

The Concern Network shares verified information to alert medical transport programs when an accident/incident has occurred. Both air and ground programs are encouraged to participate. If you have questions, contact CONCERN Coordinator David Kearns at (800) 525 3712 or www.concern-network.org.

July 1, 2009

En route to an accepting facility, the pilot for OSF Saint Francis Medical Center Life Flight (Peoria, IL) experienced #1 hydraulic system failure. Emergency procedures on the Bell 230 emergency checklist were followed and PAIP was initiated. A successful precautionary landing was made at the Peoria International Airport, followed by ground taxi to OSF Aviation hangar at the airport. The patient was transported to accepting facility by ground ambulance. The aircraft was taken out of service and maintenance personnel notified.

Upon inspection, it was determined that the #1 hydraulic pump had failed. The pump was replaced and aircraft returned to service the next day. The weather was clear and not a factor; the service is its own vendor.

July 25, 2009

The pilot attempted to start the left engine on aircraft run-up for a medevac mission for Lifemed Alaska, LLC (Anchorage, AK). The start attempt was unsuccessful and aborted. The fireguard outside the BK117-C1 observed flames in the left engine exhaust stack and was instructed by the pilot to extinguish them. The flames were extinguished by spraying fire retardant into the left engine exhaust stack. Due to the corrosive nature of the fire retardant on internal engine components, the engine had to be replaced. The patient was removed from the aircraft and taken back into the hospital. A fixed wing aircraft was dispatched from another base and completed the flight without further incident. The weather was cloudy but not a factor. Air Methods is the vendor.

Upon engine replacement, the aircraft was returned to service.

August 7, 2009

While a Sanford Intensive Air team was en route to a referring facility to pick up a patient, the ambulance was side-swiped by a car trying to change lanes. All occupants were buckled. Upon reviewing the damage, which was minimal, the ambulance continued on to its destination to pick up the patient.

August 8, 2009

While an AIRLIFE Denver (Englewood, CO) crew was en route back to base after dropping off a crew for another call, the Ford E450 Braun Type III CCT Ambulance had stopped at an intersection when it was struck from behind by a vehicle traveling at very low speed. The impact did not activate air bags in either vehicle, it did not set off the

DriveCam, and only minor scratches were found on the vehicles. The EMT immediately notified communications center and 911 and a PAIP was activated.

The driver of the other vehicle was witnessed fleeing the scene on foot by our EMT and did not return to the scene. The passenger in the other vehicle remained in the vehicle and there was a strong smell of ETOH present. The passenger denied injury, was assessed multiple times by responding agencies, and was later arrested. There was a third party witness to the accident. The weather was clear and not a factor.

All equipment in the patient compartment was properly stowed and secured and stayed in place. The ambulance was placed back in to service with the oncoming crew. After a thorough review of the incident, it was determined that nothing on the part of the program could have prevented the incident and that all equipment was properly stowed, limiting the damage and potential injuries.

August 9, 2009

While an AirMed Inc. (Augusta, GA) crew was attempting a landing at a scene call on a two-lane road, the Agusta 109E's stinger made contact with a vehicle that was blocking traffic. The helicopter landed without further incident. The patient was transported by ground. Maintenance was notified and the aircraft was flown back to base. The weather was clear and not a factor. The company is its own vendor.

August 10, 2009

While performing a training flight, the AirCare Critical Care Transport (Winston Salem, NC) flight crew smelled smoke. The EC 135 PIC aborted the flight and returned to base. Mechanic discovered a burnt wire to the aft AC blower motor. Aircraft was placed out of service due to upper 90 degree temperatures. Aircraft stayed on ground awaiting replacement part. The weather was clear and not a factor. Air Methods is the vendor.

August 18, 2009

While an AirMed (Salt Lake City, UT) crew was on initial approach to a referring hospital helipad, the Bell 430 required more than normal force to move the cyclic fore and aft. Roll and yaw controls were normal. Hydraulic temperature and pressures were normal. Airspeed was maintained and a climb was initiated. During the climb the pilot attempted to troubleshoot the problem, and the crew looked for a forced landing area. Forced trims were

turned off. The problem persisted. After several circles the “resistance” released and controls returned to normal. The crew landed at the referring hospital without further incident. The weather was clear and not a factor. Air Methods is the vendor.

The aircraft was placed out of service and an AirMed FW aircraft was dispatched to recover the crew and patient. Maintenance was also dispatched and determined that the cyclic pitch trim actuator had malfunctioned. The forced trim system was deferred per MEL and the aircraft was returned to service.

August 21, 2009

During an AeroCare Medical Transport (Tulsa, OK) patient transport from Tulsa to Cincinnati at 27,000 feet, approximately 2-3 minutes prior to beginning a normal descent into Cincinnati, the Cessna 425 experienced a pressurization failure, causing a rapid decompression. The pilot immediately declared and requested an emergent descent and donned his oxygen mask. The patient was already receiving supplemental oxygen and saturations were and remained in the high 90s. The remaining crew and passengers experienced ear popping and were briefed about what happened and oxygen availability if required. Masks were located.

The descent to 10,000 feet was expedited and supplemental oxygen was deemed not necessary for the medical crew or patient’s mother. Aircraft landed without further incident. After landing all people on board the aircraft were polled for delayed symptoms, such as headache, and none reported any.

Maintenance determined a clamp failure in the pressurization system. It was replaced and the aircraft returned to service. The weather was clear and not a factor. Flight Concepts is the vendor.

August 21, 2009

During a reposition flight for Air Methods Kentucky (Lexington, KY), the EC135P2 PIC was entering a downwind approach to land at an airport for refuel. A bird struck the nose of the aircraft and was deflected away. The PIC continued landing procedures and appropriate shutdown procedure. A visual inspection of the aircraft was performed with no damage noted, and the mechanic was summoned to the location. The mechanic detected no damage and the aircraft was returned to service. The weather was clear and not a factor. Air Methods is the vendor.

August 26, 2009

After completing organ procurement in Pennsylvania, the Survival Flight (Ann Arbor, MI organ team was transported to the airport by ambulance, traveling with red lights and siren. After stopping at an intersection for a red light and proceeding when the traffic appeared clear, the ambulance was struck by another vehicle on the right rear side. Though no one was injured in the collision, another ambulance was called to transport the team to the airport. The weather was clear and not a factor.

Upon arrival at the University of Michigan Health System, the organ was successfully transplanted.

August 28, 2009

On a routine 100-hour inspection on one of CAL-ORE Life Flight’s (Brookings, OR) Piper Cheyenne II aircraft, a 3- to 4-inch crack was found on the nose gear trunion. The crack was discovered using a die penetrant. The trunion was removed and disassembled with all associated parts inspected and replaced as necessary. Part of the crack occurred underneath the nose gear placard, denoting the turn limits that made the crack less obvious. The weather was clear and not a factor. The company is its own vendor.

The remaining four Cheyennes in our fleet have been inspected for the same issue with no abnormalities found. An FAA Service Difficulty Report has been filed. All PA31 operators are encouraged to closely inspect this area.

August 28, 2009

While an OSF Saint Francis Medical Center Life Flight (Peoria, IL) team was in cruise flight to a sending facility in IMC, the Bell 230’s #1 hydraulic system failed. The pilot and crew complied with emergency procedures, requested clearance to Peoria International Airport (PIA), and executed instrument approach at PIA. The aircraft was placed out of service, and a spare aircraft was put into service. Maintenance personnel were notified. The weather was 600 foot ceiling and 5 miles visibility.

Upon inspection, a chaffed hydraulic was found and replaced. The aircraft was placed back in service the next day. The service is its own vendor.

September 2, 2009

During an international transport, a Lifeguard Air Ambulance (OR) team stopped in Anchorage for a fuel stop. Upon departure, a high speed abort was initiated due to rear tire failure. The Learjet 36 was brought to a complete stop on the runway, and the patient was evacuated to a local medical center. No injuries were incurred due to this incident. The weather was light rain but was not a factor.

Another Learjet was dispatched to Anchorage and the transport was successfully completed without further incident.

September 4, 2009

During cruise flight at 27,000 feet, the AirMed (Salt Lake City, UT) pilot noticed a drop in oil pressure. The caution light illuminated moments later. During the turn to the closest suitable airport (Flagstaff, AZ), the oil pressure dropped to zero and the warning light illuminated. The PC-12 landed without further incident. The patient and family member were transported to their destination by another flight team.

The engine was replaced and the plane has since been placed back into service. The weather was clear and not a factor. Air Methods is the vendor.

September 8, 2009

While a WakeMed Air Mobile (Raleigh, NC) team was in cruise flight to a receiving hospital, the EC135's #1 engine starter segment light illuminated. The #1 engine was shut down I/A/W the emergency procedure checklist, followed by a precautionary run-on landing at the Johnston Co Airport (JNX). The aircraft landed without incident, and the PAIP was initiated to make arrangements for the patient and crew. Shortly after landing, the crew was met at JNX for mutual aid, and the patient was airlifted to WakeMed. The weather was clear and not a factor. Omniflight Helicopters is the vendor.

The aircraft was taken out of service for approx 4 hours and was flown back to WakeMed after the mechanic replaced a broken terminal wire on the #1 starter.

September 11, 2009

Upon climb out of Blue Springs, Mo., going to 2,500 MSL, the LifeFlight Eagle (Kansas City, MO) crew encountered a flock of birds at approximately 2,300 MSL. The Bell 407's co-pilot chin bubble was broken out, and a precautionary landing was made without incident. The PAIP for precautionary landing and management was activated and maintenance notified accordingly. The aircraft was expected to be out of service a day while repairs were completed. The weather was clear and not a factor. Petroleum Helicopters is the vendor.

The pilot and nurse were operating under NVG. The pilot had just come off of looking under the goggles while checking gauges and back to goggles when the birds were encountered. Effective crew resource management was noted during the debrief.

September 18, 2009

While a Survival Flight (Ann Arbor, MI) team was heading north at 3000' MSL, about 15 miles from destination airport, airplane traffic was observed while using NVGs. The traffic appeared to move from left to right about 10 or more miles in front and then stopped moving. Then, it appeared to slowly get bigger but didn't appear to be a threat. The flight nurse removed her goggles and verified the traffic was, in fact, closing rapidly. An evasive maneuver was initiated to avoid a collision, passing within 500 feet from the traffic. The traffic had no transponder and a very weak radio. All B430 lighting systems were operational and in use, but the airplane traffic did not see the helicopter until passed. The weather was clear and not a factor. Air Methods is the vendor.

Use of NVGs to verify distance can sometimes be hindering. Unaided visual cues can add accuracy. Also, too much dependence on automation, like Traffic Collision Avoidance Systems (TCAS), can give the flight crew a false sense of security.

September 20, 2009

A LifeFlight – Toledo (Toledo, OH) aircraft was departing a rooftop hospital helipad after a patient transfer when the A109E pilot noticed a green laser illuminating the cockpit.

The pilot also noticed the origin of the laser. A nearby police department helicopter was notified, who was also targeted by the laser. The suspect was located and arrested. The source of the laser was a laser sight mounted on a rifle. No damage was noted on either aircraft.

September 25, 2009

On Friday, September 23, a Carolina Life Care helicopter operated by Omniflight Helicopters, Inc., departed the Charleston, SC, airport for its base in Conway, SC, in night time conditions. The AS 350 B2 was immediately reported missing when failing to respond to a scheduled position check. An ensuing search located the aircraft approximately 63 miles southwest of Conway in Georgetown County. Pilot Patrick Walters, Flight Nurse Diana Conner, and Flight Paramedic Randolph Claxton Dove had been killed.

Omniflight is deeply saddened by the tragic loss of its crewmembers and wishes to express its deepest regrets and sincerest condolences to the families and friends of those who lost their lives.

September 26, 2009

While a Critical Care Transport (Birmingham, AL) team was returning to base after the patient had been dropped off, the Ford E456 - Excellence ambulance went on a narrow, soft shoulder of the interstate. Knowing the potential of flipping from overcorrection, the driver went into the median. It was dark, the road was wet, and the median had a deep ditch. This caused the unit to rock severely from side to side many times before coming to a stop after approximately 100 yards. Significant damage was done to the underside/chassis of the ambulance, and the roof of the cab had a long indentation. One team member was riding up front with the driver but had just closed her eyes. Exact travel speed has not yet been pulled off Road Safety System but is estimated high 60s.