

Medical Displan Victoria

Annual Review 2003

2003 in Review

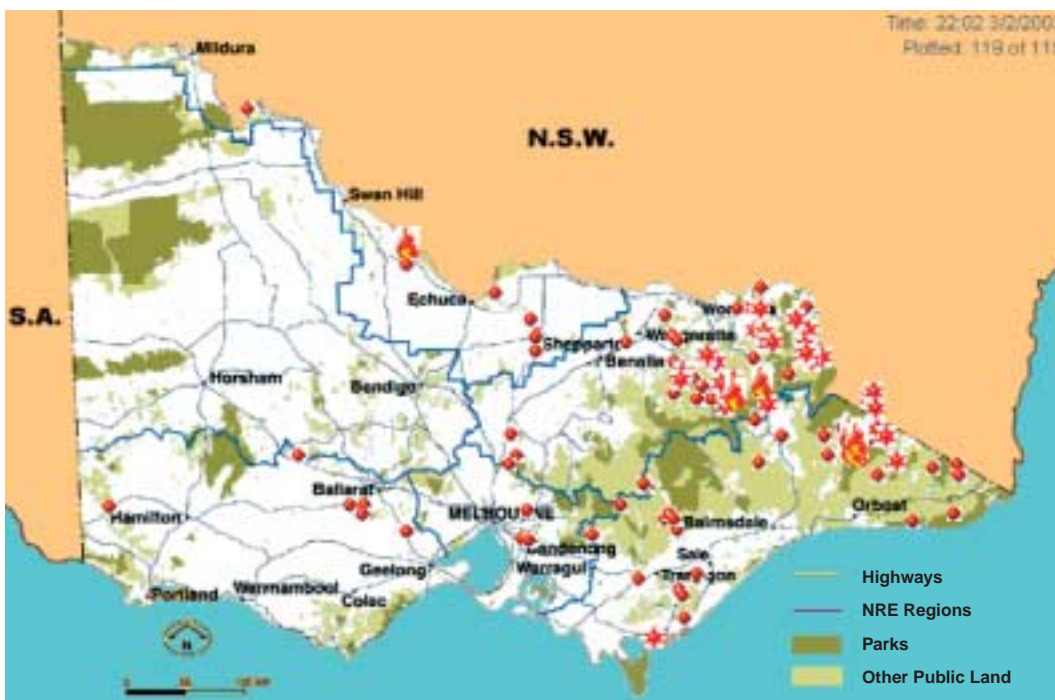
The seasonal bushfires in Victoria started on 21st December 2002 and continued for the first six weeks of 2003. Much of the Alpine Region became involved and in total one million hectares burned before the fires were brought under control. Throughout the campaign Medical Displan Victoria maintained a

coordination role of the health response: first aid organisations, ambulance services and hospitals. Some 2,540 people sought first aid treatments from St John Ambulance and Australian Red Cross. The Metropolitan Ambulance Service (MAS) assisted the scaling up of operations by Rural Ambulance Victoria (RAV) by moving resources up to branches near the metropolitan area and thereby releasing staff to go to the North East Region. Air Ambulance flew staff from non-affected regions to provide relief. St John used extra volunteers from interstate to give respite to their own crews and provide valuable on-the-job experience. Nightly reports enabled an overview to be maintained and information

flow kept key personnel informed across the spectrum of health and recovery services.

One of the temporary camps for firefighters had an outbreak of vomiting and diarrhoea that was investigated by Public Health. Two nursing homes/hostels and one hospital needed to be temporarily evacuated as the fire advanced. Locums assisted two rural general practitioners and a bush nurse was relieved to be able to attend to family needs during the emergency. From this impressive workload, only 121 patients required primary transport to hospital, with one death due to a flash flood after the fires had been controlled. This was all accomplished by regional area medical coordinators who kept a watching brief and from time to time toured areas of need. The magnificent effort of all medical and nursing staff, ambulance paramedics, first aid volunteers, the North East Division of General Practice and many individuals made the whole operation possible, assuring safety for hundreds of firefighters and dozens of threatened

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Mission Statement

The mission of Medical Displan Victoria is to coordinate all of the necessary health-related activities of planning, preparedness and response to an emergency with the potential for mass casualties in the State of Victoria.



Medical Displan
Victoria

communities. The key role of Mr Neil Akers, the RAV Senior Operations Officer – Tactical Support, deserves special commendation.

There were two other notable events among the 38 that were notified to Medical Displan in 2003: the chairlift collapse at the base of Arthur's Seat in January; and the chemical spill and evacuation of the Royal Dental Hospital in September. Both were significant for the need for an on-site medical team.

At Arthur's Seat, MAS had transported those injured in the initial impact within an hour, then the second phase began the difficult rescue operation of some 65 passengers from their chairs. Dr Jeff Wassertheil was the Area Medical Coordinator (AMC) on scene, and he initiated a plan to deal with the potential for greater problems because of the lengthy high angle rescue. There were passengers of all ages, shapes and conditions trapped in midair for many hours, together with dozens of

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rescuers. The two factors made a sophisticated first aid resource and casualty clearing station an imperative. The Central Medical Coordinator arranged for a second AMC to assist at the upper end of this extended site and a liaison officer to assist with communications. St John Ambulance provided two first aid teams with large, mobile, first aid posts capable of accommodating several casualties simultaneously; Australian Red Cross provided catering services and victim registration. The medical team came from Monash Medical Centre. The rescue involved five other organisations – Victoria Police, Country Fire Authority, Metropolitan Fire Brigade, State Emergency Service and the Shire of Mornington Peninsula. A senior police officer observer said that it was a textbook performance in cooperation and coordination under the appropriate control agency.

The Royal Dental Hospital chemical spill highlighted the vulnerability of our institutions in general. The actual incident was merely a dreadful smell, source unknown, that caused respiratory symptoms. The subsequent evacuation, monitoring, first aid, transport to emergency departments and communication problems became a first-class rehearsal for an actual central business district major incident under realistic conditions of an actual, unknown incident. The rapid response of the



team from St Vincent's Hospital highlighted the physical and logistical limitations of teams in the pre-hospital setting. It was a valuable learning exercise for all the services involved.

The three passenger-rail crashes around the State also presented opportunities to learn more about mass casualty management, and those lessons will be added to the collective knowledge of the organisations that dealt with the scene.

Other matters having a high profile for Medical Displan include: the Department of Human Services (DHS) Emergency Management Project for all health and community divisions of DHS; the development and roll out of the Major Incident Medical Management and Support courses; planning for the Melbourne 2006 Commonwealth Games; the 2005 Deaflympics; and the Australian Grand Prix.





Editorial – Dr Andrew Bacon, Chief Medical Coordinator, Medical Displan Victoria

Around the world the number and the consequences of disasters, both natural and man-made, are escalating exponentially¹. The current political focus on the ‘big one’ emphasises the need for health planners to explore the unfamiliar experiences that may lie ahead if the unthinkable happens in Australia.

Top-down planning is obviously critical to success and, although the titles differ, each State and Territory has similar plans and objectives. On scene, personnel have to understand not only how the overall plan works, but also be trained to recognise the way the on-scene detail will change as the situation becomes clearer and the on-scene time stretches from one hour to many hours. Experience teaches us that each incident is slightly different and a terrorist attack would mean considering new concepts and becoming aware of new needs. On the positive side, we can use the very solid existing procedures as a framework to help combat previously unexperienced disasters: use a Hazmat incident as a real-time rehearsal for a chemical attack, a SARS or Avian ‘flu threat to check procedures and linkages for a biological incident, a minor radioactive isotope mishap as a rehearsal for a terrorist action. In this way, the processes are rehearsed in a less-threatening but credible environment.

Our familiarity with everyday emergency work lulls us into thinking we can cope, we have seen it all before. In a very major impact incident, if there are many people trapped, then hospital-based medical teams will be needed to assist treatment for the patients on scene. To a paramedic one question might be: “Who is in charge? Senior ambulance managers? The medical team leader? The health department medical coordinator?” The on-scene picture becomes very confusing to the responder who has spent years on the job without any top brass. The answer is for the first person to take charge to remain in charge until the definitive scene commander is on scene. Both need to learn to look over the horizon, both the physical horizon and the time horizon, to identify the needs now and in the foreseeable future. Unlike the fire brigade tasks, the aftermath of flooding, or major crime scenes, very few ambulance events take more than an hour to clear up. There is very little use of relief crews or commanders in metropolitan areas. The expectation is that you are there until the job is done. A 1700-hrs shift-

finish may stretch an hour or so to complete the patient care and transport, but that is part of the job – the patient comes first and continuity of care is not just lip service.

The new threats and a ‘normal’ increase in disasters demand that in the health domain we change our thinking. This is the time to inculcate new habits, utilise the middle-scale incidents to mildly over-respond managers to give them practical experience to help to prepare them for a catastrophic event.

The new reality also means increasing the numbers of hospital teams that are capable of assisting in a meaningful manner in the pre-hospital environment. Not all the stories of bystander doctors or nurses on scene are glowing testimonies to professionalism, safety and helpfulness. Such anecdotes underline the need to provide more training for potential major incidents, a gap now filled by the Major Incident Medical Management and Support (MIMMS) courses.

MIMMS courses are the accepted standard across the western world, and are now run in most Australian States and Territories. The first year of courses run in Victoria has proven valuable as an interdisciplinary training tool. Although it is tempting for hospitals and ambulance services to consider the cost benefits of single-service courses, the interaction between the hospital personnel and the on-road ambulance paramedics sets a firm foundation of mutual respect, understanding and professional knowledge. The ‘Mimmsville’ tabletop exercises get key players together to work through set scenarios. Tabletops in general are a low cost and very useful method of providing ongoing training – as well as providing a venue for training less-experienced commanders. They can be applicable to hospitals, ambulance services and first aid organisations.

In disasters there are often two phases: the initial period of almost normal urgent routines dealing with the flood of walking wounded and immediately accessible more seriously injured victims, then the long drawn out extrication and treatment of the casualties that are initially inaccessible. The flow of casualties into hospitals is therefore also bi-phasic and this has to be understood by all.

During a major incident today’s managers need to follow the principles enunciated by Robert Heath²: i) Search for information; ii) Analyse the information; iii) Identify the tasks; iv) Manage time; v) Elaborate options.

¹ Editorial Pre-Hospital and Disaster Medicine, Jul–Sep 2002 Vol 17, No 3

² Robert Heath 2001 International Journal of Emergency Management, 1 (1) 49–60

This leads to six rules:

- 1) Work from the Worst Possible Scenario – look over the horizon (temporal and geographical), use the ‘pay-off’ principle.
- 2) Deal with Definites – focus on what you know. Ignore the ‘If only...’.
- 3) Manage the Manageable – ‘Can I do something directly about this?’ Do not get distracted by the unmanageable. Pass the other stuff up the chain of command.
- 4) Limit the Losses – people, resources, property. Sometimes, retreat is a good strategy.
- 5) Dig for Disconfirmation – beware of ‘Groupthink’. Listen to the dissenting

opinion from a ‘wise owl’ in the background. (“In 1983, I remember that this happened ...”)

- 6) First solution – first option focus
Alternative Solution – second option focus
Safety Solution – the option for preventing further losses (people/property)
Targeted Outcome – remind all present of the mission.

The Message

On scene, look over the horizon. What might happen next? What is the worst thing that could happen here? Use escalation as a legitimate practice tool.

Medical Displan Annual Seminar/Exercise 2003

The Annual Seminar/Exercise weekend was scheduled and held on the weekend 11/12 October 2003 in Bendigo, with over 80 delegates from Victoria, Interstate and Defence attending the seminar activities. This wide attendance included participants from all agencies at State and Local level normally involved with coping with major incidents.

Seminar items included varied and interesting topics on disaster medicine and related subjects, from a cross section of the medical and health profession, related to aspects of planning, response and recovery.

A delegation from South Australia presented a comprehensive cover of a recent exercise at the Royal Adelaide Hospital to test the procedures for de-contamination of casualties in that State.

An interesting aspect of the weekend was the implementation of a realistic all-agency field exercise designed to provide training for medical coordinators and for testing local Medical Displan plans for coping with a large mass casualty incident. Over 120 personnel and support agencies were involved in the field activities. The exercise scenario provided an opportunity for the necessary all-agency de-contamination procedures to be practised where a release of hazardous material is involved in incidents and many lessons were learned by participants who seldom get the opportunity to see at first hand some of the complexities of managing response to emergencies.

Dr Bernie Street, the appointed Area Medical Displan Coordinator for the Bendigo Area, located at the Anne Caudle Centre, is responsible for the day-to-day medical emergency planning issues in Bendigo and is a member of the Bendigo Emergency Management Committee. He is supported in this role with two deputies, Dr Gary Bourke in Bendigo and Dr Jenny Grounds in Riddles Creek.

During the exercise, Dr Street carried out the role as a Central Medical Coordinator providing the linkage for all medical and health resources required for the exercise.

Bendigo Hospital also had the opportunity to test the newly installed decontamination facilities outside the Emergency Department to ensure casualties do not contaminate the Emergency Department. This part of the exercise highlighted the requirement for all agencies and hospital staff to be aware of contaminated casualties presenting for treatment.

Air Commodore Tony Austin, Director of Defence Health in Canberra, was the guest speaker at the dinner held on Saturday evening.

The 13th World Congress on Disaster and Emergency Medicine

This Congress – conference and associated workshops – was held in Melbourne in May 2003. It was one of the largest gatherings of health personnel concerned with Disaster Medicine ever convened and the resulting intellectual and practical exchanges produced a stimulating environment. The evolution of the Melbourne Statement was a landmark that will stand as a keystone for future developments in Disaster Medicine (In press, Prehospital and Disaster Medicine, <http://pdm.medicine.wisc.edu>). Key sessions included Mass Gathering Medicine, Complex Humanitarian Emergencies and the concept of an Oceania Disaster Medicine Group to provide linkages across the region.

Area Medical Coordinator Register

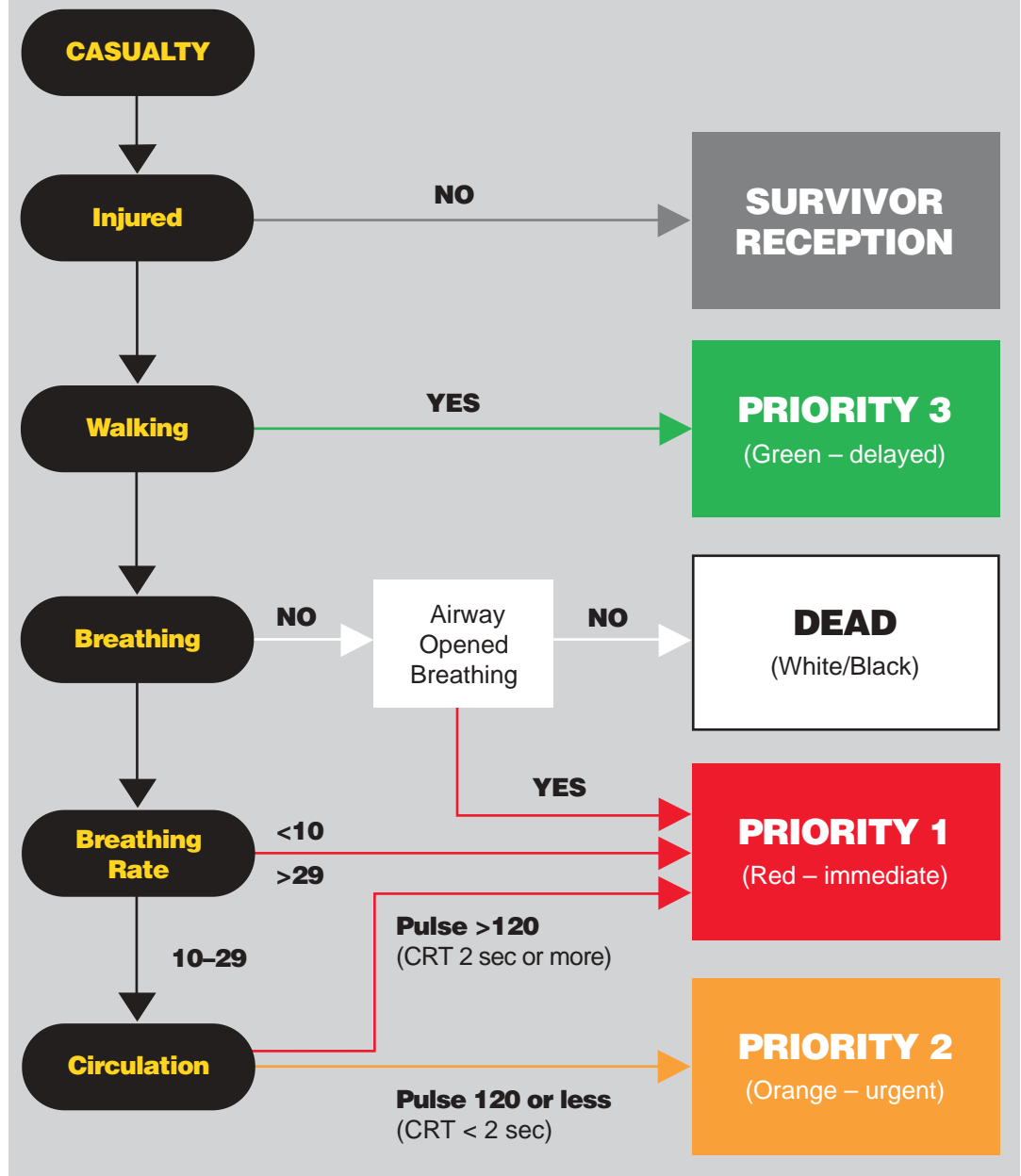
These contact numbers are for routine calls.

In an emergency, contact should be via ambulance control (000).

Police Region Old	Police Region New	Medical Coordinator	Town	Office
ALPHA Melbourne	R1 – Melbourne Division	Dr R Lowen		9816 3392
BRAVO Prahran	R1 – Melbourne Division	Dr M Westmore		9895 4861
CHARLIE Moorabbin	R1 – Moorabbin Division	Dr G Sansom		9288 2211
DELTA Frankston	R5 – Frankston Division	Dr J Wassertheil		9784 7206
ECHO Dandenong	R5 – Dandenong Division	Dr D Vissenga		9247 3865
FOXTROT Knox	R4 – Knox Division	Dr B McIlroy		9426 6300
GOLF Nunawading	R4 – Nunawading Divn	Dr J Moloney		9276 3176
HOTEL Heidelberg	R4 – Diamond Valley Divn	Dr D Mansie		9818 1471
INDIA Broadmeadows	R3 – Broadmeadows Divn	Dr C Hogan		9744 5061
	R3 – Mill Park Division	Dr C Hogan		9744 5061
JULIET Altona North	R2 – Altona North Divn	Dr J Epstein		8345 6666
KILO Geelong	R2 – Geelong Division	Dr R Fawcett	Geelong	5226 7686
		Dr J Virgona	Geelong, East	5222 4955
		Dr C Sutherland	Colac	5231 5500
LIMA 1 Warrnambool	R2 – Warrnambool Divn	Dr S Tsiouras	Warrnambool	5563 1666
		Dr P O'Brien	Warrnambool	5563 1666
		Dr R Brough	Warrnambool	5560 3222
LIMA 2 Hamilton	R2 – Warrnambool Divn	Dr D Ford	Hamilton	5572 2422
		Dr A Wark	Hamilton	5571 0222
		Mr P Kierce	Hamilton/Portland	5523 1100
MIKE 1 Ballarat	R2 – Ballarat Division	Dr M Harris	Ballarat	5320 2126
		Dr B Fensling	Ballarat	5320 4279
MIKE 2 Horsham	R2 – Horsham Division	Dr A Wolff	Horsham	5381 9111
		Dr M O'Sullivan	Horsham	5382 0011
		Dr D Leembruggen	Horsham	5382 0011
NOVEMBER 1 Mildura	R3 – Mildura Division	Dr J Russell	Mildura	5022 3333
		Dr G Murphy	Mildura	5022 1488
NOVEMBER 2 Swan Hill	R3 – Mildura Division	Dr G Williamson	Lake Boga	0409 500 979
OSCAR 1 Bendigo	R3 – Bendigo Division	Dr B Street	Bendigo	5454 6000
		Dr D Murphy	Bendigo	5454 6000
		Dr G Bourke	Bendigo	5454 6000
		Dr J Grounds	Riddells Creek	0407 287 684
OSCAR 2 Shepparton	R3 – Shepparton Division	Dr J Guymer	Shepparton	5821 5633
		Dr M Geaboc	Shepparton	5832 2322
		Dr J Teh	Echuca	5482 2800
PAPA 1 Wangaratta	R4 – Wangaratta Division	Dr P Duggan	Wangaratta	5722 0111
		Dr G McCallum	Bright	5750 1050
		Dr R Barkas	Corryong	02 6076 1733
		Dr M Robinson	Mt Beauty	5754 4003
		Dr J Moran	Wodonga	02 6051 7111
		Dr W Twycross	Mansfield	5775 2591
PAPA 2 Seymour	R4 – Seymour Division	Dr P Kelly	Benalla	5762 1022
		Dr E Jarman	Seymour	5793 6100
QUEBEC 1 Morwell	R5 – Morwell Division	Dr M Bensley	Korumburra	5655 1355
		Dr D Pedler	Traralgon	5173 8000
		Duty Doctor	Foster	5682 2088
QUEBEC 2 Bairnsdale	R5 – Bairnsdale Division	Dr M Chapman	Bairnsdale	5152 5145
		Dr I Nicolson	Sale	5144 4111
		Ms M Goss	Sale	5143 8770
		Flt Lt L Lim	East Sale	5146 6261
WHISKY Water Police	Water Division	Mr E Williams (Liaison)		9419 3533

Triage Labels

Triage Sieve



Contact Information

Office of the Medical Displan Coordinator

Street Address: 3rd Floor
55 Victoria Parade
Fitzroy Vic 3065
Australia

Telephone: +61 3 9419 3533 or +61 3 9419 0195
Fax: +61 3 9419 0585
Email: MedicalDisplanVictoria@dhs.vic.gov.au
Internet: <http://www.health.vic.gov.au/displan>

Staff:

- Dr Andrew Bacon**
Chief Medical Coordinator
- Mr Eric Williams**
Executive Officer
- Ms Dorothy Manuel**
Office Manager