



Australian Government

Australian Transport Safety Bureau

ATSB TRANSPORT SAFETY INVESTIGATION REPORT

Aviation Occurrence Investigation – AO-2007-022

Final

**Crew incapacitation
1,390 km WNW Cairns, Qld – 9 July 2007
VH-OGP
Boeing Company 767-300**



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Published by: Australian Transport Safety Bureau
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ISBN and formal report title: see 'Document retrieval information' on page iii.

DOCUMENT RETRIEVAL INFORMATION

Report No.	Publication date	No. of pages	ISBN
AO-2007-022	29 November 2007	8	978-1-921165-54-2

Publication title

Crew incapacitation – 1,390 WNW Cairns, Qld – 9 July 2007 - VH-OGP, Boeing Company 767-300.

Prepared by

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PO Box 967, Civic Square ACT 2608 Australia
www.atsb.gov.au

Reference No.

Nov2007/DOTARS 50413

Abstract

A Boeing Company 767-300 aircraft, registered VH-OGP, was being operated on an overnight international passenger flight from Nagoya, Japan to Cairns, Qld. On board the aircraft were a pilot in command (PIC), a copilot, seven cabin crew and 162 passengers. The copilot was the pilot flying for the sector and had just completed a period of crew rest. The PIC handed back the control of the aircraft to the copilot at about 1600 UTC and got up to go to the toilet. The copilot heard a bang and turned to see the PIC had collapsed on the cockpit floor. There was no response from the PIC to the copilot's questioning. The copilot switched on the cockpit lights and saw that the PIC appeared to be staring into space and remained unresponsive. The copilot then alerted the cabin service manager to come to the flight deck.

At approximately 1650 UTC, the PIC had recovered sufficiently to return to the cockpit, where he remained for the duration of the flight. A PAN call was transmitted by the PIC when the aircraft entered the Australian Flight Information Region and emergency services were placed on standby for the aircraft's arrival and landing at Cairns.

The PIC was subsequently examined and cleared to return to flight duties by a Designated Aviation Medical Examiners (DAME). The DAME determined that the PIC probably had been affected by a gastro-intestinal illness that had previously been experienced by members of the PIC's family. A Norovirus gastro-intestinal disorder was prevalent in the Queensland region at the time.

THE AUSTRALIAN TRANSPORT SAFETY BUREAU

The Australian Transport Safety Bureau (ATSB) is an operationally independent multi-modal bureau within the Australian Government Department of Transport and Regional Services. ATSB investigations are independent of regulatory, operator or other external bodies.

The ATSB is responsible for investigating accidents and other transport safety matters involving civil aviation, marine and rail operations in Australia that fall within Commonwealth jurisdiction, as well as participating in overseas investigations involving Australian registered aircraft and ships. A primary concern is the safety of commercial transport, with particular regard to fare-paying passenger operations.

The ATSB performs its functions in accordance with the provisions of the *Transport Safety Investigation Act 2003* and Regulations and, where applicable, relevant international agreements.

Purpose of safety investigations

The object of a safety investigation is to enhance safety. To reduce safety-related risk, ATSB investigations determine and communicate the safety factors related to the transport safety matter being investigated.

It is not the object of an investigation to determine blame or liability. However, an investigation report must include factual material of sufficient weight to support the analysis and findings. At all times the ATSB endeavours to balance the use of material that could imply adverse comment with the need to properly explain what happened, and why, in a fair and unbiased manner.

Developing safety action

Central to the ATSB's investigation of transport safety matters is the early identification of safety issues in the transport environment. The ATSB prefers to encourage the relevant organisation(s) to proactively initiate safety action rather than release formal recommendations. However, depending on the level of risk associated with a safety issue and the extent of corrective action undertaken by the relevant organisation, a recommendation may be issued either during or at the end of an investigation.

The ATSB has decided that when safety recommendations are issued, they will focus on clearly describing the safety issue of concern, rather than providing instructions or opinions on the method of corrective action. As with equivalent overseas organisations, the ATSB has no power to implement its recommendations. It is a matter for the body to which an ATSB recommendation is directed (for example the relevant regulator in consultation with industry) to assess the costs and benefits of any particular means of addressing a safety issue.

About ATSB investigation reports: How investigation reports are organised and definitions of terms used in ATSB reports, such as safety factor, contributing safety factor and safety issue, are provided on the ATSB web site www.atsb.gov.au.

FACTUAL INFORMATION

Sequence of Events

A Boeing Company 767-300 aircraft, registered VH-OGP, was being operated on an overnight international passenger flight from Nagoya, Japan to Cairns, Qld. On board the aircraft were a pilot in command (PIC), a copilot, seven cabin crew and 162 passengers. The copilot was the pilot flying for the sector and had just completed a period of crew rest. The PIC handed back the control of the aircraft to the copilot at about 1600 (Coordinated Universal Time) UTC and got up to go to the toilet. The copilot heard a bang and turned to see the PIC had collapsed on the cockpit floor. There was no response from the PIC to the copilot's questioning. The copilot switched on the cockpit lights and saw that the PIC appeared to be staring into space and remained unresponsive. The copilot then alerted the cabin service manager (CSM) to come to the flight deck.

The inward opening cockpit door could not be opened by the CSM due to the position of the PIC laying unconscious on the floor. The copilot was required to vacate his seat and pull the PIC partially clear of the door, which enabled the CSM sufficient room to access the cockpit. The copilot then returned to his seat and maintained his focus on managing the flying duties. An assessment of the aircraft's location and options for diversion was made by the copilot. The aircraft was midway between Guam and Cairns, with tropical storm activity behind. The copilot decided to continue to Cairns and the aircraft's speed was increased slightly. The copilot turned and noted that the PIC was being treated with oxygen and was becoming more responsive. Contact was then established with a company aircraft that relayed via satellite phone details of the emergency to the company. The PIC advised the CSM that he needed to go to the toilet and they left the cockpit.

The copilot contacted MedLink¹ and relayed information on the PIC's condition provided by the CSM. A medical practitioner, who was a passenger on the aircraft, was also requested to provide an assessment of the PIC's condition. The PIC was administered a gastrolyte drink and medicated with *Imodium* tablets. An injection of 1cc of *Stemetil* was considered but rejected by the pilots as the effect of the medication would have precluded any flight duties by the PIC for the remainder of the flight.

At approximately 1650 UTC, the PIC had recovered sufficiently to return to the cockpit, where he remained for the duration of the flight. A PAN² call was transmitted by the PIC when the aircraft entered the Australian Flight Information Region and emergency services were placed on standby for the aircraft's arrival and landing at Cairns.

1 MedAire has been providing immediate 24/7 telemedical assistance to the aviation industry since 1986. Through its MedLink services, those resources are put to use on more than 70 commercial airlines and hundreds of corporate flight departments all over the world. MedAire's services are considered so vital, that even the world's top jet manufacturers (Boeing, Bombardier, Embraer and Gulfstream) make them a standard feature onboard every aircraft sold.

2 Radio code indicating uncertainty or alert.

The PIC was subsequently examined and cleared to return to flight duties by a Designated Aviation Medical Examiners (DAME). The DAME determined that the PIC probably had been affected by a gastro-intestinal illness that had previously been experienced by members of the PIC's family. A *Norovirus* gastro-intestinal disorder was prevalent in the Queensland region at the time.

