SURVIVAL FACTORS ATTACHMENT 3

NTSB Interviews

Palm Springs, CA

HWY17MH005

(5 pages)

INTERVIEWS

1. Desert Regional Medical Center Emergency Department Staff

Members of the DRMC ED staff and administrators were interviewed at DRMC on October 26, 2016. They were asked about the hospital response to the event. They noted that the hospital had a place for the families to gather, which may have been a reason the Riverside County EOC was not needed. Families started arriving about 10:30 or 11 in the morning. They noted that the victims and family assistance contact phone number announced by Riverside was for the Coroner's office, which was not well facilitated to handle incoming family calls. Family members were also sent directly to the Coroner's office which was not well facilitated to receive the family members. They noted that there were 2 fatal crashes prior to this crash, but they did not invoke a burden on staff. Because the shift change was about to occur, they held over the night shift to about 9am, and called some of the upcoming staff early.

2. Palm Springs Fire Department

Members of the PSFD were interviewed at Fire Station 2 at 300 El Cielso Rd. in Palm Springs on October 28, 2016. Two of the participants joined via conference call, as noted. Interviewed were:

Chief Jason Loya, Bat. Chief and IC, 4430
Captain Jeff Van Lierop, Truck 442
Captain Greg Lyle, initial IC, Engine 443 (via telephone)
Captain Todd Fite, triage unit leader, Engine 441 (via telephone)

Captain Lyle said that the call came in through dispatch and was copied at the base station. Engine 3 and Engine 1 were the first units to be dispatched. Based on what he heard, he decided to request a 1st Alarm call, knowing that the event might not warrant this level of response, but not wanting to take any chances. As he went enroute, he realized that he had still not heard that it had been elevated to 1st alarm. Then enroute he heard that it had been elevated. When they approaching I-10, they could see that there was no traffic moving at all in the westbound lanes, and realized it was going to be a big event. They approached from the east, and they were able to move westbound around traffic to the site of the crash via the center median. When they arrived they saw only 1 CHP unit onscene. The visual situation was overwhelming. He assumed initial IC, and assigned a FF to get an estimate of the number of injured. He did not recall the number he initially reported, possibly just said "multiple", and immediately declared an MCI. He then assigned Captain Hayes to be Medic Communications. This assignment remains with this person throughout the event. Next they needed access to the bus. They used roof ladders to access the windows. At this point he recalled that there were maybe 2 windows broken out by bystanders. He believed there were approximately 8 people already outside the bus. He assigned a FF to open the windows and noted that it was difficult to break the windows and their needs to be a better way. He was asked about the emergency egress function and noted that they tried this, but that the windows kept swinging shut and that it was too frustrating to work with them like this. He noted that they also needed the windows to remain open for ventilation. He said that he was

the initial IC for about 10 minutes before transferring it to the arriving chief. As IC, he also directed ambulance parking, asked for additional resources. After transferring command, he went inside the bus to help with extrication. He estimated there were still approximately 20 people in the bus. Some of these were walking wounded, that needed assistance to evacuate. Space was a problem, given that the trailer had intruded large portion of the bus, as well as luggage and people. A large person was on the bus that needed significant help to evacuate, and it was very difficult to get some people out the windows and down the ladders. Even for the walking wounded, they felt they needed a better method of evacuation other than lifting people up to the window level. They decided to cut a larger access hole in the sidewall of the bus. They first tried general purpose saws, and this required repositioning trucks for electrical cord access, but these could not get through the frame. They also tried the pinchers and the Hurst tool, but these also did not work. They decided to use gas powered rotary cutters, despite concerns and issues with the sparks and smoke from the engines. They felt that markings of the structural areas of the bus, similar to aircraft that direct rescue operators, would be a good thing to have. Once they had the "doors" cut, they extended down to the floor level of the motorcoach and this greatly assisted evacuation. They estimated that at least 7 patients used the cut out doors. These doors were used for all of the deceased. There was no room to manipulate back boards in the bus, so patients were handed out the sides onto backboards that were held outside the bus. He noted that FF fatigue was an issue, and that they were working to extricate patients for more than 2 hours. He expressed extreme difficulty in removing seats due to tool access and difficulty in cutting the attachments. He described that they first used the standard Hurst tools, but that these were not able to effectively cut the legs of the seats. Fortunately the department had recently upgraded to a heavy duty JL500 tool, which was able to do the job. He described concerns about the extrication, as they worked on removing debris and patients from the "wall" piled up in the bus. There were concerns of injuring someone, determining the location and differentiating the location of people and their extremities, and of shifting mass and structural concerns. They considered pulling the vehicles apart in order to better access patients, and fitted a sling around the trailer for structural support in case it collapsed but decided the risk for patients was too great. They also looked at the axles of the trailer, that they were resting on the bus, as well as other aspects of the vehicles and realized that the trailer would not roll or separate cleanly. He described the decision to transport less immediate patients while more immediate patients were still being extricated. They were aware that protocol was to wait, but they saw how long it was taking to extricate each patient, and that they had good resources available. He felt that the helicopter that was hovering should have landed in case they needed it, but recognized that is had come fairly late in the process.

Todd went enroute from station 1 and had heard the request for a full response. He said they got out quick because the crew was already awake. He also described seeing the highway traffic on the approach, and that it would be a big event. They pulled up behind the other engine. They helped get people down the ladders. Most of the patients were taken out of the passenger side. They worked out a system that removed seats and debris out the driver side and passengers went the opposite direction. Asked to recount the number of evacuations according to the method, they estimated about 20 outside before they got there, about 8 or 9 by climbing down ladders, and about 10 extricated and lifted out on backboards. He noted that there was 1 victim ejected. As he approached the scene, the CHP officer noted that there was a victim outside the bus, laying near the driver side front wheel. He checked and saw that this victim was not viable, so turned his

attention to viable patients. He was not sure but thought that this ejected victim may be the driver. At one point they tried cutting the seat sidewall attachments by cutting through the sidewall on the outside. He noted that when they were first discussing the option to separate the vehicles there were still 2 viable victims on the bus, and decided to wait. As noted, they did use a heave wrecker to wrap and support the trailer. He described the triage area that was set up on the north side, this assignment was given to Cal Fire Engine 37. Their first job was to check on the ejected fatality, and then set up the triage. He noted that one of the first arriving FF saw a man who he thought was the bus driver, but it turned out to be the truck driver. He asked this man how many passengers were on the bus, and the man said he did not know. Since he didn't realize this was the truck driver, he told the man to give him a number, and he recalled that the man said something around 22 (logs will indicate), and that this was how the original number was provided to dispatch.

Chief Loya got onscene and immediately transferred IC by verbal, but it was not announced to dispatch for sometime after. They had established the 1st alarm, and so he know all their equipment on enroute plus 2 from Cal Fire, and he requested an additional 2 units for backfill plus other support. He also requested a logistics support team to set up at station 1. When he checked on EMS, he was told that AMR were short, so he requested support from Cathedral City. He set up the MCI positions including a treatment leader, triage leader, transport leader. At this point there were 4 AMR ALS on scene. He had set up unit 8111 as the lead, and confirmed that the AMR supervisor was enroute (Mike English). He described communications and noted that face to face was key. He describe the call routing and more about the MCI command, and that Bat. Chief 10A was rescue group supervisor, below him is extrication leader, which was Captain Clardy, 444 who was on unit E443R. the first 4 is the county designator, the second 4 is the city, the 3 is the station, and the R is rescue. He described the air support process. He requested air EMS, and this request initially goes to H60 CHP or Star 90 Riverside Sheriff. But he said both were not available. He described how these were the go to groups because they only do EMS, and that the process is more complex and difficult with Perris, which has both mountain rescue and medic air capability. He retried them and still found crews unavailable, so then requested air support from Perris. He estimated the excessive ETA, but noted that the logs will have accurate values. Perris dispatch heard the communications about extricating the patients and indicated that they would not dispatch until there was a patient ready. He noted that the extrication was in process and a patient would be available, but they denied support until a patient could be identified and was staged. The identified a patient and got the Mercy Air 5 enroute. He noted that about 2 hours into the accident the helicopter had arrived in the air above the scene, but that there was some communication issue with the landing zone coordinator. He said he is working on establishing details. The helicopter never landed and was then cancelled. He described the Perris County Command and provided contact information for checking on various aspects of the response.

The group discussed the response and Jeff affirmed the account by the others. They noted that the first access cuts were on the passenger side just in front of the rear tires, and that the little access hole on the driver side at the "DA" was the attempt to cut seats from the outside. They described that this was done because a patients feet were trapped under this seat. They described taking about 4 additional viable victims out from the area in front of the cut out, and that there was a female victim rolled up in a ball in the middle of aisle at around row 3. They noted that by

8am, all were transported. They noted that Walter Hays (PSFD) was the medic communication and made contact with DRMC. They noted that DRMC initial wanted to send some patient to outlaying hospitals with concerns that they could be overwhelmed with injured, but they noted that these outlaying trauma centers are quite far away and cause issues for needing the EMS resources. It turned out that there were less immediate patients than anticipated.

They noted that the 5 captains that worked this crash are all highly trained extrication/rescue experts. They described the training and that they work with Cal Fire on this. They have annual MCI training and a triannual full drill at the airport, and that they have gone county wide with their emergency preparedness plans.