Pine Lake Tornado

To the editor:

I would like to acknowledge the important points raised by Barker and Jarvis [1] in their letter to the editor. As part of an urban tertiary care service that arrived early in the response it is my opinion that the rural and regional scene management was extraordinarily well done. I agree that most discussions both in print and at various debriefing sessions seem to centre from an urban perspective on what could have been done differently at the rural scene. The rapid extrication of patients from this scene was a success. Key learning points may have been underemphasized.

I played a small role, rather than hinder in triage and transport selection due to the organization of the scene by rural and regional services. The first rural services on scene were confronted with overwhelming numbers of victims needing care. Yet these individuals had the disaster training, foresight and strong will required to stick to resource notification and scene set-up. Later, rural emergency medical technicians, physicians and nurses provided invaluable reassurance and aid to the victims in the triage areas.

To briefly review the scene, there were approximately 90 stretcher patients, and approximately 30 of these were triaged critical (red). Initial estimates had us expecting 200 to 300 stretcher patients. The tornado occurred between 1830 and 1900 hours. The calls for mutual aid went out by 1913 hours. The triage and transport centre was in full operation by approximately 2030 hours. All patients were directed to the "Lead Hospital" from scene (although some were redirected to other destinations by various services enroute). The last stretcher patient was clear of the scene at 2226 (approximately 2 hours from set-up)! Despite the critical nature of the injuries there were no fatalities in the triage area or in transport. I believe the ingredients for success of this disaster scene were as follows.

1. Early call for mutual aid ("Got big fast")
2. Early scene control
3. Geographic layout/organization
4. Light structural objects
5. Prompt mutual aid responses
6. Minimized on-scene treatments
7. Visual systems for directing and organizing resources

To name some highlights of the many debriefings that have occurred since the tornado, the following elements have been recurrently identified.

1. Improved communications systems
2. Uniform disaster courses for wider interest groups (to include rural and tertiary care hospitals)
3. Common disaster management models for uniform terminology and systems (items 2 and 3 would reduce need for some communications)
4. Patient tracking service (build a real-time evolving medical problem list from scene triage through to definitive care and make available to an Emergency Operations Centre [EOC] and receiving hospitals by Web site, or updating faxes)
5. Rapidly deployed EOC (in addition to scene command), to which all information pools may aid in steering resources and patients to the most appropriate destinations

By operational definition, a "disaster" overwhelms available resources. Hence, by the very nature of the event, it is difficult for any responding agencies or individuals to serve without being exposed to retrospective critique — often misdirected. I will never forget how well the local agencies responded to this event, how quickly the tertiary care centres provided help, or how brave the victims were.

Lance Shepherd, MD
Shock Trauma Air Rescue Service
Calgary, Alta.

Reference

1. Barker E, Jarvis R. Pine Lake Tornado: the rural response [letter]. CJEM 2001;3(3):178.

For reasons of space, letters may be edited for brevity and clarity.

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