NOTE OF A MEETING TO DISCUSS HPSS STRATEGIC ISSUES ARISING FROM THE RESPONSE TO THE OMAGH BOMB HELD IN ROYAL ARMS HOTEL, OMAGH, FRIDAY 23 OCTOBER, 1998

1. INTRODUCTION

1.1. A list of officials attending the meeting is attached. Mr McGrath, HSS Executive opened the meeting and explained that the purpose of the debrief was to examine strategic issues arising from the HPSS response from the time of first alert on Saturday, 15 August to the time the last body was identified on Sunday 16 August. He advised that the debate should be open, concise, positive, constructive and non-defensive.

2. COMMUNICATIONS

2.1. Deficiencies and lack of effectiveness in the current NIAS radio system which has been operational for 7 years were discussed. It was noted that the Northern Ireland Ambulance Service operated a "closed" emergency channel whereas the other Emergency services had a dedicated "open" channel which facilitated two-way conversations between mobile units without the necessity to route messages via a central control.

2.2. It was considered desirable to have the capacity for on-line medical advice between emergency ambulances and receiving hospital's A&E Department and it was recalled that the LAP initiative for the use of dedicated mobile phones to accomplish this has been agreed by the Eastern and Southern Boards. A number of blackspots were identified in the 1997 survey and a further survey will be carried out. The HSS Executive noted that it would be desirable for the initiative to be extended to the Western and Northern Boards.

2.3. Although it was recognised that the whole issue of effective communications would be within the remit of the recently announced strategic review of Ambulance Services, it was agreed that NIAS should consider submitting a business case to the HSS Executive and Health Estates for review of the radio

system including proposals for NIAS access to the emergency channel. Communications with other emergency services and hospitals should also be an integral element of the review. Batteries on hand-held radios should be immediately replaced and this should enhance their effectiveness.

2.4. Concerns were expressed about the lack of information for secondary receiving hospitals about the numbers and type of casualties in transit to them. Communications between hospitals and helicopters cannot be obtained as the NIAS does not have access to military frequencies. It was suggested that the NIAS must ensure that information from the Ambulance Loading Officer at the incident site or despatching hospital is relayed to the receiving hospital including details of any casualties being transported by helicopter.

2.5. Communications among the emergency services and the health service could have been enhanced by predetermined location for silver tactical and gold strategic control of the incident with input from senior health service managers in addition to NIAS representation.

2.6. Physical damage to the BT network diminished the availability of "normal" telephone linkages although it was noted that the inter-hospital network continued to function during the Omagh incident but was not at optimum use. Additional land lines should be obtained for hospitals with unpublished numbers.

2.7. It was suggested that hospitals should seek to develop a "cascade" system for alerting relevant staff in the event of a major incident.

2.8. Sperrin Lakeland Trust indicated that its community-based Emergency Plan was entirely reliant on the existence of an effective communication network and accordingly, they were reluctant to restrict access to the system in case numbers had not been registered. The Northern Ireland Ambulance Service indicated that it had requested the RUC to invoke the ACCOLC arrangements to restrict traffic on the mobile networks but that this had not been done partly because of

a perception that some essential users had not been registered. The RUC indicated that they had taken a deliberate decision on grounds of humanity, not to invoke the ACCOLC arrangements. It was agreed that there was an urgent need to review the arrangements for ACCOLC registration and the protocols surrounding its use.

2.9. It was agreed that NIAS and hospitals should designate appropriate staff as dedicated communications officers during major incidents.

3. TRANSPORT

3.1. It was reported that over 200 casualties presented at the Tyrone County A&E Department within 20 minutes of the explosion and it was agreed that self-evacuation to hospital by the general public from urban incident site could not be controlled. Transport on the day took the form of ambulances, private transport and an Ulsterbus which was commandeered by the RUC.

3.2. Accordingly, there is a clear need for effective command and control arrangements at BOTH the scene of any incident and at the local A&E Department

3.3. It was reported that considerable confusion existed about the arrangements for secondary transfer from the local hospital to other receiving hospitals. There had been little evidence of a coherent approach in the selection of patients to be transferred by helicopter. It was agreed that access must be controlled by the Ambulance Loading Officer at each hospital egress point. Access to the egress point must be controlled by hospital security staff and the RUC if necessary.

3.4. Similarly, secondary receiving hospitals were often unaware of the number or condition of casualties in transit to them, whether by road or helicopter. This tended to preclude effective preparatory work at the receiving hospital and it was agreed that information on transport arrangements, ETA and condition of casualties must be sent to receiving hospitals by the NIAS Control.

3.5. NIAS staff should also receive training in helicopter loading and unloading of casualties and safety arrangements. Local army units may be able to assist the training. The provision of a dedicated Helipad, adjacent to the A&E Department was considered an essential feature.

3.6. It was also agreed that the RUC could provide transport for medical teams to incident sites in remote locations or during prolonged entrapment of casualties.

4. CASUALTIES

4.1. It was reported that the incident had been particularly stressful for the staff at Trusts and Human Resources Tyrone County Hospital partly because of the scale of the event and the number of casualties presenting at the A&E Department, but also because of the nature of the local community where many of the casualties were well known to the staff on duty. The primary concern was to carry out an effective triage on the casualties who had arrived, to decide on the most appropriate source of effective treatment and to make appropriate arrangements for their transfer following stabilisation.

4.2. Tribute was paid to the manner in which staff had responded to news of the incident and there were many instances of off-duty staff returning voluntarily to offer their services. There were also instances of medical and nursing staff from other locations arriving to offer assistance. This was recognised as a potential medico-legal problem and it was agreed that hospitals must ensure that the status of volunteer doctors and nurses is confirmed before deployment on clinical duties. Dual registration of nurses in border counties should also be encouraged.

4.3. It was recognised that the nature and extent of an incident would largely determine whether the optimum course of action would be to bring additional teams to the hospital and/or disperse patients to other hospitals after triage and stabilisation procedures. It was generally agreed that this decision should be taken locally in the light of the scenario. It was regarded as significant that,

despite the scale of the explosion, there had been no instances where casualties had been entrapped within buildings for a lengthy period. Clearly there would be instances where the services of a specialist unit eg burns or traumatic head injury, where reliance would automatically be placed on the Regional services. Additionally, the scale of the event might itself overwhelm the physical capacity of the services available at the local hospital and no amount of additional surgical teams could operate effectively in the absence of available theatres.

4.4. It was reported that the senior clinician had carried out the triage within the primary receiving hospital and it was considered essential to have appropriate arrangements in place to effectively manage the transfer of patients to appropriate specialist centres..

4.5. It was noted that the vast majority of surgical work carried out at both Tyrone County Hospital and at South Tyrone Hospital had been done by General Surgeons with considerable experience. Concern was expressed that specialist surgical training arrangements may have the effect of reducing smaller hospitals capability to respond during major incidents..

4.6. Altnagelvin Hospital confirmed that the right decisions on triage had been made in Tyrone County and that appropriate documentation had accompanied the patient. Of the 23 patients who arrived at Altnagelvin Hospital, all but 2 had been effectively stabilised prior to transfer. It was noted that Altnagelvin was undertaking a study of data on patient injuries and hoped to be in a position to develop an Injury Severity Score which would assist in determining clinical priority of patients. It was agreed that this should be extended to a Province-wide study. The Altnagelvin clinical summaries sheet should also be made available to all hospitals.

4.7. Some concerns were expressed about the difficulties experienced in tracking patients within and between hospitals, although Altnagelvin Hospital commented on the quality of the documentation which had accompanied the patients transferred to its care. {See Documentation}.

4.8. The sheer scale of the incident had resulted in numbers of casualties presenting at the normal A&E Department which had completely swamped its resources. Overspills had been successfully accommodated in the out-Patients Department which was not in use (the incident was on a Saturday). It was agreed that it would be helpful if additional areas for treatment of casualties during large scale incidents could be identified in hospital major incident plans. Similarly, the use of GPs co-operatives and other out-of-hours arrangements could usefully be included in hospital major incident plans as an additional resource.

4.9. It was suggested that elements of the current MIMMS training (with particular reference to Triage sieve and Triage sort could also be suitable for use in hospitals major incident response. It was considered that appropriate elements of the MIMMS training could be cascaded by preparation of teaching packs for one or 2 hour lectures in hospital.

4.10. NIAS co-operation with the Republic of Ireland should be extended.

4.11. NIAS officer on-call system should also be addressed.

4.12. The disruption to the normal work of the Tyrone County Hospital had been minimal due to the time and day on which the incident had occurred. Fortuitously this had facilitated the flexible use of off-duty staff and facilities which would otherwise have been in use. It was considered that all hospital major incident plans should include planning for business continuity.

5. DOCUMENTATION

5.1. It was considered that, so far as possible, hospitals and NIAS day to day documentation should be included in major incident documentation as this facilitates familiarisation by staff and does not call for a dramatically revised procedure in the event of a major incident. Altnagelvin Hospital noted the high quality of the clinical information which had accompanied patients transferred to their care. It was reported that the Cambridge Cruciform Triage Card (CCTC), which had been issued to Northern Ireland Ambulance Service and to all A&E Departments had not been employed on this occasion by any of the hospitals involved or by the Northern Ireland Ambulance Service.

5.2. It was generally accepted as good practice that documentation of casualties during major incidents should include provisions for clinical audit of patients from pre-hospital care to hospital treatment. It was considered that the dynamic use of the CCTC should provide an accurate contemporaneous account of the care of the individual to whom it relates.

5.3. During major incidents the HPSS has to provide patient names and addresses to other key services ie RUC and staff manning the relative centre and this has the potential to cause problems of confidentiality. Altnagelvin Hospital reported that the arrival of an RUC documentation Team had been very helpful in freeing staff resources within the hospital. It was agreed that formal protocols relating to the release of information should be developed.

5.4. A Casualty Bureau had been established by 1645 hrs and a public call line with 10 lines was established by 1845 hrs but RUC did not have sufficient resources to deal with the volume of calls during the incident. The RUC is now linked to the North West police region and has the potential to receive Casualty Bureau support from 8 other police forces in the North West region during major incidents. The RUC also has not completed training in the new casualty bureau documentation system.

5.5. The establishment of a Relatives' Centre in the local Leisure Centre was highly commended as it moved the focus of the incident away from the local hospital. Problems had arisen, however, because of the public failing to ring back to eliminate names of missing persons who had subsequently turned up safe, or whose whereabouts were otherwise satisfactorily accounted for. This had tended to delay the close down of the incident.

5.6. Hospitals non-clinical staff and social services staff can be used to assist the documentation process by recording data such as dates of birth or age and gender in the documentation form.

6. FOREIGN NATIONALS

6.1. The incident had been unusual in that it involved a number of foreign (Spanish) nationals. Basic communication had not been a significant problem, although the age of some of the casualties meant that they required a greater degree of physical and emotional support than older casualties. Consideration had been given to contacting local educational (including F/E) establishments to identify individuals with appropriate linguistic ability in the immediate area. In addition, it was reported that RUC Aliens Branch maintains a database of foreign nationals (who might be approached to provide translation services.

6.2. Altnagelvin has identified a standard booklet which asks questions on medical assessment in 30 languages. This was considered helpful and it was suggested that each A&E Department should carry a copy for reference purposes.

6.3. It was reported that a medical team of Spanish clinicians had arrived with a minimum of advance notice. They had arrived at Altnagelvin Hospital and were seeking to treat Spanish nationals in the Intensive Care Unit. This had caused some degree of confusion for the local hospital staff and it was agreed that it would be helpful to develop protocols for the deployment of any foreign clinical staff.

6.4. Reference was made to the very different attitudes held by persons of differing religious faiths and even between persons from different European cultural backgrounds. It was considered important to recognise these differences and some difficulties had arisen with the Coroner's Office over the issue of the appropriate documentation to allow the release and repatriation of one of the Spanish victims of the incident. It was considered that, as a minimum hospitals and community major incident plans should include arrangements for burial requirements of various faiths.

7. MEDIA

7.1. It was recognised that the media had an important role to play in the effective dissemination of accurate information, and that, properly handled, they had the potential to provide a positive contribution to the overall management of the aftermath of a major incident. The proactive use of media informs the public and provides support to the local community.

7.2. It had been decided that all contact with the media would be by way of regular Press Conferences rather than a single spokesperson. Accordingly, it was important to convey the right messages and the issue of media liaison was a feature of the Senior Management Team meeting each morning immediately following the incident.

7.3. It is desirable to establish any media centre within hospital grounds but away from the main A&E Department in the hospital. In the case of the Tyrone County Hospital it was established in the Post-Graduate Centre.

7.4. Additional PR resources have to be deployed at the start of an incident. The Association of Health Care Communicators has agreed to send back-up resources to any hospital in Northern Ireland.

7.5. It was recognised that circumstances could arise when a Trust decides for operational reasons to close down media access. This could be on account of staff fatigue or to enable a more strategic overview of all the available

information. It was reported that the media generally had no problem with this approach although it was important to gain their confidence by ensuring that all appropriate staff are available for interview when media access is re-opened, and that all possible gaps in data have been filled..

8. RESUPPLY

8.1. It was reported that an incorrect message had issued via the media on requirements for blood donors, which were not in fact requires as the NIBTS supplies were adequate for the purpose. The broadcast had significantly increased the unnecessary volume of calls to hospitals, which tied up the hospital switchboard and carried the potential to disaffect prospective blood donors by refusing their offers. As with the Communications and Media sections it is important to have in place robust systems for the effective management of information to the public, and to maintain the capacity to effectively rebut erroneous statements.

8.2. Northern Ireland Ambulance Service reported that it had identified a need for replacement uniforms which rapidly became contaminated with bodily fluids. Additionally there had been instances where ambulance equipment eg defibrillators and oxygen giving sets were transported with casualties by helicopter and accordingly, "lost" to the system. It was recognised that arrangements must ensure specialist equipment, clothing and resupply is available at strategic locations.

8.3. The RAS Medical Centre, Aldergrove was not permitted to assist in the Omagh response but holds medical supplies for air evacuation of casualties.

8.4. Equipment lists for use in army helicopters for air evacuation should be prepared.

8.5. There was an important dimension in the need for stocks of consumable items eg food (especially baby food), disposable nappies and blankets, at any centres identified for the reception of uninjured relatives.

9. SUPPORT TO PATIENTS, RELATIVES AND STAFF

9.1. It was recognised that meeting the spiritual needs of relatives of those killed and injured was a vital dimension in the immediate aftermath of an incident and it was considered that it would be useful to develop protocols for social services staff to work with clergy, voluntary organisations and district councils. Such protocols should be included in major incident plans.

9.2. It was clearly recognised that staff are not immune to the stresses involved in such situations and Boards, Trusts and Agencies have a duty of care to ensure all necessary and appropriate support is offered to staff on an ongoing basis.

10. PRODUCTS

10.1. Mr McGrath closed the meeting and indicated that a note of the proceedings woul;d be circulated in due course. He also gave an undertaking that all the various issues identified would be addressed.

Altnagelvin was undertaking a study of data on patient injuries to develop an Injury Severity Score which would assist in determining clinical priority of patients. Altnagelvin Province wide study to be completed May 1999.	4.6
Altnagelvin clinical summaries sheet should also be made available to all hospitals.	4.6
Additional areas for treatment of casualties during large scale incidents should be identified in hospital major incident plans.	4.8
Element of the current MIMMS training (with particular reference to Triage sieve and Triage sort could also be suitable for use in hospitals major incident response.	4.9
Appropriate elements of the MIMMS training could be cascaded by preparation of teaching packs for one or 2 hour lectures in hospitals.	4.9
NIAS co-operation with the Republic of Ireland should be extended.	4.10
NIAS officer on-call system should also be addressed.	4.11
All hospital major incident plans should include planning for business continuity.	4.12
So far as possible, hospitals and NIAS day to day documentation should be included in major incident documentation.	5.1
The dynamic use of the CCTC should provide an accurate contemporaneous account of the care of the individual to whom it relates.	5.2
Formal protocols relating to the release of information should be developed.	5.3
Non-clinical staff and social services staff can be used to assist the documentation process.	5.6
Each A&E Department should carry, for reference purposes, a copy of a standard booklet which asks questions on medical assessment in 30 languages. Communimed Multilingual Patient Assessment Manual Moseby Lifeline ISBN 0-8151-5241-8.	6.2
It would be helpful to develop protocols for the deployment of any foreign clinical staff.	6.3

ACTION	PARAGRAPH
LAP initiative for mobile phone contact between emergency Ambulance and hospitals should be extended to Western and Northern Boards.	2.2
NIAS business case to review the radio system and include provision for emergency channel.	2.3
Batteries on hand-held radios should be immediately replaced.	2.3
Hospitals should seek to develop a "cascade" system for alerting relevant staff in the event of a major incident.	2.7
Urgent need to review the arrangements for ACCOLC registration and the protocols surrounding its use. THRD completed action March 1999 for ACCOLC registration of HPSS mobile phones. List passed to Central Secretariat EPU for Home Office registration.	2.8
NIAS and hospitals should designate appropriate staff as dedicated communications officers during major incidents.	2.9
Need for effective command and control arrangements at BOTH the scene of any incident and at the local A&E Department.	3.2
Secondary transfer from the local hospital to other receiving hospitals must be controlled by the Ambulance Loading Officer.	3.3
Access to the egress point must be controlled by hospital security staff and the RUC if necessary.	3.3
Information on transport arrangements, ETA and condition of casualties must be sent to receiving hospitals by the NIAS Control.	3.4
NIAS staff should also receive training in helicopter loading and unloading of casualties and safety arrangements.	3.5
RUC could provide transport for medical teams to incident sites in remote locations or during prolonged entrapment of casualties.	3.6
Hospitals must ensure that the status of volunteer doctors and nurses is confirmed before deployment on clinical duties.	4.2
Dual registration of nurses in border counties should also be encouraged.	4.2
Essential to have arrangements in place to effectively manage the transfer of patients to appropriate specialist centres.	4.4

Hospitals and community major incident plans should include arrangements for burial requirements of various faiths.	6.4
Media liaison should be a feature of the Senior Management Team meetings following an incident.	7.2
It is desirable to establish any media centre within hospital grounds but away from the main A&E Department.	7.3
Important to gain media confidence by ensuring that all appropriate staff are available for interview when media access it re-opened, and that all possible gaps in data have been filled.	7.5
Important to have in place robust systems for the effective management of information to the pubic, and to maintain the capacity to effectively rebut erroneous statements.	8.1
Arrangements must ensure specialist equipment, clothing and resupply is available at strategic locations.	8.2
Equipment lists for use in army helicopters for air evacuation should be prepared.	8.4
Useful to develop protocols for social services staff to work with clergy, voluntary organisations and district councils. Such protocols should be included in major incident plans.	9.1
Boards, Trusts and Agencies have a duty of care to ensure all necessary and appropriate support is offered to staff on an ongoing basis.	9.2

NAME	TRUST/BOARD/DHSS ETC.
Hugh Mills	Chief Executive, Sperrin Lakeland
David Bolton	Director Community Care, Sperrin Lakeland
Eugene Fee	Director Acute Hosp Services, Sperrin Lakeland
Dr Garrett	Consultant Physician, Sperrin Lakeland
Mr Pinto	Consultant Surgeon, Sperrin Lakeland
Mrs Glynis Henry	Clinical Services Manager, Sperrin Lakeland
Mrs Maureen Gormley	Information Services, Sperrin Lakeland
Dr Clive Russell	Medical Director, Sperrin Lakeland
Gabriel Carey	Director Mental Health & Elderly, Sperrin Lakeland
Mrs Stella Burnside	Chief Executive, Altnagelvin
Dr Raymond Fulton	Medical Director, Altnagelvin
Miss Irene Duddy	Director of Nursing, Altnagelvin
Mr Tom Melaugh	Director Clinical Supp Services, Altnagelvin
Mr Alan McKinney	A&E Consultant, Altnagelvin
Robert Sowney	Clinical Nurse Specialist, A&E, Armagh&Dungannon
Mr Peyton	Consultant Surgeon, Armagh & Dungannon
Gerry Carson	Director Corporate Affairs, Royal
Mr L Rocke	A&E Consultant, Royal
Dr Brian McNicholl	A& E Consultant, Royal
Dr Hilary Johnston	Anaesthetist, Royal
Sister Helen Patterson	Sister, A&E, Royal
Jim Symington	Dir Corporate Services, Ulster Comm & Hospitals
John Martin	A&E Consultant, Ulster Comm & Hospitals
Paul McCormick	Chief Executive, NIAS
Artie McMurray	Divisional Officer, NIAS
Jim Christie	Director of Operations, NIAS
Alan Cahill	Divisional Officer, NIAS
Dr B McConnell	WHSSB Director Public Health
Dr Paul Darragh	EHSSB, Public Health Consultant
Dr Campbell	Chief Medical Officer (CMO)
Dr P McClements	CMO's Office
Mary Hinds	Chief Nursing Officer's Office
Paul Martin	Social Services Inspectorate
Dominic Cafolla	Health Estates
Brian Godfrey	Health Estates
Jim Hamilton	DHSS Information Office
Don Norrie	Central Secretariat, EMP
Harry Whan	Central Secretariat, EMP
Julie Morgan	Central Secretariat, EMP
John McGrath	HSS Executive, THRD
John Townson	HSS Executive, THRD
Christine Campbell	HSS Executive, THRD
Maureen Johnston	HSS Executive, THRD

NAME	TRUST/BOARD/DHSS ETC.
Geoff Geddis	Blood Transfusion Service
Gerry Killen	Sites Co-ordinator, Ulster Community & Hospitals HSS Trust
Dr Duncan McPherson	Dept of Health, EMP Co-ordination Unit
Doctor	Medical Centre, Lisanelly Barracks, Omagh
Nurse	Medical Centre, Lisanelly Barracks, Omagh
Superintendent Baxter	RUC Omagh Sub Division