(500–5000) needing emergency care in the prehospital and hospital settings. This type of event usually goes beyond the capabilities of a certain region and requires reinforcement of resources from adjacent and remote regions. Due to its exceptional nature, a MMCE dictates a different organization of all emergency services and agencies involved. As a result of the recent experience, and in order to adequately prepare for such future events, a novel MMCE doctrine was developed by a committee of diverse emergency professionals. This doctrine was transferred to guidelines referring to MMCE recognition and the following series of actions that need to taken at all levels. It holds organizational, operational, and clinical aspects, as well as command and control elements. In November 2009, a large-scale drill of 1,000 mock casualties was performed in order to validate and evaluate the MMCE plan. This drill emphasized the need for the involvement of all pertinent emergency services and agencies, and their optimal collaboration and coordination, subjected to regional and national headquarters' command and control. In addition, the need for dedicated educational programs and o-going training was recognized. It was accepted that adequate planning is obligatory for better outcomes in the future.

Prehosp Disaster Med 2011;26(Suppl. 1):s63–s64
doi:10.1017/S1049023X11002196

(A234) Disasters as an Opportunity to Train and Prepare for Future Disasters

T. Ranasinghe,[1] E.K. Vithana,[2] H. Herath,[2] L. Pattuwage[3]

1. Ministry of Health, Colombo 10, Sri Lanka
2. Colombo, Sri Lanka
3. Melbourne, Australia

Asian tsunami in 2004 had a tremendous impact on the health system of Sri Lanka leaving many healthcare institutions damaged in the costal provinces and destabilizing the healthcare delivery network. Immediately after the tsunami, health authorities in Sri Lanka realized, health workers should be prepared well if they are to face any future disasters successfully. In this background, the Ministry of Health set its agenda to train all levels of health cadres on disaster preparedness and mitigation whenever there are opportunities. Ministry of Health established the Tsunami Rehabilitation Unit (TRU), later renamed as Disaster Preparedness and Response Unit (DPRU) and mandated it to prepare the health sector for future disasters. During a disaster, well trained health cadre is an asset to any health manager facing the burden of the emergency at the ground level. Trained health personnel on disaster management become a human resource multiplier to fill the gaps of scarce skilled health staff in the field operations. We reviewed the Ministry of Health reports, plans, meeting minutes, reports of training institutions, routine reporting from Ministry of Health departments and reports from health sector partners to compile and then analyze to construct this case study. We provide an overview of how DPRU coordinated and used the opportunities following Tsunami 2004 and then during the humanitarian crisis at the end of 30 years of armed conflict in 2009 to train the health staff. This case study also describes how DPRU networked with government and non governmental organizations to train the different categories of government health staff.

Prehosp Disaster Med 2011;26(Suppl. 1):s64
doi:10.1017/S1049023X11002202

(A235) Australian Medical Assistance Teams in Australia

A.G. Robertson,[1] M.G. Leclercq,[2] S. Poke[1]

1. Disaster Management, Regulation and Planning, East Perth, Australia
2. Disaster Preparedness and Management Unit, East Perth, Australia

Western Australia (WA) was one of the first states in Australia to deploy medical team members to the tsunami-stricken regions of the Maldives and Banda Aceh in 2004. This early experience led the WA Department of Health to develop and pilot these teams locally and to progress a national model for their future development, which could be implemented further by other Australian jurisdictions. Further experience with these teams in Yogyakarta after the 2006 Java earthquake, Karratha after Tropical Cyclone George in 2007, Ashmore Reef after the 2009 boat explosion, Samoa after the 2009 tsunami, and during the Pakistan floods in 2010 have signaled both the utility of the Australian Medical Assistance Teams (AUSMATs) and the commitment by the Australian Commonwealth and State Governments to utilize these teams in both domestic and international settings. This presentation will examine the implementation of the AUSMAT model in Australia over the last five years, the modifications to the original model to suit the unique geographical and resource challenges faced by Australian teams, both within and outside Australia, and the lessons learned from recent team deployments. The challenges of delivering health care over vast, sparsely populated distances, and the inherent and increasing natural and industrial disaster threats in the Asia-Pacific region, have contributed to the modification of the model to ensure that the AUSMATs are flexible, modular, and capable of responding to a variety of major incidents. The national model continues to evolve to ensure that well prepared, equipped and trained civilian AUSMATS remain able to effectively deploy to a mass casualty situation in Australia's area of interest.

Prehosp Disaster Med 2011;26(Suppl. 1):s64
doi:10.1017/S1049023X11002214

(A236) National Guidelines on the Management of the Dead after Disasters

J.R. Bhardwaj,[1] T.S. Sachdeva[2]

1. Gurgoan, India
2. Medical Preparedness, New Delhi, India

Despite technological advancements, India is vulnerable to disasters. Disasters of any etiology have the common denominator of a large number of deaths in a short span of time. Thus, the Administration is saddled with the indomitable task of retrieving and recovering dead bodies, then identifying them to enable the handing over of the remains to their next-of-kin. Initial media focus is often based on the myth that dead bodies cause epidemics. Therefore, bodies often are placed in mass burials or mass cremations universally, without being identified and without preserving the individuality of the deceased. This culminates into social, psychological, emotional, economic, and legal repercussions (financial compensation, property rights, inheritance, and issues of remarriage) regarding the legacy of the deceased, thereby exacerbating the damage caused by disasters. With the paradigm shift from the erstwhile response-centric approach after the enactment of the Disaster Management Act in 2005, to the holistic management of disasters, the National Disaster