two coronial inquests into two separate EHN helicopter crashes with multiple fatalities involving EHN flight crew, QAS paramedics and a patient and family member. These crashes occurred in July 2000 and October 2003. There were

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also two Independent Reviews during 2004 and 2005 which supported the move to a central point of tasking for all aeromedical taskings allowing for standardised processes and defined responsibility and accountability for tasking decisions.

18. Within QEMSCC, QH provides the clinical capability and QAS the logistics support required to task and track all aeromedical assets all in a collocated facility.

19. The QEMSCC is the only tasking agency authorised to task the EHN on aeromedical tasks to support QAS 000 calls from the community and interfacility transfers between health care facilities (Public and Private). It does not task the EHN for any non aeromedical tasks.

20. It should be noted that 89.5% of all EHN engine hours used are attributable to QEMSCC coordinated and tasked patient retrievals during times of non disaster operations.

21. The main non QEMSCC tasked EHN engine hours are related to:
    a. Search and Rescue operations 6.49 % (when tasked by QPS and AMSA);
    b. law enforcement 0.46% (when tasked by QPS); and
    c. Disaster Operations 0.82% (when tasked by EMQ/QPS and others).

22. EHN helicopters are the only helicopters in Queensland capable of transporting stretcher patients and clinical crew in an aeromedical configuration endorsed by QAS and QH. This ensures optimal safety for patients and personnel and quality patient care.

23. Importantly, all of the above tasking agencies task helicopters from the EHN directly, with EMQHR receiving the majority of such requests.

24. The tasking of EHN helicopters by multiple agencies is governed by the Queensland EHN Tasking Guidelines (**the Guidelines**). The Guidelines, to the best of my knowledge, have not been updated or endorsed since 2003. Although a number of draft versions updating the Guidelines have been in existence since then (most

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recently April 2011), my understanding is that these agencies still use the 2003 version of the Guidelines.

25. The QEMSCC tasks Emergency Helicopter Network providers according to a number of RSQ and QAS Standard Operating Procedures (**SOP**). I refer the Commission to RSQ/SOP number 12.3 *Tasking Considerations for Aeromedical Operations* (attached and marked **Exhibit A**).

26. RSQ was established in January 2009. RSQ forms part of the Health Coordination Services Directorate (**HCSD**) of the Division of the Chief Health Officer, QH.

27. This integrated Unit is responsible for:

    a. Statewide quality governed clinical coordination services for all adult, neonatal, paediatrics and high risk obstetric services providing safe, timely and efficient aeromedical service provision, to at risk patients and the communities of Queensland;

    b. RSQ provides a multidisciplinary operational partnership between QH and QAS via the QEMSCC located in Brisbane (Southern Operations) and Townsville (Northern Operations). Both centres are equipped with multiple state of the art communications technologies to provide real-time virtual linkages capable of ensuring seamless clinical coordination and patient retrieval capability across the State; and

    c. Statewide clinical and operational leadership and governance structure for QH's specialised and contracted retrieval services and aeromedical transport providers across the State ensuring whole of system performance monitoring and subsequent policy and system enhancement and development.

28. Clinical coordination describes the process whereby medical and nursing coordinators are involved in direct supervision of the transport or retrieval of at risk sick and injured patients. This is to ensure high level clinical advice is available prior to and during transport, the safe and efficient use of expensive and finite transport and clinical retrieval services and that the patient is directed in a timely manner to the most appropriate receiving health care facility.

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29. QH has identified that clinical coordination and retrieval services for adult, paediatric neonatal and high risk obstetrics patients is a significant element in providing specialist level support to rural/remote/regional communities, identifying at risk patients, facilitating equity of access of patients to specialist care and providing timely, quality clinical care and ethical, safe and efficient patient escort and transport.

30. RSQ has its primary focus on the patient and Medical Coordinators have the responsibility and delegated authority to:

a. Provide high level clinical consultancy and governance on the clinical care for patients requiring retrieval and transport to a higher level of clinical care;

b. Provide specialist level clinical advice/support to a referring clinician in preparation for transport/Retrieval;

c. Provide clinical supervision of Retrieval and/or transport service;

d. Identify the appropriate health facility destination, including critical care bed availability, as determined by the patient's health care requirements;

e. Approve and authorise the transport and clinical escort needs of the patient to effect safe, efficient, timely and effective patient retrieval services;

f. Task QH and external contracted retrieval services as required; and

g. Liaise with QAS, RFDS, EMQHR, CHP and contracted retrieval services to ensure alignment of the transport vehicle and patient escort requirements, optimising patient care and safety.

31. The QEMSCC received 18,432 clinical coordination referrals in the financial year 09-10. Of this total, 14,778 patients were aeromedically retrieved/transported by a combination of fixed wing air ambulance (11,551 or 78%) and EHN Helicopters (3227 or 22%).

32. Queensland is now the benchmark in Australia for such an integrated retrieval service. No other State provides this level of integrated specialist level aeromedical service provision across all age groups.

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B. Which Agency or agencies have responsibility for tasking of emergency helicopters during a disaster event and, in particular, which agency was the central tasking agency for emergency helicopters during the 2010/2011 flood events?

33. During a defined disaster event, the tasking agencies referred to in paragraph 15, task EHN helicopters directly. The main difference between normal daily operations and a disaster response is that SDCC and DDCC also directly task EHN helicopters.

34. QEMSCC maintains its role in tasking EHN assets to assist in the QAS Regional Ambulance Communication Centres (**RACC**) response to 000 calls and interfacility retrieval and transport requests. QH is responsible for the aeromedical retrieval and transport of sick and injured patients. The EHN is one set of assets utilised to provide safe aeromedical retrieval and quality care.

35. When the State Disaster Management Plan (**SDMP**) is activated and the State Disaster Coordination Centre (**SDCC**) is stood up, the State Disaster Coordinator (**SDC**) is responsible for the coordination of the disaster response operations for the State Disaster Management Committee (**SDMG**). The SDC is supported in this role by the State Disaster Coordination Group (**SDCG**).

36. In my experience the tasking of EHN helicopters during a disaster is no different to that followed during normal operations. They are tasked directly by the tasking agencies outlined above. The difference is that during a disaster the volume of requests directed to the EHN, in particular EMQHR, increases. This is specifically from SDCC, DDMG, EMQ and QPS.

37. In my opinion, direct tasking by multiple agencies to EHN helicopters can place the pilot in command of the helicopter in the invidious position of having to triage multiple requests for urgent assistance. There is no specific central group or agency that triages tasking requests or exercises command and control of EHN helicopters during normal operations or a disaster.


38. In my opinion and based on my qualifications and experience, not having an EHN central tasking agency is a fundamental flaw in the tasking of EHN assets. This is because it can provide scope for confusion and miscommunication for EHN tasking agency members during normal operations and specifically during the system stress of a disaster scenario. My opinion as to the ability to centralise and coordinate helicopter tasking between different agencies is addressed further in my response to the Commission's question (D) below.

(C) The role of the Queensland Emergency Medical Service Coordination Centre (QEMSCC) during the 2010/11 floods, and in particular:

(a) whether the QEMSCC was the central tasking agency for floods; and

(b) whether QEMSCC had primary responsibility for tasking the SCHRS during the floods.

39. In response to (a) above - QEMSCC was one tasking agency for EHN assets during the 2010/11 floods but it was not the central tasking agency. This is because there is no central EHN tasking agency (see further my explanation in paragraphs 36-38 above).

40. In response to (b) above, QEMSCC did not have primary responsibility for tasking the SCHRS during the floods. This is because there was no central EHN tasking agency with primary responsibility for tasking the SCHRS during the floods.

41. QEMSCC maintained its clinical and operational governance of all referred requests for clinical coordination of patients and subsequent road or aeromedical retrievals/transport during the 2010/11 floods.

This included support to QAS RACC to respond to 000 community requests for assistance as well as the retrieval and transport of sick and injured patients between health care facilities. This was articulated early on in the flood event. I refer to **Exhibit B** which is my memorandum dated 29/12/2010.

42. It should be noted that the volume of calls for assistance to QEMSCC during these events increased significantly. This was attributable to the following factors:

a. Road closures which resulted in an inability of QAS to respond to 000 calls for assistance from the community by road ambulance. Where this occurred and the patient was unable to be reached in a clinically appropriate time frame by alternative means, QEMSCC were asked to consider aeromedical (EHN) support; and

b. Road closures resulting in an inability to transport sick and injured patients between health care facilities by QAS road ambulance. Again, QEMSCC were requested to provide aeromedical support in these scenarios.

43. During the periods where QAS were unable to provide a road ambulance response to a 000 call for assistance, QEMSCC Nursing and Medical Coordinators consulted directly with members of the public to ascertain their medical requirements, provide advice and attempt to optimise their management whilst awaiting a 000 transport response. When clinically appropriate, these patients waited for road or SES transport. If it was determined that these patients required an immediate response (eg Chest Pain) every effort was made to task an EHN aeromedical response with QAS Flight Paramedic either alone or accompanied by a Doctor.

44. Where there was no QAS road, EHN or fixed wing option to retrieve patients from a lower level of care to a higher level of care, QEMSCC Medical Coordinators provided specialist level advice to referring facilities to optimise patient care whilst an asset was sourced.

45. Given the higher volumes of referrals to QEMSCC, there were occasions during the flood event when patients had to wait longer for a 000 response or gain access to a higher level of care than would normally be tolerated or clinically acceptable as a direct result of road, EHN and fixed wing asset availability. It must be recognised that normal operations were maintained during this period.

46. The QEMSCC maintained its daily functions during these events by increasing RSQ Medical and Nursing Coordinator positions and QAS Emergency Medical

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Dispatchers and implementing a 24/7 Incident Command structure. RSQ clinicians, QAS and Careflight Medical Services (CMS) personnel were rostered appropriately to ensure core, and flood related, business continuity for QEMSCC.

(D) The ability to centralise and coordinate helicopter tasking between different agencies (for example, the Queensland Emergency Medical Service, the Queensland Fire and rescue Service and the Queensland Police Service.

47. Under the current arrangements in place since July 2001, the members of the EHN are administered by different Government Departments. EMQHR are part of the Department of Community Safety and the CHP and AHPL are administered by QH. Of note, all QAS inter-facility road transports and fixed wing contracts are administered by QH.

48. In my opinion and based on my qualifications and experience, whilst the administrative and contractual arrangements are separate, the performance, governance and integration of the EHN will be sub optimal. Whilst the concurrent tasking of EHN helicopters from multiple tasking agencies (managed under different contracts and by different Government Departments) remains, there will always be an increased operational potential for tasking conflict and miscommunication. I refer the Commission to paragraph 72 in my response to the Commission's question (F) below.

49. Operationally, the obvious solution is the establishment of a single point of access to the EHN. This has been discussed between agencies for some time and is referred to as Single Point Tasking.

50. This would channel all requests via one portal, allowing for:
    a. EHN system oversight and governance;
    b. Equitable and definitive access to an available and appropriate EHN helicopter;
    c. Appropriate officer level consultation between agencies if potential concurrent tasking requests occur, prior to tasking of an EHN asset;

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d. Defined escalation policy in cases where there is tasking conflict over access to an individual asset;

e. Maintenance of the EHN for other concurrent tasks; and

f. Provision of defined tasking responsibilities and accountabilities.

51. In my opinion and based on my qualifications and experience, to enable Single Point Tasking a number of specific issues would require discussion between Government agencies to endorse and enact:

a. Targeted training and resource allocation to ensure operational capability for the unit designated to take on this pivotal role;

b. Specific policy definitions surrounding access to EHN assets and agreed response priority definitions;

c. Robust protocols and guidelines are required to support prioritisation of EHN tasks;

d. Specific policy regarding the interface between SDCC, QPS, EMQ and QEMSCC in time of disaster;

e. Delegated responsibility and accountability for making complex and difficult decisions, with an identified ultimate decision maker; and

f. Development of an organisational structure to align all EHN under a single administrative structure to ensure standardised operational governance across the entire EHN. This should include standardised KPI (specifically availability) and reporting definitions.

52. With the establishment of operational capability at the new Queensland Emergency Operations Centre at Kedron later this year and the relocation of QEMSCC to this facility, there is the opportunity for enhanced communications between SDCC, EMQ, QEMSCC and QPS for EHN operations. Liaison Officers and aviation experts could be co-located to enhance operational oversight and single point tasking of the EHN.

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(E) The considerations for appropriate prioritisation of tasks for helicopters during a disaster event.

53. The current EHN tasking arrangements do not allow for appropriate prioritisation of tasks. Essentially all requests go directly to the helicopter provider. In my opinion and based on my qualifications and experience and for the reasons outlined in paragraphs 36-38 above, prioritisation of tasks and any subsequent triage of conflicting tasks should be resolved prior to the tasking of an EHN asset.

54. Currently every tasking agency sees its requirements as important, but unfortunately operates in isolation with no visibility of the strategic picture. Each tasking agency is also not aware of the impact on other agencies if an EHN asset is tasked for a low priority or an inappropriate task (ie a task that another non EMS configured helicopter could adequately and safely perform).

55. It should be recognised that the EHN assets are a scarce, finite and expensive resource that have tailored response capabilities. These assets are a specific subset of helicopters that should have a defined role which requires even tighter triage of tasking in disaster scenarios.

56. It is acknowledged that tasks involving Search and Rescue where a winch capability is required, take priority. I refer to **Exhibit C** (my own email dated 05/02/11 and response received to that email on the same date).

57. For non time critical tasks, not requiring the unique capabilities of an EMS configured aircraft; other helicopter assets should be considered, such as ferrying of tarpaulins, food drops and the ferrying of engineers and non critical staff.

58. A single point of responsibility and accountability is required, supported by robust guidelines, to prioritise EHN tasks. The EHN should only be accessed under specific predetermined criteria. Such criteria have not been established.

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(F) The effectiveness of the tasking and coordination practices and policies of the Emergency Services Helicopter Network during the 2010/2011 flood event.

59. It is recognised that this event was unique to Queensland and that up 75-80 % of the State was affected by flooding. These specific events lasted over a prolonged period of time and placed significant pressure on all responding agencies.

60. I am unable to comment on any data relating to other tasking agencies of the EHN, but QEMSCC received an unprecedented number of requests for aeromedical assistance during this period from 26/12/10 through to the final repatriation of patients to Cairns Base Hospital on 28/02/11. The normal daily average of referrals to QEMSCC is 50.5 cases and this Statewide 24/7 background core business for sick and injured patients was maintained during the flood event. Time in Motion studies carried out at QEMSCC show that every aeromedical task clinically coordinated, on average, involves 14 clinical interactions and 23 logistic interactions, most by telephone. The two (2) busiest daily totals during this period were 114 cases on the 11/01/11 and 119 cases on the 13/01/11. I refer to **Exhibit D** (the enclosed graphs and data) which articulate the increased level of activity during these events for QEMSCC.

61. In my opinion and based on my qualifications and experience, the QEMSCC worked very effectively in maintaining strategic visibility of all pending and active aeromedical tasks during this period.

62. Such events test even the most robust of systems and there were times where extreme frustration was experienced by operational personnel attempting to perform their duties to the best of their ability during these extreme system stressors.

63. Queensland is a big State. Given the above additional activity and normal background demands on the system, this flood event demonstrated the robustness and effectiveness of Queensland's aeromedical system. Specifically, that QH and QAS work together in a transparent, integrated and responsive fashion, through the QEMSCC operational partnership, in the best interests of patient care.

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64. In my opinion and based on my knowledge and experience, these events proved the effectiveness of QEMSCC in ensuring optimal patient advocacy in supporting and providing access to best care, in close partnership with the respective transport and retrieval providers (fixed wing, rotary wing and QAS road).

65. During the vast majority of the flood event, there was significant interagency collaboration and effective working relationships. Specific instances that I recall are:

a. EHN Helicopter Airbridge and Tactical Medical Facility establishment at Gladstone Airport during the height of the Rockhampton/Emerald Region flooding. I refer to **Exhibit E** (my email dated 06/01/11 at 2106 hrs).

b. Collaborative decision with Mark Delany on 06/01/11 to deploy the EMQHR Cairns Helicopter from Gladstone to South East Queensland instead of back to Cairns. This difficult decision, in retrospect, allowed for two EMQHR helicopters to be rapidly deployed into the Grantham area on 10/01/11 by QPS.

c. Aeromedical evacuation of Goondiwindi Hospital and Nursing Home on 13/01/11. I refer to **Exhibit F** (my email dated 14/01/11 at 0019hrs).

66. Despite the challenging and extraordinary circumstances of the disaster period, no patient died and there were no reported adverse patient events as a result of QH being unable to access EHN or fixed wing assets. This is a reflection of the excellent relationship between QH and QAS that ensures a quality integrated patient transport system. Specifically, no patient died under the care of QH or QAS retrieval teams as a direct result of flood effects. All stakeholders in our aeromedical system require acknowledgement of their dedication and professionalism in achieving this outcome.

67. I have reviewed all RSQ documents, specifically relating to the flood related events on 10/01/11, 11/01/11 and 12/01/11 (a summary of which is **Exhibit G**). I have also reviewed the statements by Mr Hall, Mr Thompson, Mr Kempton and Mr Delany and I have been informed of the outcomes of a number of subsequent operational debriefs.

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68. My observations are:

a. This was an unprecedented event in Queensland with no apparent warning to allow a tailored response;

b. There were minimal communications from the affected area secondary to destroyed and damaged phone and radio infrastructure;

c. There was a lack of recognition by multiple agencies as to the gravity of the situation due to the rapidity of the flooding, minimal if any warning and the uniqueness of the event to Queensland;

d. There was terrible weather that hampered the subsequent response that lasted late into the 11/01/11;

e. EMQHR received multiple requests for assistance from multiple tasking agencies with minimal approach to CHP assets;

f. There was significant pressure placed on the pilot in command of EMQHR to triage these direct requests;

g. QEMSCC had no visibility of the unfolding events due to the reasons articulated in (c) above and was placed under extreme pressure as a direct result of a large number of requests to support QAS 000 calls and inter-facility transfers with limited aircraft availability. I refer to **Exhibit H** (a collection of emails dated 09/01/11 and 11/01/11) and **Exhibit I** (my own email dated 12/01/11 2354hrs); and

h. There was a whole of system lack of awareness of helicopter movements, positioning and alternatives. No one agency had a global view of the EHN at a time of significant system stress. There was EHN tasking confusion, multiple tasks to EMQHR and a sub optimal system response.

69. It was recognised during 11/01/11 that the tasking of EHN helicopters was problematic and Mark Delany and I made the decision then to quarantine the EMQHR helicopters at Archerfield (R500 and R510) to Search and Rescue work as tasked by QPS and the Major Incident Room (**MIR**). I refer to **Exhibit I** (my own email dated 12/1/2011 23:54hrs). This would allow some delineation of workload and responsibilities. QAS and the CHP were aware of this decision. Careflight Toowoomba and Gold Coast Helicopters and CQRESQ Helicopter were approached to relocate to Archerfield to support aeromedical operations as tasked by QEMSCC.

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I refer to **Exhibit I** (my own email dated 12/01/11 2354 hrs with reference to EMS Helicopter Operations). On the morning of 12/01/11, I confirmed this arrangement verbally face to face at SDCC and verbally with Sean Henlon at the QPS MIR.

70. In my opinion, despite outdated policy guidelines around the tasking of EHN assets, an operational solution was negotiated between QEMSCC/EMQHR/CHP/QPS/SDCC following an initial period of confusion during the first 24 hours (10 – 11 January 2011). The intent was to optimise the balance between SAR/Counter Disaster Operations and EMS.

71. This event, in isolation, illustrates the requirement for single point tasking of the EHN.

72. In my experience and with my knowledge in Queensland, confusion around tasking of the EHN as a result of tasking agencies approaching the operator directly is not limited to this single event. Through internal RSQ clinical incident review, a similar lack of EHN coordination and resulting miscommunication appears to have been demonstrated during other disaster responses. This also manifests itself occasionally during normal operations where there are conflicting tasks by AMSAR, QPS and QEMSCC. On review, such incidents could have been resolved, and an appropriate prioritisation decision made, between the relevant tasking agencies if direct consultation had occurred prior to the tasking of an EHN asset. I can provide the Commission with specific incidents as required.

(G) The matters raised in Mr Hall, Mr Thompson and Mr Kempton's evidence.

73. I can confirm I have reviewed the statements of Mr Hall, Thompson and Mr Kempton.

74. All three statements articulate frustration with the current system of tasking EHN assets and a willingness to be involved and assist in efforts to mitigate the effects of the disaster on our community.

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75. There appears to be a perception that QEMSCC has authority over tasking of CHP. This is not the case as outlined in my statement.

76. Again, the situation is described where EHN pilots and crew are placed in a situation where they are determining which task should be undertaken and becoming involved in tasking conflict.

77. In respect to the statement from Mr Kempton, he refers to a specific interaction with QEMSCC on the morning of 12/01/11. In this specific case, QPS and QEMSCC approached and tasked EMQ-HR directly, placing the pilot in the invidious position of having to choose between a Search and Rescue or critical care neonatal interfacility retrieval. This was ultimately resolved but caused significant confusion and frustration as a direct result of non standardised, circuitous communication loops.

78. It should be acknowledged that EMS aeromedical operations, worldwide, make a significant contribution to reducing death and disability in the community. EHN primary helicopter responses in support of QAS 000 calls, specifically in response to trauma and acute myocardial infarction, save many lives every year in Queensland. It must also be acknowledged that interfacility aeromedical operations, the largest cohort of aeromedical missions for both fixed wing and rotary wing, save lives, reduce morbidity and positively affect countless lives.

79. A recent QH Interfacility Aeromedical Helicopter Tasking Audit Review confirmed that EHN helicopters are being used to provide interfacility retrieval of the sickest patients and those requiring a high level of clinical care.

(H) Any other recommendations the representative wishes to make as to the effectiveness of the emergency helicopter network arising from the 2010/2011 flood events.

80. The comments and opinions expressed in this statement are not reflective of QH policy but are drawn from my professional knowledge and experience over the last 20

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years and observations made during my clinical and operational involvement in the recent tragic events.

81. These events, specifically during the 10/01/11 to 12/01/11 have highlighted existing system deficiencies in the coordination and governance of the EHN as well as disaster helicopter coordination in general.

82. QEMSCC coordinates 89.5% of engine hours attributable to EHN activity within a robust and established operational system and coordinates over 14,500 aeromedical tasks every year across fixed wing and EHN assets. Search and Rescue operations constitute 6.49% of all EHN engine hours during non disaster periods. In my opinion, it is imperative all EHN tasks are integrated under the one tasking and tracking structure at a State level and that unit that is adequately structured, empowered and resourced to perform this pivotal role.

83. Based on my professional knowledge and experience, my recommendation to the Commission of Inquiry would be to establish Single Point Tasking for the Queensland Emergency Helicopter Network via the Queensland Emergency Medical System Coordination Centre.

84. On a personal level, I was constantly amazed at the resilience, professionalism and dedication displayed on a daily basis during this prolonged disaster period. I wish to formally acknowledge and sincerely thank all personnel who worked tirelessly across the respective organisations to optimise patient care and safety and maintain an effective aeromedical network. Queenslanders should have great pride in their aeromedical retrieval system.

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Mark Stewart Elcock Justice of the Peace/Legal Practitioner

85. I would like to thank the Commission for the opportunity to present evidence.

Justices Act 1886

I acknowledge by virtue of section 110A(5)(c)(ii) of the Justices Act 1886 that:

(1) This written statement by me dated 17 May 2011 and contained in the pages numbered 1 to 20 is true to the best of my knowledge and belief; and

(2) I make this statement knowing that, if it were admitted as evidence, I may be liable to prosecution for stating in it anything that I know is false.

[redacted].....Signature

Signed at Brisbane this 17th day of May 2011

[redacted]

Mark Stewart Elcock

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Justice of the Peace/Legal Practitioner