COASTGUARD

THE CHARITY SAVING LIVES AT SEA

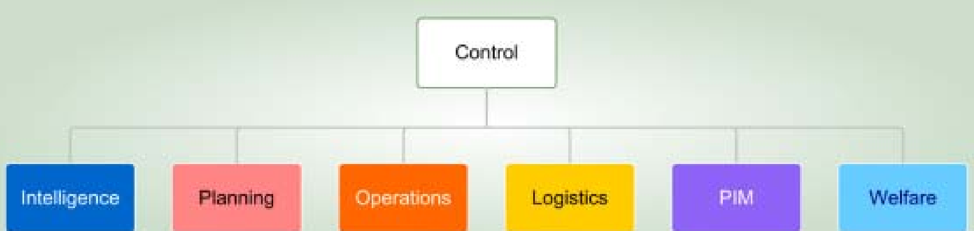
New Zealand POLICE
Nga Pirihimana O Aotearoa

Rescue
COORDINATION CENTRE
MARITIME
NEW ZEALAND

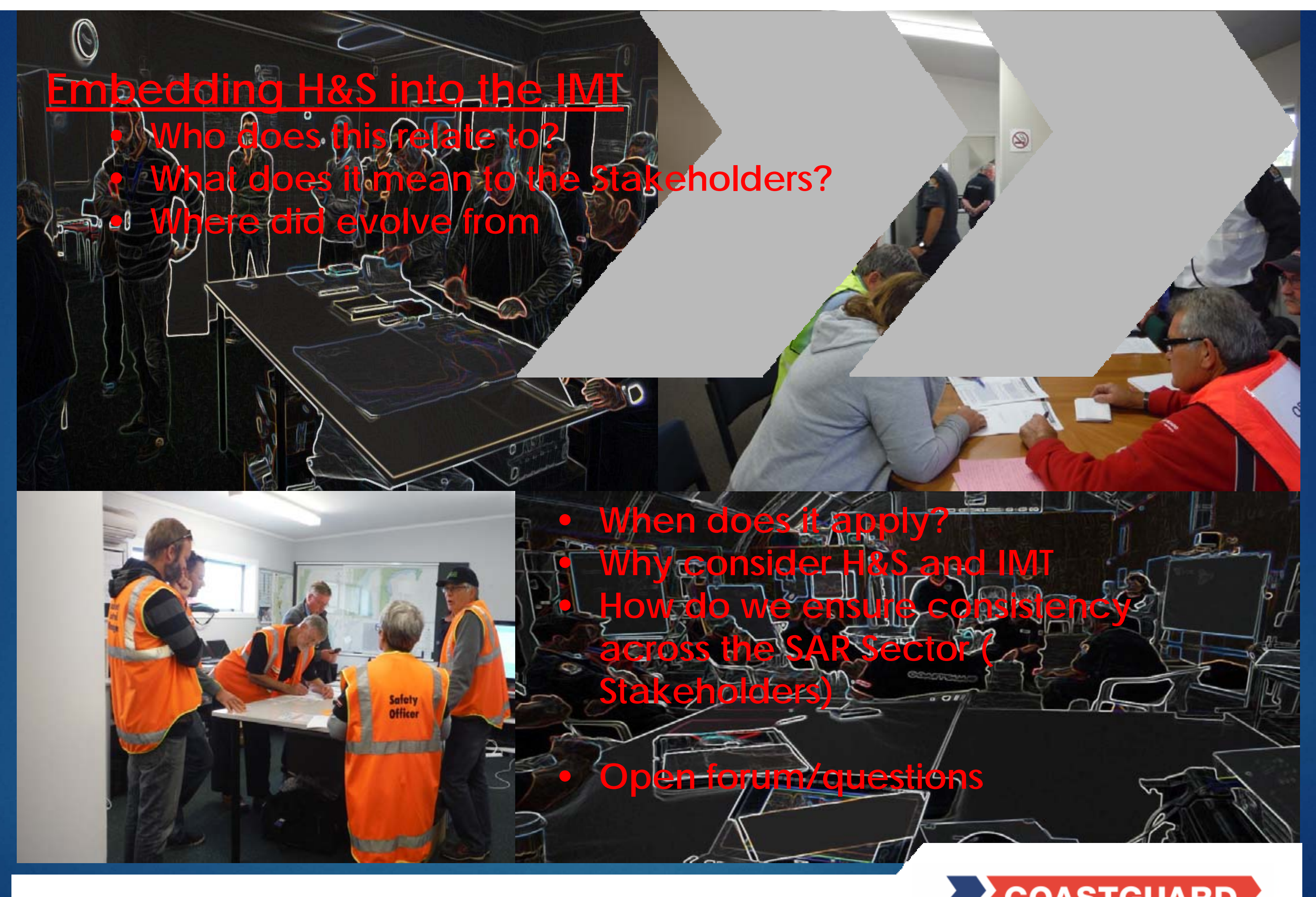
SURF LIFE SAVING
NEW ZEALAND

BOATIE'S BEST MATE.

Incident Management Team (IMT)



BOATIE'S BEST MATE.


Embedding H&S into the IMT
• Who does this relate to?
• What does it mean to the Stakeholders?
• Where did evolve from
Safety Officer
• When does it apply?
• Why consider H&S and IMT
• How do we ensure consistency across the SAR Sector (Stakeholders)
• Open forum/questions

IGROW MODEL
ISSUE
• Confidence that H&S is Embedded into IMT?
Success =
Goal
• Consistent Approach
• H&S into the IMT
• SMART Goals
Reality
• Current situation (What happens now)
Opportunities
• What can we all do to move towards achieving our Goal
Wrap up
• What is our action plan moving forward
Nō te rere moana Aotearoa
MARITIME
NEW ZEALAND
SEARCH & RESCUE
LAND SAR
NEW ZEALAND
NZSAR
New Zealand Search and Rescue
Need to Report Someone Lost or Missing? Call 111 Ask for Police
Rescue
COORDINATION CENTRE
MARITIME
SURF LIFE SAVING
POLICE
THE CHARITY SAVING LIVES AT SEA
Find us online: coastguard.co.nz
COASTGUARD
NEW ZEALAND

S#!t That Was Close (Near Misses?)

Capturing the Near Miss (STWC)

- ***Why? How? When? What?***
- ***What are the road blocks?***
- ***How do we remove them?***

BOATIE'S BEST MATE.

landsar.org.nz

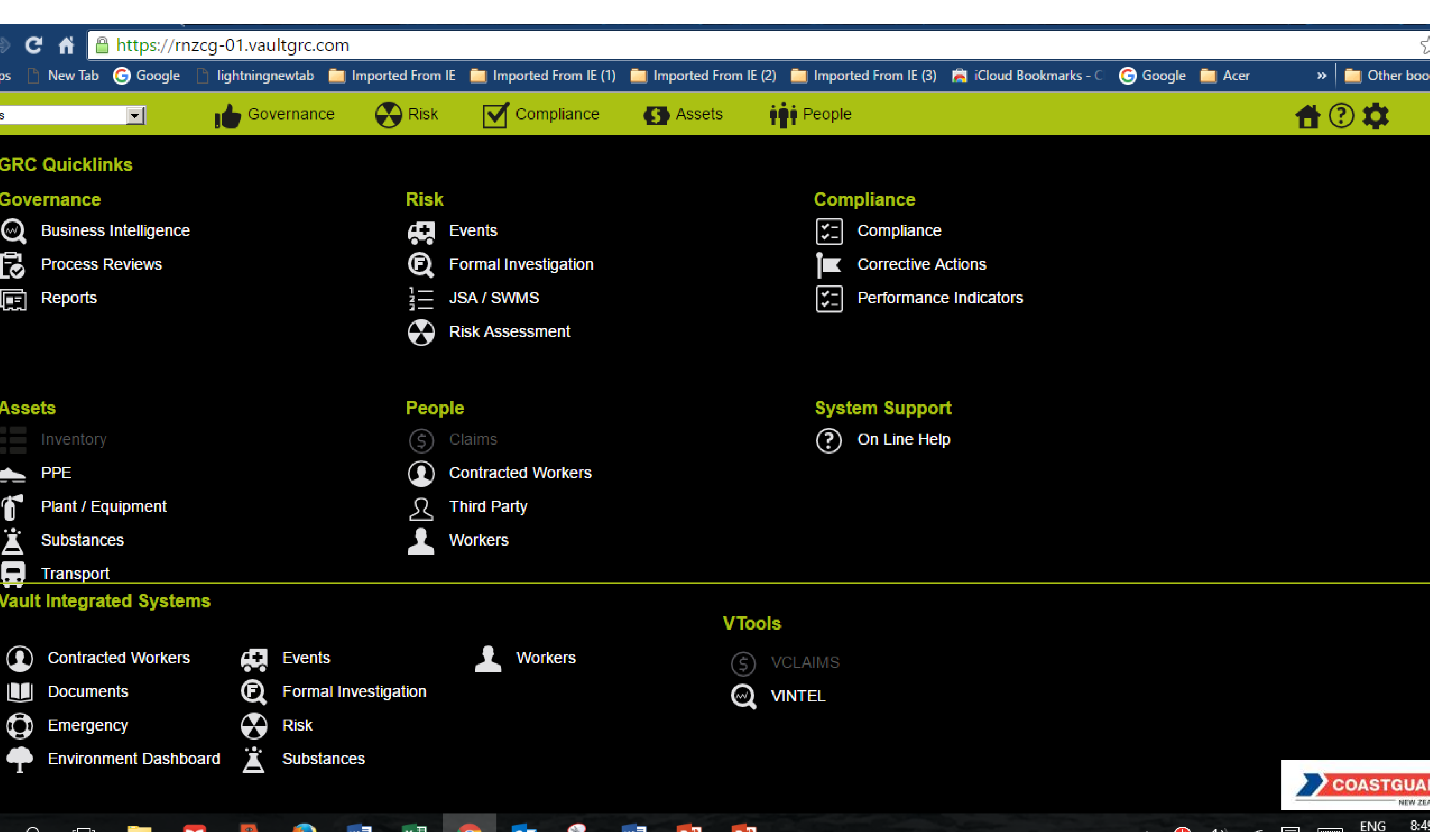
Safety Advisory - Rockfall Hazard and Safe Use of Stretchers

On the 5th March an incident occurred during a SAR training exercise when, during a vertical stretcher raise, a fist-sized rock was dislodged by the rope system and struck the 'face guard' over the face of the patient in the stretcher. The face guard clearly prevented possible serious injury to the patient.

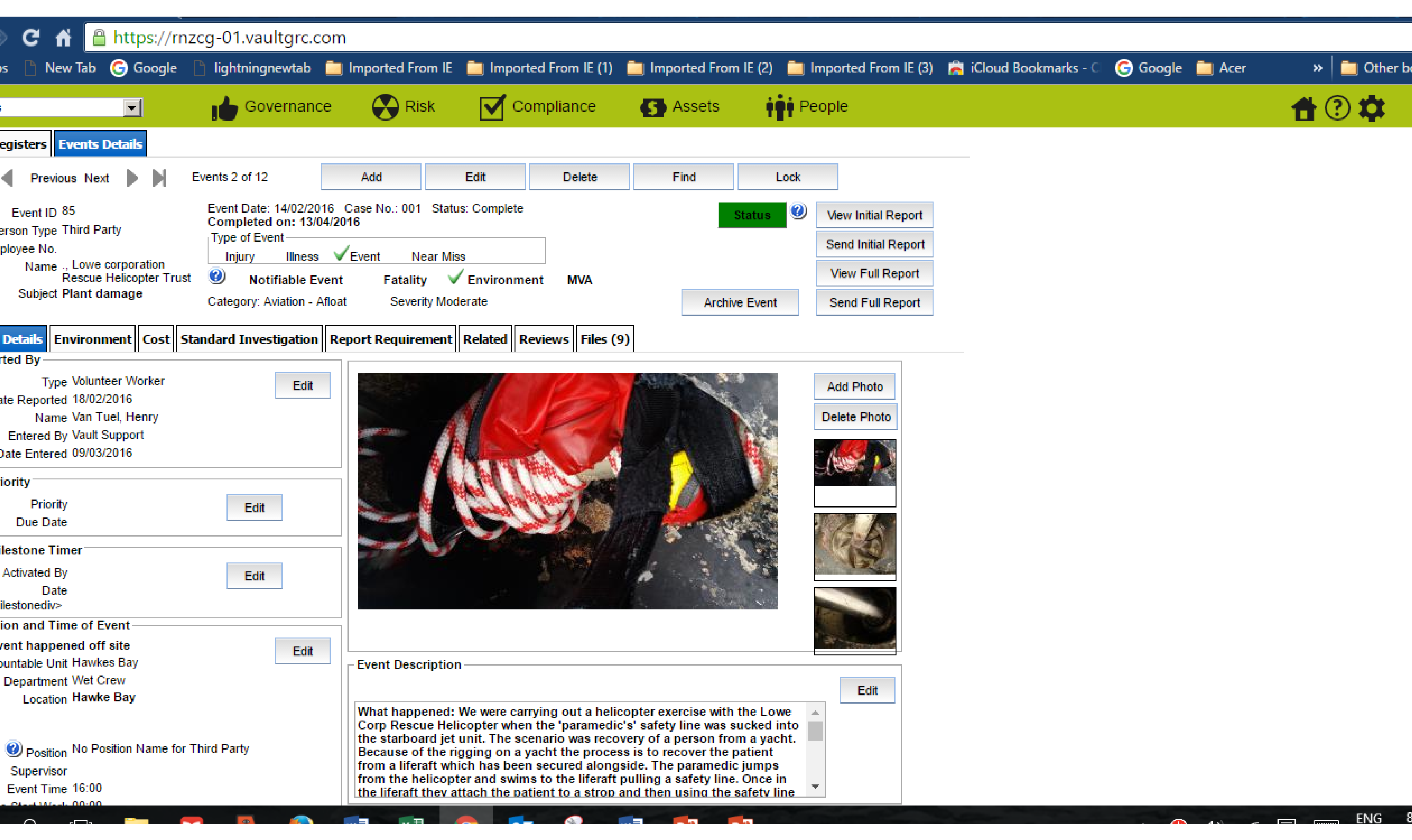
I have asked the Backcountry Technical Rescue Advisory Group to advise me on follow up actions relating to this incident, and they have come up with the following statements/guidelines to be to be implemented as good practice:

- For effective risk management, all LandSAR groups should report near miss incidents as well as moderate and serious harm accidents. LandSAR will share all lessons learnt from those incidents.
- Training: When carrying out a high angle rescue, a sufficient risk assessment of the slope needs to be made. It would be appropriate to use this assessment as part of a briefing, pre-plan, standard operating procedure or safety plan.
- Operations: It is acknowledged that it is often not practical to do a formal site assessment prior, as often the site is unknown until arrival. In such situations, a verbal discussion should take place to assess/discuss the hazards and measures put in place to mitigate the hazards. In these situations, it's crucial to have an experienced and competent Team Leader who can make these decisions through a robust scene assessment.
- When available and/or appropriate, a shield, guard or protection should be used with a stretcher in a situation where a patient may be in danger from dislodged objects. It is acknowledged that when dealing with a critically ill patient, face protection can limit the way an attendant can administer treatment.

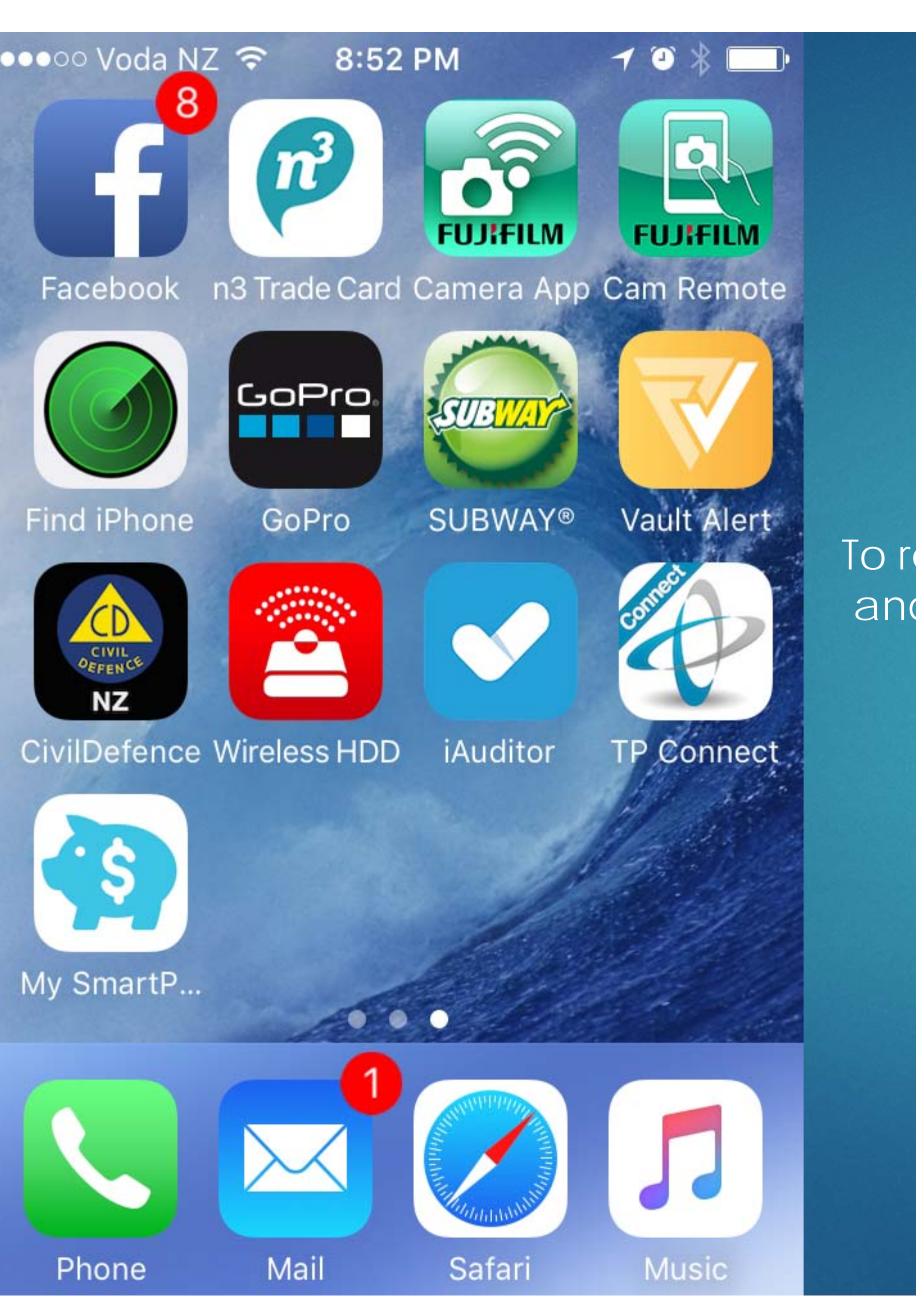
Incident Reporting
A learning and improvement opportunity



https://rnzcg-01.vaultgrc.com
New Tab
Google
lightningnewtab
Imported From IE
Imported From IE (1)
Imported From IE (2)
Imported From IE (3)
iCloud Bookmarks - C
Google
Acer
Governance
Risk
Compliance
Assets
People
GRC Quicklinks
Governance
Business Intelligence
Process Reviews
Reports
Risk
Events
Formal Investigation
JSA / SWMS
Risk Assessment
Compliance
Compliance
Corrective Actions
Performance Indicators
Assets
Inventory
PPE
Plant / Equipment
Substances
Transport
People
Claims
Contracted Workers
Third Party
Workers
System Support
On Line Help
Vault Integrated Systems
Contracted Workers
Documents
Emergency
Environment Dashboard
Events
Formal Investigation
Risk
Substances
Workers
VTools
VCLAIMS
VINTEL
ENG



https://rnzcg-01.vaultgrc.com
New Tab
Google
lightningnewtab
Imported From IE
Imported From IE (1)
Imported From IE (2)
Imported From IE (3)
iCloud Bookmarks
Google
Acer
Other book
Governance
Risk
Compliance
Assets
People
Registers
Events Details
Previous
Next
Events 2 of 12
Add
Edit
Delete
Find
Lock
Event ID 85
Person Type Third Party
Employee No.
Name ., Lowe corporation Rescue Helicopter Trust
Subject Plant damage
Event Date: 14/02/2016 Case No.: 001 Status: Complete
Completed on: 13/04/2016
Type of Event
Injury
Illness
Event
Near Miss
Notifiable Event
Fatality
Environment
MVA
Category: Aviation - Afloat
Severity Moderate
Status
View Initial Report
Send Initial Report
View Full Report
Archive Event
Send Full Report
Details
Environment
Cost
Standard Investigation
Report Requirement
Related
Reviews
Files (9)
Reported By
Type Volunteer Worker
Date Reported 18/02/2016
Name Van Tuel, Henry
Entered By Vault Support
Date Entered 09/03/2016
Edit
Priority
Priority
Due Date
Edit
Milestone Timer
Activated By
Date
Edit
Location and Time of Event
Event happened off site
Accountable Unit Hawkes Bay
Department Wet Crew
Location Hawke Bay
Edit
Position No Position Name for Third Party
Supervisor
Event Time 16:00
Add Photo
Delete Photo
Event Description
Edit
What happened: We were carrying out a helicopter exercise with the Lowe Corp Rescue Helicopter when the 'paramedic's' safety line was sucked into the starboard jet unit. The scenario was recovery of a person from a yacht. Because of the rigging on a yacht the process is to recover the patient from a liferaft which has been secured alongside. The paramedic jumps from the helicopter and swims to the liferaft pulling a safety line. Once in the liferaft they attach the patient to a strop and then using the safety line
ENG
8:50



To reduce reporting times and barriers

Vault Alert

Injury

Incident

Near Miss

Hazard

Actions

IGROW MODEL
ISSUE
• Not Confident that Near Misses are being reported
Success =
Goal
• Confidence Near Misses are being Capture
• SMART Goals
Reality
• Current situation (What happens now)
Opportunities
• What can we all do to move towards achieving our Goal
Wrap up
• What is our action plan moving forward
MARITIME NEW ZEALAND
SEARCH & RESCUE LANDSAR NEW ZEALAND
NZSAR New Zealand Search and Rescue
Need to Report Someone Lost or Missing? Call 111 Ask for Police
Rescue Coordination Centre
SURF LIFE SAVING NEW ZEALAND
THE CHARITY SAVING LIVES AT SEA
POLICE
Find us online: coastguard.co.nz
COASTGUARD NEW ZEALAND

BOATIE'S BEST MATE.

Embedding H&S into the IMT

Presentation by Stuart Lowth, Coastguard

Who does this relate to?

To all stakeholders:
- IMT
- All agencies and functions
- Responders, rescuers, rescuee, general public

Everyone involved
Small initial response – when escalating, dedicate resource to H&S

What does it mean to the stakeholders?

Confidence – investment – reassurance
Responsibility to interact and communicate
IMT has the ability to make changes to minimise risk
Rescue – that it is done safely
Rescuers – not exposed to unforeseen risk; can say "no"
To keep people safe – get home safe and well (**S**AFE **H**OME **E**VERY **D**AY - **SHED**)

Where did it evolve from?

Past events / mistakes / learnings
Change in culture – everyone as an individual has a responsibility and as a collective
Growing number of multi-agency SAR activities
Introduction of new Act, better understanding
IMT – reflex to formal IMT
Best practice

When does it apply?

Always
From first notification, driving to IMT
Consider H&S of responders right from the initial call, getting to operation and home again
Isn't just field staff – consider IMT as well

Why consider H&S and IMT?

Asking members to respond – what state are they already in?
IMT are creating the plan – H&S must be part of the plan
Moral and legal obligation
If IMT are not implementing H&S the field teams are unlikely to

How to get consistency?

Simplification
NZSAR to invest in IT
IMT exercises; multi-agency exercises
Use tools that exist and have H&S embedded
CIMS structure
Debrief and share lessons observed
Joint training
Seminars

Development of common set of principles
Consider audit regime
Direction from above (NZSAR, Police)

Capturing the near miss

How are we doing? What is the organisation's culture for reporting near misses? Reporting the near miss provides an opportunity for learning.

Why?

- Measure / record
- Learning opportunity – prevent it happening again – continuous learning
- Prevention – system maintenance – reduces risk
- "We want to" culture
- To avoid it being an actual incident next time
- Keep people informed

How?

- Document / review / mitigate
- Verbal / written / Apps
- Reporting imbedded into process
- No blame environment – culture where it is okay to put your hand up / learning culture

When?

- Any incident that we could find learnings from
- Anything that has potential for H&S
- Immediately

What are the Roadblocks?

- Culture – fear of repercussions or retribution, don't care
- Complexity of reporting
- Misunderstanding
- Deemed as a negative (rather than positive)
- Poor performance issue / embarrassment

How to remove the roadblocks?

- Embed into culture – this is what we do
- Education
- Simple reporting system
- Blame free
- Need a positive culture

Near Miss - Examples of incidents:

Vertical face rescue training incident

The ‘near miss”:

Mike spoke of an incident which occurred during a training event being carried out on a vertical face. A loose rope caught and dislodged a rock from a crag and the rock landed smashing into the face shield of the person on the stretcher. It was reported immediately which initiated a review.

The learning:

Recommendations were sought from a specialist group and these were sent to the CEO. The safety officer checked with all teams who were doing vertical face rescues and found three out of 17 teams did not have facial masks. Some said they would use them if there was a risk.

The outcome:

Decision was made to update the procedures stating facial masks must be used. Those teams that did not have them were provided with them. If there had been a person on the stretcher the person would have ended up with no face.

IRB incident

The incident:

The incident: Allan gave an example where an inexperienced person was in an IRB with one foot in the foot strap. One strap is actually to help removal of the floor board. The IRB tipped and the person broke their tibia and fibula.

The learning:

In training all agreed not to use the foot strap. A practical solution was investigated and decision made that the strap be removed as it was not needed. Other clubs had not had exposure to this and a memo was circulated to clubs suggesting they remove that strap. It is not often the ones that have had the accident it is the ones that have not experienced the accident that were against the change.

The outcome:

The issue was raised with the boat manufacturer and the boats are now made without the strap. If we had removed it at the beginning there would not have been a problem.

Helicopter rescue incident

The incident:

There was a near miss at Hawkes Bay involving a helicopter during a training exercise. People were recovered from a life raft tied to the Coastguard Rescue Vessel (CRV). The life raft was only secured to the CRV with one rope and best practice suggests two ropes should be used to hold the raft in a secure position.

As best practice, the access door to the raft is placed directly outboard of the CRV hull to ensure maximum clearance.

The rescue helicopter have recently incorporated a combi-line when deploying rescue swimmers, to enable the swimmer to be recovered if the winch fails. The rescue swimmer is responsible for the control of the combi-line along with the helicopter crew.
The rescue swimmer did two successful lifts, but then the life raft turned, placing the life raft access door in line with the hull and very close to the CRV jet unit.
On the third recovery with the raft door now incorrectly in position the combi-line was free to engage with the CRV jet unit. Quick thinking by the CRV crew moved the jet unit in question to idle and the line was cut free. No injuries were incurred, and an investigation is ongoing.

Vault

Coastguard are moving to Vault as a system for capturing health and safety related issues, including the near miss and have Vault alert on their phones. Only management currently have the system but will be drilling down to other staff. The app was demonstrated. It is one way of increasing the reporting within Coastguard. It is possible to take ground shots. The H&S manager receives an alert on his phone as soon as someone has completed all the mission checks, it also goes through to another person's phone. Staff can then decide who it should go to. Cost is based on the number of people who use it. It is an app that Boeing, Air NZ and other organisations use. Vault is reasonably simple, reasonably intuitive and NZ based. There is a PC version also. It is in infancy stage at Coastguard for their SMS use..