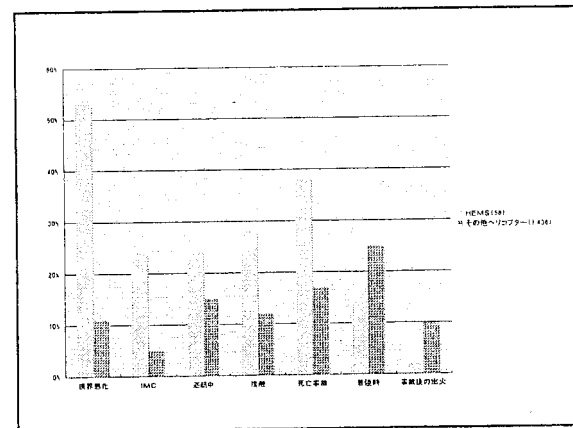
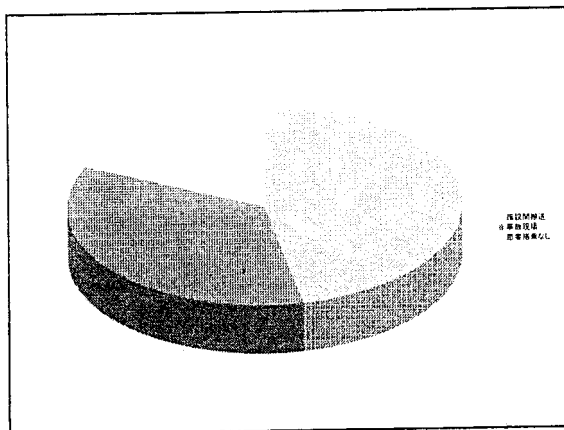
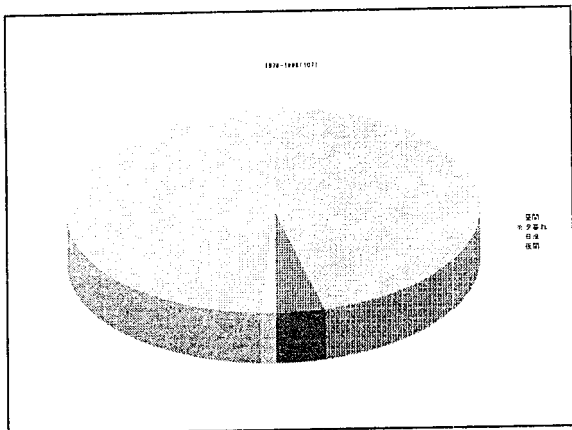
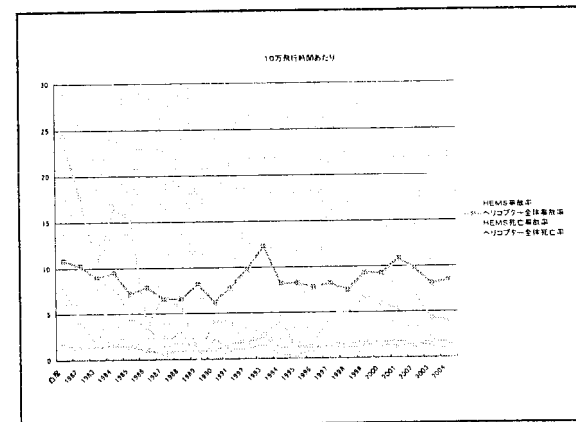
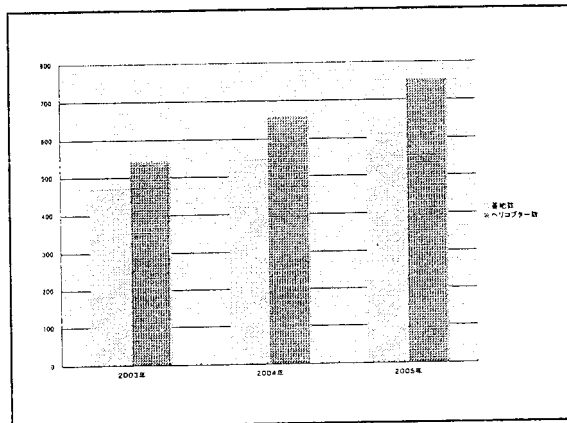
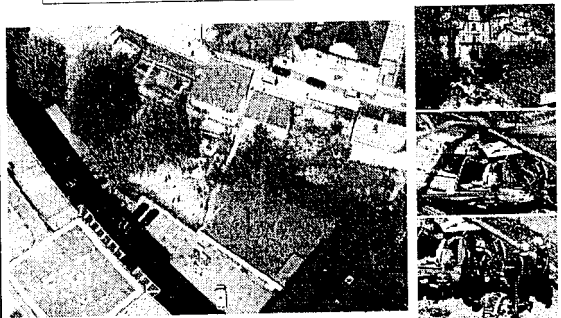


2006年5月1日事故発生
クリストロフ6(オーストリア)



AIR MEDICAL ACCIDENT ANALYSIS: CONSOLIDATED PROBLEM STATEMENTS

Pilot Performance Issues: <ul style="list-style-type: none"> • Lack of instrument scanner • Poor situational factors rating • Limited awareness of work load • High work rate associated w/ symptoms: loss of focus • Pilot disrupted cockpit posture • Inadequate cockpit planning • Pilot did not observe weather briefing • Time spent on briefings • Pilot not wearing helmet • Pilot received 27th flight on "D" condition • Pilot descending to avoid DME • Pilot took no manual rate turn • Pilot did not produce post-departure briefing • Incomplete response to full RPT emergency • Inadequate No. from RPTA visual • Pilot did not recognize and avoid power setting • Incomplete pitch response • Pilot bank left with nose in climb • Inadequate pitch rate entered as symptoms in power • Pilot in bank for too long • Pilot banked to bank on RPTA ground VFR clearance • Pilot's attention is directed to work of cockpit 	Aircraft Issues: <ul style="list-style-type: none"> • Aircraft was RW extended • No warning or alert given • Low maintenance of engine component • Fuel unable to decrease altitude above LL • Fuel unable to shut off • Fuel unable to shut down • Fuel/ignition issue fuel quantity issue • Airframe structure requires fix pending fix resolution • Low maintenance fuel tank Infra-structure Issues: <ul style="list-style-type: none"> • ATC unclear regarding pilot's request • Knowledge error in ATC w/ engine function • Pilot unable to receive ATIS (Extended Tower and Information Service) information • Airport uncontrolled • Airport computer reporting briefing no copy • No ground • No ground uncontrolled by clearance • Pilot/ATIS did not meet briefing criteria • Clearance not obtained on departure or arrival Language Barrier Issues: <ul style="list-style-type: none"> • Difficult identifying briefing error • No briefing was reported • Incomplete/incorrect altitude information on LL • Confused briefing error • Unreadable numbers Company/Management Issues: <ul style="list-style-type: none"> • Company pressure to complete the mission • Limited capacity to complete the mission • "Wash Annual" (ump) manual equipment review • Flightlog preparation needed
---	--

Figure 1-10. Consolidated Problem Statements
Adapted from the Medical Accident Analysis, 2011

事故要因 (NTSB1988)

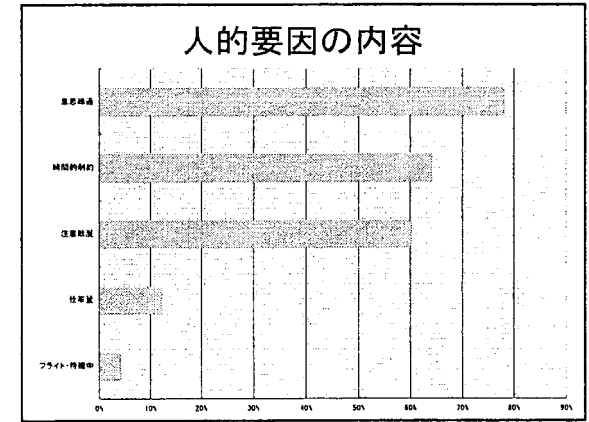
人的要因 68%

天候要因 30%

(死亡率) (61%)

機械的トラブル 25%

接触 20%



- 1988年のNTSBの勧告
- プログラムごとのマニュアルの整備 (年次更新)
 - 安全責任者などの役割の明確化
 - フライトクルー訓練の実施
 - 個人安全装備
 - 勤務体制の基準設定 (週48時間以内)
 - 第三者機関の評価システム

- 小児・周産期医療の崩壊と対策
- 世界的な流れ (歴史)
 - 米国・ヨーロッパ・オーストラリアなど
 - 日本
 - 狭い地域内での医療システム
 - 広域搬送システムの欠如
 - 欧米
 - 広域医療ネットワークの整備 (人口300~1000万人対象)
 - 24時間搬送システムの整備

- 今後の課題
- 安全性の確保と24時間体制の両立
 - 運航クルーの確保
 - 負荷のない勤務体制
 - 運航支援システムの確立
 - ヘリコプターIFR運航
 - GPS誘導システムの確立
 - 財政的な基盤の確立