The final deliberations of the Trust’s response to the third major incident in five years are not available at the time of going to press, but an amended major incident plan will be detailed in future issues of the journal. This report, for which the editor acknowledges the help of Sophy Stewart, editor of the Trust’s newsletter, The Weekly Messenger, and of the editor of the Westmorland Gazette, is a preliminary report of the lessons learnt on the night of 23rd February 2007 and the subsequent days.

© The Westmorland Gazette

A quiet Friday evening in February. The Lancaster Medical Book Club was meeting to hear from Dr Andrew Whitton about the world of elite sports. The intensive care unit was full of ventilated patients. Heather Trousdale was just finishing a routine day in the Accident and Emergency department at the Royal Lancaster Infirmary (RLI). Peter Dyer was watching the evening news. Ross Spence received a phone call from a colleague in the portering department.

It might as well have been one of those wretched exercises that had been threatened so often and postponed due to the hospital being full. It might as well have been one of those dreaded scenarios dreamt up by the planners where the radios don’t work, the weather is foul, and the site is inaccessible...

But this time it was for real. Heather joined the team at the barn in Grayrigg where she helped with triage. Ross and his colleagues prepared trolleys, equipped the makeshift helipad and waited. Peter set up the incident room and waited.

It was as bad as the worst scenario the planners could have invented. A rural location. A single dirt track was the only access to the site. The skies were dark and it was raining. And the radio communication was unreliable.

The editor of the Journal had privileged access to the control, X-ray and Emergency Rooms and visited the wards the following day.

This was an accident involving deceleration from high speed, but one in which the integrity of the carriages meant that the number of open wounds and long bone fractures, the obvious injuries which draw the attention of clinical staff, was minimal. Rather, there was a profusion of spinal and head injuries, with a few other peculiar fractures, such as isolated lumbar spine body burst injury and a scapular injury consistent with massive blunt trauma. From the hospital triage perspective, these pose particular dangers once the immediate assessment has been made. They may not be immediately life threatening but may result in serious secondary complications which may be preventable. Furthermore, these injuries may be occult – they require computed tomography (CT) imaging as a matter of course – so the arrival of, say, three patients in the same helicopter will pose problems. The bland diagnosis ‘back pain’ on the board in the incident room may not carry the same sense of urgency as the label ‘unconscious’ or ‘chest injury’. In the event of a serious problem being identified at CT imaging, the prospect of the patient having been initially triaged on site as ‘yellow’ or ‘green’ and waiting longer to be evacuated and longer to be seen in hospital than more obviously serious ‘red’ injuries has to be remembered. It is also, as we discovered, more difficult than usual to arrange secondary transfer to a regional neurological unit when every available resource is at the scene of the disaster.

A second feature of civilian trauma in this context is the confounding effect of advanced age and pre-existing conditions. It was possibly no coincidence that the only fatality, despite being amongst the first to arrive at hospital, was an elderly lady. One of the five serious injuries was an elderly man who had seen a cardiologist and had had recent investigations for new cardiac symptoms only four days beforehand. These are not just surgical injuries; they are injuries sustained by old people, not fit military fighting men. They need the expertise not only of surgeons and anaesthetists, but of physicians from the outset. Furthermore, this interdisciplinary involvement may work on an ad hoc arrangement for the occasional elderly patient admitted with multiple trauma on a day-to-day basis, but the existing system for occasional review by, for example, the medical registrar of a patient with heart disease undergoing surgery, is clearly inadequate when there are multiple casualties. Putting all elderly casualties, irrespective of injury, on the same ward may be an efficient way of making the expertise of all specialties available to all patients.

© The Westmorland Gazette
At the debrief meeting on March 13th, the Medical Director, Peter Dyer, chaired a multiprofessional gathering of medical and nursing staff, hospital engineers, rescue service, ambulance staff, representatives of the local council, the Association of Train Operating Companies (ATOC) and Virgin Trains.

The meeting was of the opinion that problems of communication were present at all levels, from the failure of mobile phones, range of radio communication, and the fact that the improvised helipad had, almost by definition, no fixed communication link. Of the communication issues that needed most urgently revisiting, the issue of ‘standdown’ was pre-eminent. Many staff were on their way home when the first helicopters started arriving. Some returned, but many would be not be in contact till after they had returned home. Clearly there is a need for a staged ‘standdown’, with different staff released at different times, according to the clinical priorities.

Representatives of ATOC and Virgin Trains were complimentary about the way in which University Hospitals of Morecambe Bay (UHMB) had responded. They outlined their own agreed procedure, which includes the procurement of available hotel space in towns near the hospitals and accident scene for the use of relatives.

The use of Westmorland General Hospital (WGH) as a centre for minor injuries was recognised. It was noted that both in this accident and the coach crash a few years earlier, the convenience of Kendal was important for the logistics of ambulance journeys, as well as a place to which patients could be transferred from the Royal Lancaster Infirmary (RLI).

The on-site medical officer and Consultant in Accident and Emergency Medicine, Darryl Wood, was impressed by the sheer turnout and reliability of the staff, rescue and volunteer services, but felt that the communication system needed a considerable rethink. Mobile phone systems are vulnerable to system shutdown in the event of a major disaster. Air evacuation was vital to success, particularly where roads were easily congested. The use of the Accident and Emergency department as a congregating area for staff was also felt to be unhelpful, and alternatives need to be considered.

Clinical staff who read this journal can be forgiven for underestimating the value of other staff who keep the surgical instruments clean, the lights working and the heating running. They are an army of Works department professionals who are recognised by only a few clinical staff during normal operations and they have a wealth of experience in enabling clinicians to achieve good results. In the event of a major accident, they double up as air traffic controllers, logistics experts, helipad ground staff, floodlight providers and providers of refreshments, controllers of parking, the press, the public and are the ‘shop front’ of the hospital. They allow clinical staff to be shielded from extra pressures. Their invisibility in their day-to-day work is a problem if they cannot be properly recognised or their authority not accepted in a major accident scenario. There is a clear case for them to be clearly identified. Stephen Townsend, who heads the Works department, recognised that for future planning it may be valuable to install fixed lighting and warning lights on chimneys for helicopter operations, as the small helipad is unsuitable for large rescue machines.

Acting Chief Executive of UHMB, Kevin McGee, expressed his satisfaction that although there were many things to be discussed in terms of better inter-agency liaison, radio communication and command structure the clinical care had been first class and all patients had been dealt with satisfactorily.