Ditching of VH-NGA off Norfolk Island

18 November 2009

AUDIO CLIP OR SCRIPT

- Hello CareFlight International, this is Paul speaking.
- Hi Paul, this is ???? From Ausar in Canberra,
- Hey, how are you going?
- Good mate, Paul do you have a medical crew on a Pel Air jet, VH NGA, travelling from Apia to Melbourne via Norfolk,
- Yes I do, I have been trying to call them, they should be on the ground in Norfolk by now,
- Paul, we have been contacted by Auckland SAR, they have received a message from Norfolk tower,
- Yes,
- They received a message from the airplane about 20 minutes ago, they said they were running low on fuel and that they were preparing to ditch in the water off Norfolk.
- ?#%&
- Norfolk has heard nothing since, we are mounting a search but it doesn't look good,
- OK, ……I need your name again and your phone number,

Overview

1. Initial notification of incident
2. Incident response plan
3. Subsequent events
4. Completion of medivac and recovery of our team
5. Internal communication to staff
6. Media management

Overview

7. Impact on crew
8. Commercial impact
9. Internal review
10. External investigation
11. Lessons learned

What we can't discuss

1. Medical information about patient

2. Any factors responsible for crash
   - ATSB and CASA reports pending

Incident Response Plan

- CareFlight has always had an incident response plan
- Based on a helicopter incident as we assessed this to be our highest risk
- Generic enough to easily be adapted to suit this incident

Incident Response Plan

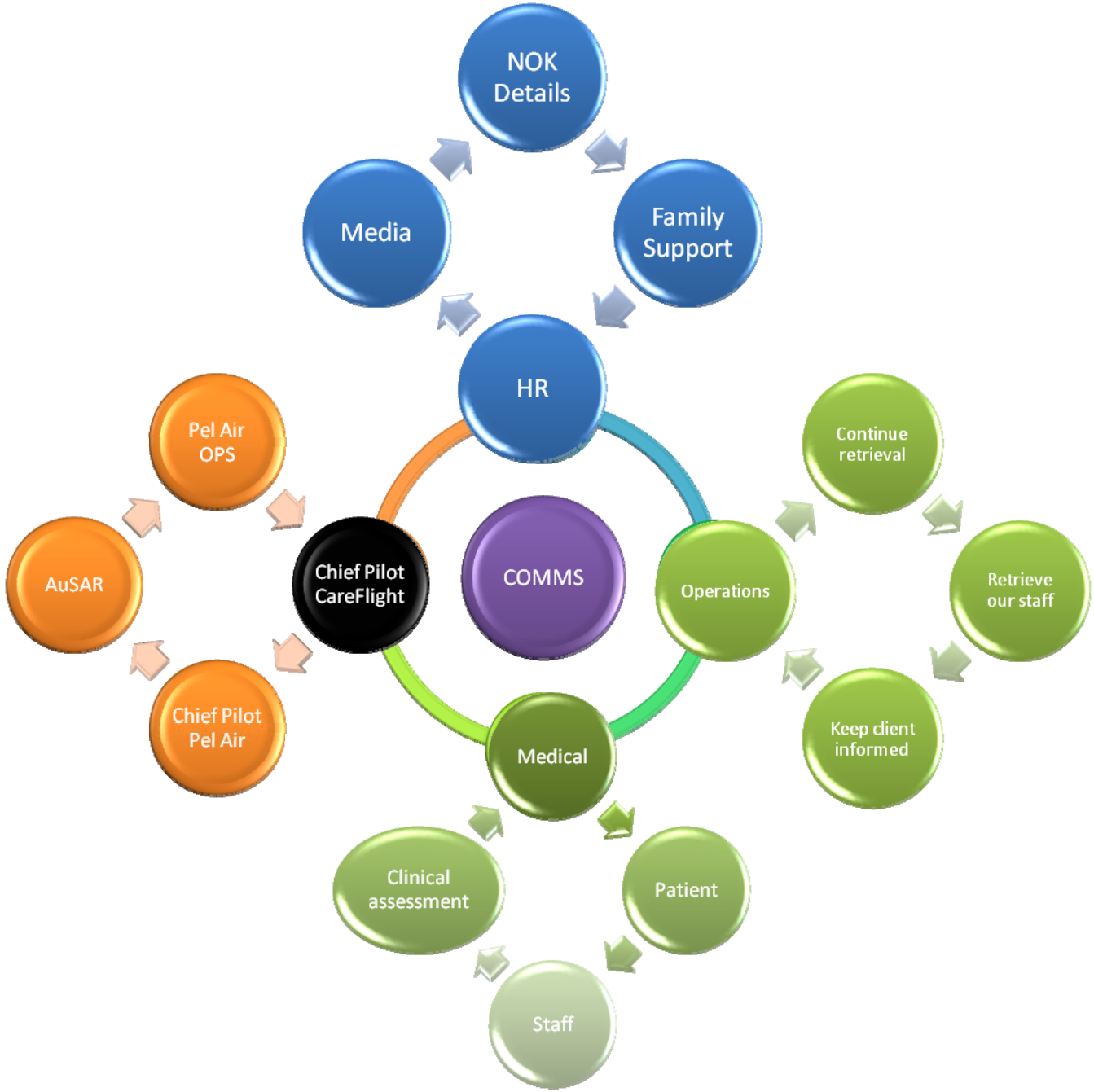
- Telephoned Incident Response Team members
  - First notification at 2210 AEST
- Meet at headquarters
- Meeting room with teleconference facilities, white boards, computers/projectors etc
- En route to HQ, CFIAA Operations Manager notified the customer of the incident.

Incident Response Team - composition

- Chief pilot
  - team leader (see later)
- CEO
- Member of Board of Directors
- CFIAA management
  - National Manager
  - Operations Manager
  - CFIAA Medical Director

Incident Response Team - composition

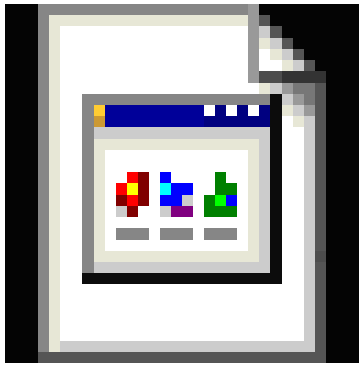
- HR manager
  - held NOK details
- CF Medical Director
- Support personnel
  - Scribe, maintained a contemporaneous log
  - Coffee!
  - Whatever was going to be required


NOK Details
Family Support
Media
HR
Pel Air OPS
AuSAR
Chief Pilot Pel Air
Chief Pilot CareFlight
COMMS
Operations
Continue retrieval
Retrieve our staff
Keep client informed
Medical
Clinical assessment
Patient
Staff

Incident Response Team - leader

- Led by our chief pilot
- Responsible for IRP and hence fully understood this
- Important that IRT leader is independent of business unit involved

Subsequent events



vh-nga_underwater.mp4

http://atsb.gov.au/publications/investigation_reports/2009/aair/ao-2009-072.aspx

Subsequent events

- Big hit (approx 200 kph), plane broke in two
- Sank very quickly
  - No time to deploy life raft despite it being identified and positioned at door prior to crash
  - Last two people to leave aircraft swam out
- Both clinical crew had done HUET
  - Attributed their survival to this
  - Surprised how quickly aircraft sank

Subsequent events

- Ditched approx 3 NM west of NI
- Rough seas, cold water, night, poor visibility due to fog
- Only 3 of 6 had lifejackets
- Huddled together and supported those without lifejackets

Subsequent events

- Norfolk Island airport authorities activated local rescue personnel
- Some uncertainty about exact location
- All 6 POB located by fishermen approx 90 minutes after ditching
  - Lucky it wasn’t winter!

Subsequent events

Subsequent events

- Within 60 minutes of IRT being assembled, we learned that all 6 had survived the ditching and had been recovered by Islanders, and were being taken to the Norfolk Island hospital.

Completion of Mission

- As soon as we knew outcome, we believed we had a responsibility to complete mission
- Good clinical information regarding the condition of those involved
  - Minor injuries, mild hypothermia, ? aspiration
- Initial uncertainty about how / when to complete mission given night and fog!
- Decision to send out another jet next morning

Completion of Mission

- Doctor & RN to assess all people and escort our team back
  - Andrea had been on leave and returned to Sydney
- Patient had decided she wished RPT to Melbourne so 2nd doctor sent as escort for this
  - Noel had been at a conference in Melbourne and got on a flight to Sydney within the hour
- Staff went well above and beyond

Completion of Mission

- 2nd jet arrived back in Sydney following evening with our team plus pilots on board

- Patient and husband together with our doctor arrived in Melbourne following evening via RPT. Fortunately her condition had not been significantly worsened by her ordeal

Internal communication

- Were aware that all our staff would hear about the incident on the morning news
- Key managers telephoned early the following morning
- Email sent to all staff explaining what had happened and that all were “well”

Internal communication

- Jeff (IRT leader) chaired a briefing session for all our Sydney staff at HQ 1000 that morning
- Telephoned managers and sent email to all staff at other bases.
- Provided updates over following days.

Media management

- Expected media interest almost immediately
- Prepared media statement and released overnight
- Subsequently a senior member of staff with extensive media experience participated in media conferences off-site

Impact on crew

- A suitably trained staff member conducted peer debriefing of doctor and RN
- Ongoing physical and psychological issues
  - PTSD
    - Crew and other staff
  - Chronic Injury Management

- RN met with patient and husband

Commercial impact

- Aircraft operator decided to suspend operations for several days
- Subsequently CASA restricted the operator to domestic operations only for a prolonged period
- We did not resume full operations with the operator until early January (6 weeks)
- Substantial financial impact

Commercial impact

- Reputational damage
  - Other retrieval services contacted customers to advise them that they had not crashed an aircraft!
- We met key customers, and kept advised of developments. They appreciated this open approach.
- When we resumed operations, quickly resumed previous level of activity.

Internal review

- Formal multidisciplinary debrief several days later
  - Contemporaneous log of events reviewed
  - Examined key decisions made
  - Asked ourselves what lessons were to be learned
  - “Where to from here?”

External investigation

- Both ATSB and CASA investigation
  - ATSB concerned with what went wrong.
  - CASA responsible for regulatory issues. How things went wrong, and were regulations followed.
- Our staff were interviewed
  - Dr / RN on board aircraft
  - Managers
  - Documentation requested
  - Cooperation with this compulsory

External investigation

- Preliminary ATSB report released 20 Jan 2010

http://atsb.gov.au/publications/investigation_reports/2009/aair/ao-2009-072.aspx

- Final report pending 10 months on!

Lessons learned

1. Have an Incident Response Plan
   - Multiple fatal HEMS crashes in USA & Australia
   - PNG crash last week
   - Ours has been updated following this incident
   - Based on Incident Command System principles
   - Must be realistic and rehearsed
   - Needs to be sufficiently generic to be adapted to the specific incident

Lessons learned

1. Have an Incident Response Plan
    - Must work 24/7
    - Position specific rather than person specific
        - Must still work when key people are on leave
    - Leader should be separate from business unit involved

Lessons learned

2. Have a current comprehensive database of NOK details
   - Locked up in filing cabinet in Human Resources is not that helpful
   - Must be kept updated
   - Needs to be accessible
   - Limited access password protected document on intranet

Lessons learned

3. Safety
   - HUET demonstrated its usefulness for FW operations. Doctor and RN attributed their survival to this.
   - EPIRBs
     - Personal issue EPIRBs / strobes were not carried by our crew at the time – but now are!
   - Crew also now carry their own life-jackets equipped with appropriate survival aids
   - Crew now carry sat phones in addition to mobile
     - This incident prompted a wider OH&S review

Lessons learned

"If you think safety is expensive,
try having an accident."

Lessons learned

4. Accreditation of aircraft operators / providers
   - We have always done this
   - Now a more in-depth review

Lessons learned

5. Education and Training
    - HUET for FW Clinical Staff if flying over water
    - Discuss possibility of event in training
    - Discuss ethical issues related to saving yourself with or without your patient
    - Familiarity with life jackets
    - Securing equipment in flight
    - Don’t become blasé about safety briefings

Lessons learned

6. Crew fitness –tread water for 90 minutes and physically fit to withstand environmental factors of exposure

7. Balancing clinical /commercial urgency against clinical crew fatigue and night/water flying