Today, we are going to discuss an incident with you that took place about a year ago. We will share: what happened, what we did, what we learned and what you can takeaway from this experience to apply to your organization.
CN
Environmental non-profit
Partner with scientists around the world
Run scientific research expeditions all over the world
Connect public to science
Work with individuals, corporates, and teachers/students
CN
Talk about expedition, versus trip, team – internal lingo
7 day team
Working in a national park, assisting researcher
TIMELINE

Week 1
- 4 teens
- 4 teachers
- 2 educators - partner
- 1 Earthwatch staff member

Week 2
- 12 adults
- 3 corporate fellows

Week 3
- 8 adults
Ask Audience who knows what HepA is?

Our educational partner called to inform us that Sarah was at a hospital and had been diagnosed with Hepatitis A.
Hep A is an infectious disease caused by the HAV

Explain incubation period

Incubation period is important to know because it gives a clue to when Sarah could have been infected with the virus. It had been 13 days since the beginning of the project, so it is pretty much not possible that she contracted the virus at the project. However, there is a possibility that Sarah could have unknowingly spread HAV to others while fielding.

All meals, in this project were taken together in a cafeteria/buffet style
She had her own room but share bathroom and cafeteria
The team that fielded with Sarah had both teens and adults and all interacted with her throughout the week, as well as staff members from the field station

One of the reason we acted so quickly was to makes sure we give any participants the chance to get treatment if they were indeed exposed to the virus.

- Due to the nature of this virus – live on surfaces for months - This could become a bigger incident – more people can become contaminated

- Something that can start as a very small thing – can escalate. We need to be
observant, and act fast. This is a good example, but we have other situations that this approach should also be applicable.
FIRST STEPS

- Gather Information
- Assemble an Incident Management Team
- Start an Incident Report
At this point we do not know if it is HepA for a fact. Need to confirm with Sarah or educational partner or hospital. This was because it was communicated through 3 people.

We do have a colleague at that point that fielded with Sarah and she gave us some factual information.

Sarah kept refusing medical care

Discuss our collection of forms
RG
We tried calling Sarah – check on her health and confirm diagnosis – we still don’t know it is Hep A at that point. We were not able to reach her. We tried the hospital and again we could not reach her. The hospital was not letting us talk to her or give us info. So we still do not know, but we have to act under the assumption that it is Hep A and we have to keep moving because if others got contaminated, there is a small window for them to get treatment.

Health and Medical Insurance Provider: start a case for Sarah – Learn more about HepA. What I explained to you guys, it was confirmed from them in particular the incubation period

Educational partner: They were our source. We asked for confirmation of diagnosis. Also, we kept in constant contact and updates. Ask if we can contact their participants. Hesitant at first

Field staff at project: How are they? Let them know of Sarah- we will delve into this a little bit further. Could not reach at first
We assembled a team to deal with this incident and attributed different roles to different staff members. We have an Incident management team composed of about 15 people – mix of voluntary and part of job role membership. We are highly trained in Risk management, incident management and wilderness first aid, and can easily switch roles or be assigned a different role depending on the incident. This is very helpful because we can cover for each other, or take on multiple roles in one incident.

For this specific incident we have the following roles:

- Incident manager - Caroline was our incident manager. She made all the hard decisions. She was updated constantly by everyone on their steps. She would be meeting with our executive and informing them, and then meeting with us and getting another update. She was constantly juggling responsibilities and keeping an oversight of the whole incident.
- Deputy - Caroline’s right hand. The person helped make decisions. Took over for Caroline in specific meetings, informed members of the team on decisions. Supported anyone that needed extra support.

- Note Taker - This person kept accurate and very detailed records of all the different tasks happening at once. Once we meet and updated each of our action items, this person would take the notes.

- Participant and Educational partner - Our partner liaison called our other 3 teachers on the team and told them about the incident.

- Family Liaison - because we had 4 teens, we also had 4 sets of parents. Very sensitive. So we have someone getting in touch with them. She asked if they were feeling healthy, asked about the vaccination status. One parent did not know about the vaccination of their kid, also the kid was feeling that he was coming down with the flu - very tense!

- Field Staff Liaison - This staff member called our field staff numerous time. For that first evening she could not get a hold of anyone. This added to the stress of course.

- Hospital and Medical insurer Liaison - So our medical liaison both attempted to call Sarah and the hospital to get information on her status - without avail. This staff member also connected with our insurer, tried to get more info on HepA, on the incubation period of this virus, on any health updates.
- Point of contact - This person was basically on call with our team to get any calls that Earthwatch got related with this incident. Calls would be directed to this person.
CN
Activity – In groups discuss what they would do for next steps
Reveal what we did – and hand out timeline at the moment
We are going to go over the big items that we did, but there are small details that we did to keep the org running, such as switch DO away from Stacey to Caroline, etc.
Timeline was updated by note taker that gathered info from all members on the incident management team

Constant contact with Medical provider – updates

Meet regularly with IMT – Check ins
CN
Team in the field – were they okay? Ask about vaccinations
Talk in more detail about cleaning, especially the vehicle
CN
Make sure participants know they can call and ask questions, updates, etc...
Confidential – we never told them it was Sarah who was sick, but on week 1 we assumed they would figure it out so we asked for them to keep it confidential
Week 3 – didn’t want them to find out they got into the field
All participants let us know they either already had their vaccine or they were going to receive the preventative treatment. No one got Hep A!
This message is an internal message only. It is confidential and should not be discussed openly or distributed.

Regular updates to an executive

- What happened - Keep it short and sweet
- IMT - our location and please give space
- Where to direct questions/calls

- Updates and answering questions - Examples:
  - Where it was contracted
  - What we are doing
  - Informing about staff member

- “Please continue to respect the sensitivity and confidentiality of this incident.”

CN
Exec – CEO but Scott not there so KK is backup
Earthwatch partners with organizations across all sectors of business to improve both environmental and corporate sustainability

Week 1: educational partner
Week 2: corporate partner

Participants: included educational partner participants
CN
Hospital confirmed diagnosis. Due to exposure needed to inform dept of public health. Going through their protocols
Ex questions:
How was food prepared?
How many people in contact with Sarah?
How did we inform those in contact with her?
Has anyone shown any symptoms?
How is the location being cleaned?

Needed list in order to follow protocol of reaching out to everyone

Reach out to field location to discuss cleaning procedure

Contracted likely from trip to Egypt

List: password protected for confidentiality
<table>
<thead>
<tr>
<th>Action</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicated with field staff</td>
<td>✔</td>
</tr>
<tr>
<td>Contacted our participants</td>
<td>✔</td>
</tr>
<tr>
<td>Informed our internal staff</td>
<td>✔</td>
</tr>
<tr>
<td>Updated our partners</td>
<td>✔</td>
</tr>
<tr>
<td>Spoke with Department of Public Health</td>
<td>✔</td>
</tr>
<tr>
<td>Convened Incident Management Team</td>
<td>✔</td>
</tr>
<tr>
<td>Consulted our medical provider</td>
<td>✔</td>
</tr>
<tr>
<td>Kept detailed records</td>
<td>✔</td>
</tr>
</tbody>
</table>
CN
Earthwatch partners with organizations across all sectors of business to improve both environmental and corporate sustainability

Week 1: educational partner
Week 2: corporate partner

Participants: included educational partner participants
FIELD PERSPECTIVE: LESSONS LEARNED

Communication
Only share what you know

Prioritize
Can only control what you can control

Keep calm
Put your health and safety first

RG
Takeaways for you!
Introduce EW to partner participants, co brand challenging, but can introduce as org that takes care of RM and IM, safety etc

Formalize internal policies and how IM happens with partners, part of contract

Not able to contact field staff on the first night, need to resolve that and have a plan

Staff member trying to help at first but better for her to step back as she was also a participant and needed to care for her self
RG
Activity: Introduce 4 scenarios and ask groups to talk about what additional steps they would need to take (all must have legal and financial implications)

- Media
- Contracting virus at project
- Infecting others
- Worse pathogen
- Legal implications
Takeaways for you!
Questions?

Rita Galdos
Program Manager
rgaldos@earthwatch.org

Caroline Nassif
Operations Manager
cnassif@earthwatch.org

US 😊