

Desert Emergency

We're continually lecturing travellers on the importance of being prepared should there be an accident in the bush. On a recent trip into the heart of the Simpson Desert we found our own preparedness being put to the test.



The rumble of heavy rocks crashing down the steep slope froze us in our tracks. Then came a piteous cry: "Help me! Help me!" One of our party had fallen down the boulder-strewn slope and was obviously badly injured.

As we scrambled across the unstable, rocky slope towards the accident I ran through the most likely first aid process in my mind: 'He yelled out, so that suggests no major head injury – that's a positive'.

I expected spinal damage and the extremely unpleasant sight of compound fractures, but when I arrived at the spot where he'd finished up, some 20 metres down the slope from where he'd dislodged a huge rock, I was surprised to see him sitting up. There were no visible broken bones, but he was moaning softly, had difficulty breathing and was obviously in great pain.

We were lucky to have a couple of nurses in our group and one retired nursing sister. The girls set to work assessing the injury situation.

Our mate's breathing difficulty and his inability to move from a sitting position indicated rib and possibly spinal and internal organ damage. He had full feeling in his extremities, so that was a plus.

The retired sister and the nurses determined that it was unwise to move him, so we made him as comfortable as possible, while we decided on the next step. Pillows were brought up from our nearby campsite, to provide a padded back rest against the rocky face and we put a fly mesh over his cap.

We took turns holding an umbrella over him, to keep the desert sun's heat at bay.

The retired sister always travels with a compact, battery-powered blood pressure machine, so this was put to good use, confirming that our mate's heart was working reasonably well, if showing the expected signs of shock. She also set up a patient log in a notebook that could be used to record blood pressure, pulse and respiration-count readings every quarter hour.

We gave the patient some water to sip and a couple of paracetamol tablets, to dull the pain somewhat.

Away from the accident site, while the nurses kept him company, we had a quiet meeting to determine the next step. We acknowledged that we couldn't move him safely and even if we could have got him off the rocky slope, what would we do next?

We couldn't drive him out of the area without bouncing him over Spinifex clumps and sand ridges for a minimum of 60 kilometres to the nearest fixed-wing aircraft landing strip. If he had spinal injury or a punctured lung the trip out could paralyse or even kill him.

The obvious rescue solution was a Flying Doctor helicopter.

We had several hand held GPS units and four satellite phones, on both the Globalstar and Iridium networks, so communication and providing our location weren't going to be a problem.

We went back up to our mate and told him that we planned to request a chopper to airlift him out and that news cheered him enormously.

We rang the RFDS number in Alice and were transferred very quickly to a doctor at the Remote Area Medical Service. We spelled out the situation and it didn't take the RAMS staff long to agree with us that an airlift was the best option. However, there was a helicopter flying range issue, because the accident site was exactly 391 kilometres from The Alice, meaning that the chopper would have to fuel up somewhere en route.

Fortunately, our Aboriginal guide knew that there were four drums of Jet A1 fuel at a nearby property, so we were able to give the doc the approximate position of that property landing strip. Our guide also knew a chopper pilot who was familiar with the property and the area where the accident had occurred. The rescue plans were falling into place nicely, but we knew that it would take several hours to organise the chopper, kit it out with a stretcher, get the flying doctor aboard, and then fly the best part of 400 kilometres, with time out to refuel en route.

We reckoned on around six hours before we saw the helicopter, so we set up the accident site support system. The retired sister and the nurses rotated, so there were always two in attendance; food and drinks were ferried up; and we kept as merry a flow of conversation as we could, to keep our mate as relaxed as possible.

Other crew members set about the tricky task of building a track of sorts, to get our mate off the rocky slope. We cleared some of the mallee scrub and did the best job of road building we could, but the track off the craggy slope couldn't be made smooth enough for safe stretcher transport. Carrying him out on a stretcher risked further injury and the possibility of another patient, if one of the bearers lost his footing. We hoped that when the flying doctor arrived he'd be able to dose our mate up with morphine to the point where he'd be able to walk off the hill.



One of our crew used to fly Jumbo Jets for a living so he was the obvious person to organise the landing area and to communicate with the chopper pilot. He had the crew move vehicles into an arrow shape that pointed directly at the accident scene, with orange V-sheets and bright safety vests on their roof racks and the

gang cleared the larger rocks from a landing site close to the accident scene.

We needed satellite phone communication with the pilot, because the latitude and longitude 'fix' we'd given the RFDS office had been incorrectly written down: '04 degrees' had been written as 40 degrees'!

As the afternoon wore on the blazing sun dropped below the plateau and the temperature dropped to a much more comfortable level. The readings had filled a page in the notebook by the time we heard the soft pulsing of a rotor in the distance. What a sight when the glittering white bird dropped gently onto the landing pad!

The green-suited doctor lost no time scrambling up the slope and spent the next half hour examining our mate. He confirmed that we'd done the right thing in not trying to move the patient and was surprised to find that there wasn't a doctor in our group, because of the quality of the medical information we'd given over the sat phone. He checked out our escape route and agreed that a stretcher party would involve too much risk to all concerned. A morphine-dosed, slow walk off the rocky slope was his choice.



Doped somewhat, our mate was gently helped to his feet and, flanked by willing hands, was led gingerly off the slope. At the side of the chopper the doctor asked us to lay him on the aircraft stretcher, but even the morphine couldn't dull the extreme pain this action caused, so the doc reluctantly opted for a seated transfer to hospital.

Our feelings were mixed as we watched the helicopter bank away sharply towards the fast-setting sun: cheered that our mate was on his way to hospital care, but saddened that the trip had been marred by the accident.



Next morning the sat phone crackled with the news that he was recovering, but with a punctured lung and five broken ribs he was going to be a sore boy for quite some time.

However, when we looked at the accident scene and traced the path of the rock he'd accidentally dislodged and the extent of his fall down this dizzy slope with its sharp rocky surface we appreciated that he'd got off relatively lightly. It could have been fatal.

We were also buoyed by the fact that we'd teamed up well in this crisis and that our bush first aid had done the job as well as it could.

Without GPS location and satellite or HF radio communication we'd have had no choice but to try to get the patient to civilisation and the consequences of the rough handling he'd have had to endure could also have been fatal.

Remote area necessities

Comprehensive first aid kit

Thermal blanket

Water bottles

Satellite phone or HF radio, or both (Telstra's Iridium coverage is better than Globalstar at present)

Hand-held GPS

Backup batteries for phone and GPS

Emergency phone numbers or radio call signs

V-sheet or fluoro clothing

EPIRB

At least two convoy members with current first aid certificates; preferably Remote Area First Aid grade