The Purley train crash: procedural difficulties

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INTRODUCTION

This paper describes procedural difficulties that were encountered during the acute management of 55 victims of the Purley train crash. We report them in the hope of stimulating the development and implementation of a National Protocol for such emergencies.

Notification of major accident

At 13.42 hrs on Saturday 4th March 1989, London Ambulance Service (LAS) received the first report of a train crash close to the centre of Purley. The immediate response of the LAS included not only mobilizing its own resources, but also informing the Police, Fire Brigade, and Emergency Bed Service of the incident. Surrounding hospitals were contacted and warned that a 'Yellow Alert' existed. Communication is by telephone with standard phrases read by LAS telephonists from a protocol.

At 13.52 hr Mayday Hospital received a 'Yellow Alert' from the LAS. 'Yellow Alert' is a term originally introduced over 10 years ago during the IRA bombing campaign in London to indicate that a bomb warning had been received: an advanced warning that a Major Incident might occur. The LAS also notified Mayday Hospital that it was the Designated Hospital (implying it would receive the bulk of the casualties if the incident became confirmed). Within the Hospital the term was taken as a warning, and the A&E Department was cleared and prepared whilst the key personnel were contacted.

However, the implied uncertainty around the incident was extended to the status of the Hospital: if the incident was confirmed, it was anticipated that the Hospital's role as Designated Hospital would also be confirmed. When reviewing the incident, misinterpretation of the term was found throughout all grades of Hospital staff. 'Yellow Alert' implies the progression to 'Red Alert'. This no longer occurs, and the term fails to describe the situation it represents. Recently it has

been suggested that because of the uncertainty surrounding the phrase, that the concept should be abandoned. We found the warning useful, and suggest that 'Yellow Alert' is changed to the phrase 'Major Incident Reported', which clearly describes the situation and cannot be misinterpreted.

Confirmation of Major Incident

Confirmation of the Major Incident was received 30 min after the 'Yellow Alert', at 14.22 hrs. The LAS use the term 'Major Incident Declared', whereas the Hospital plan and subsequent discussions within the Hospital have used the term 'Red Alert', occasionally dividing it into 'Red Alert Declared' and 'Red Alert Confirmed'. A standard term is needed, perhaps 'Major Incident Confirmed'.

Hospital medical services at the incident site

The term used by the LAS for the doctor who will co-ordinate the incident on site is the 'Medical Incident Officer', the Mayday Hospital Major Incident plan equivalent was 'Site Medical Officer'. The nearest equivalent to the LAS term within the Hospital was 'Hospital Incident Officer', which is adopted by the duty Hospital Administrator.

The LAS assume that a doctor will be sent from the designated Hospital to fill the role of 'Medical Incident Officer', and ask only whether transport is required. The Mayday plan assumed that such a doctor would be requested if required, and it appears that no message was received at the Hospital about the transport or presence of a doctor at the crash site. As a result, no-one was dispatched from Mayday to occupy this role. This, in retrospect, was a mistake, and may have occurred due to misunderstanding of jargon: we suggest that the term 'Site Medical Officer' be universally adopted for this post.

Evacuation and triage

The proximity of the crash site to the road, and the rapid response of the Emergency Services allowed almost immediate evacuation of all casualties to Hospital. The medical team from a neighbouring Hospital reached the site at about 15.40 hrs when only one patient with a fractured femur still awaited evacuation.

At Mayday Hospital a fleet of both private and emergency vehicles arrived with 55 casualties, the vast majority between 14.28 and 14.50 hrs.

The first two ambulances brought five patients with injuries of varying severity, all without priority labels. Therefore it became necessary to perform triage within the ambulances in the Casualty parking bay. The less seriously injured were kept within the ambulances until more room was available in A&E. We hope that the Casualty labelling system which has already been agreed upon by the Chief Ambulance Officers Association would be accepted nationally and used in the event of every Major Incident.

Communication: site to hospital and within the hospital

The Mayday Hospital received no direct contact from the crash site at any time. As a consequence, there was no information on the number or severity of casualties with which the Hospital would need to cope. We would reiterate the view of those dealing with the M1 disaster that a portable radio or telephone link be established direct, from doctor to doctor (Staff of Derbyshire Royal Infirmary *et al.*, 1989).

Communication within the Hospital also proved to be deficient. The bleep system was too cumbersome for the number of contacts that key personnel received. The attendance of consultants from other hospitals proved invaluable, but no easy method of communication was available. We suggest a supply of emergency incident bleeps and portable radios be kept in A&E.

Documentation of casualties

One of the roles of the Police in Major Incidents is to provide a team of officers who will document the casualties as they arrive at the Hospital. To cover this incident in South London, a documentation team was despatched to the Hospital from North London, causing considerable delay. On arrival at the Hospital the team had no suitable forms causing further delay whilst these were obtained. One result was difficulty in matching names and numbers of injured that had been recorded firstly using Hospital emergency documentation, and then allocated another reference code by the Police.

We suggest that a sealed box containing integrated Hospital and Police documentation be kept A&E, to be broken open once the incident is confirmed. Initially, such forms could be completed by Accident and Emergency clerical staff, until the police documentation team arrives.

Communication with the public

Friends or relatives of the injured were invited to contact a single telephone number. This proved grossly inadequate, and the press and distressed relatives in desperation blocked the Hospital switchboard, further hindering communication. From the start of the incident, the Hospital actively cooperated with the media, displaying signs to welcome them and direct them to an out-patient clinic, which had been adapted to provide facilities for them. This attitude proved extremely useful with all but a small minority of the tabloid press displaying ethical and considerate behaviour. Later several comments thanking the Hospital for its positive approach were received.

CONCLUSIONS

In the drafting of the Mayday Hospital Major Incident Plan, careful note was taken of guidelines prepared by the Department of Health and Social Security in 1977 (DHSS, 1977). Only when a crisis occurs are the attributes of a major incident plan revealed. When coping with the Purley train crash we were lucky, and despite the

administrative difficulties that we have described, no patient suffered a preventable death or had definitive treatment for their injuries delayed. The difficulties were largely procedural and are probably universal. Doctors are mobile during their medical training and we suggest that a national framework and terminology for coping with major disaster is urgently required.

REFERENCES

- Department of Health and Social Security (1977) Health service arrangements for dealing with major accidents. *Health Circular HC 1(77)*, January.
- Staff of the Accident and Emergency Departments of Derbyshire Royal Infirmary, Leicester Royal Infirmary, and Queen's Medical Centre, Nottingham (1989). Coping with the early stages of the M1 Disaster: at the scene and on arrival at Hospital. *British Medical Journal* **198**, 651–654.