found their telephones so jammed they couldn't reach their own offices. Staff found it impossible to call out as all the outside lines were tied up.

The police had problems calling in extra personnel.

The airlines phones were completely jammed. The head of its security department finally borrowed San Diego police radios so he could keep in touch with developments on site.

Even though both fire and police rolled their communications command vehicles to the scene within minutes of the incident, the two could not communicate with each other. The fire command vehicle had only a fire radio while the police vehicle had only its own police radio, an outside phone line which was kept opened as a direct link to Headquarters, and a radio-telephone which did not work properly.

The radio telephone did carry some sporadic calls into the van. Unfortunately there came from agencies other than the police, mainly the media, and became a problem rather than an asset.

About an hour into the incident, fire and police exchanged liaison officers carrying portable radios, primarily because of problems caused by the abandoned police vehicles.

At the crash site itself communication was made difficult by the noise from helicopters overhead. These flew low enough to make hearing difficult.

One fire captain found it so noisy he had to send a runner to his engineer manning water pressure controls at the pumper.

When the police decided the helicopter could provide useful information about the scene from its overhead vantage point, they discovered it was impossible to make contact. The Sheriff's Department radio frequencies were different from those used by the City police force.

In the police mobile command vehicle, communications were constantly disrupted by staff walking in and out, making it impossible for the police commander to hold discussions or meetings.

Communications overload on the police radio also made it difficult to monitor who was doing what. The police were never quite sure what personnel they had on site and where they were.

Problems also arose when a tactical radio frequency was used. They soon discovered the hilly terrain made it difficult to get messages through. Portable radio battery problems made the situation still worse. One police officer would often have to repeat what another had said.

The biggest problems, however, related to the ambulances. Although police ambulances and private ambulances both carried the station X frequency, it was not normally used except to communicate with hospitals when transporting patients. Because there were no victims, the ambulances were not in touch with each other or with the hospitals.

When the directors of emergency medical and the Red Cross arrived on site, they went to the police command post and didn't realize for some time that a separate fire command post had been set up. Similarly, when the medical director wanted to communicate with the County dispatcher, he discovered this wasn't possible from the police command vehicle and that the ambulances with radio contact were some blocks away.

There were also problem with outside agencies.

Fire vehicles could not talk to personnel from other departments without going to the shared fire channel. But if they did this, they couldn't talk to their own dispatcher or monitor their own department's activities.

There were other problems.

Firemen often could not recognize off-duty or plainclothes policemen. They had to keep asking these officers to identify themselves.

And a lack of communication between police, fire and paramedics resulted in the duplication of searches.

11. Perimeter Control

Initial problems with perimeter control stemmed from inability of many police officers, all of whom were trained medical technicians, to believe there was nothing they could to help the victims.

Even though it was mere minutes before those on site began to comprehend there were no survivors, convergence had already become a problem.

Those officers who then did begin to man a perimeter, those sergeants and later lieutenants who tried to organize

control, did go in a haphazard, unorganized manner. It was not until noon, when police observed the area by helicopter, that they realized cars were being rerouted in circles, and that the area of impact involved only two blocks. They were able to pull the perimeter in, making control more manageable.

The command post, however, did not at any time designate grid assignments to facilitate a more organized and effective control.

As a result, control of the area proved to be difficult.

Each individual officer was left to decide who should pass and who should not. There was no overall perimeter control and no designated entry or exit routes.

The problem was especially difficult because without adequate radio communication, police officers could not consult anyone of higher authority for information about who should and should not enter.

It was easier to simply allow any person who carried official identification into the area. Since no one initially knew what kind of response was necessary, it was difficult for these officers to turn anyone linked with emergency response away.

Navy personnel got through easily.

So did anyone who could identify himself as a peace officer.

So did the Salvation Army, the Red Cross and anyone who could prove he was a physician or nurse.

So did ambulance personnel, paramedics and other medically trained persons.

So did anyone who could produce something which seemed to indicate they had official status. One couple got through in a car bearing a hastily home-made red cross on a white background.

Others got through when they copied the yellow armbands PSA officials used. Once the danger from fire was over, it also became difficult to decide who else should or should not be allowed in. Many residents living within the perimeter and their friends and relatives wanted to find out if their homes or their loved ones were alright.

One police officer refused to let a man go down the street to see if his elderly parents were all right. They lived just two houses from the crash site.

Some of these problems were solved when the perimeter was called in at noon. Police eventually overcame the problem of distinguishing genuine relatives and friends from sightseers by having a runner bring a member of the family living in the area to the perimeter to verify requests for entrance.

Before the incident was over, however, police made 48 arrests: 41 for refusing to leave the area, four for drunkeness on site, and three for conflict with police on site.

12. Relief

For police, the problem of perimeter control was tied to the problem of relief.

Because so many police officers had responded to the scene on their own -- often without checking in, either over the air or with anyone on site -- the police incident commander had no idea who was on site and who was not.

This problem was exacerbated by the more than one hundred police officers who had also responded from other agencies.

As a result, relief was handled in a haphazard manner

One lieutenant, who had arranged to relieve some of the first officers to respond, discovered someone else had sent them back to work without a break. When he arrived at the police staging area adjacent to the on site command post, he discovered other men he had relieved were standing in line behind new arrivals, trying to get a cool drink. becoming angry, he ordered the new arrivals to move out of the way.

The problem was typical. One of the first responding officers found himself on perimeter duty for 12 hours. No one had ever debriefed him to find out what he knew, checked with him to find out how long he had been there.

As the day wore on, the Police Department started to call in off-duty officers to fill in for those who had already put in an exhausting day.

They discovered that many of these officers were already on site. They were among those who had responded without checking.

in, making it difficult for police commanders to find sufficient personnel for adequate relief.

Policemen often respond to incidents on their own initiative. Firemen usually go only when they are dispatched. For this reason, the Fire Department found it much easier to control its men.

The first fire crews were relieved when they had finished dealing with the fire. Physically exhausted, they were sent back to their stations after conducting a final search of the area.

Other firemen were then brought in to perform standby duties and to assist the Coroner's staff.

13. Utilities

In addition to causing damage to homes within the area of impact, the PSA jet also caused at least some problems for all four utilities -- water, telephone, gas and power.

When the plane hit, demolishing part of a house and bouncing off a curb, it punched a hole in a water-main. This water leaking to the surface, and several hydrants dry just south of the point of impact.

The first responding fire crews had headed for one of these hydrants but were forced to make an adjustment in their plans when they found it dry. Damage to the water system did not severely affect the way firemen handled the fire. There were no problems with water pressure as the city's grid system guaranteed the immediate isolation of the break.

In addition to damaging a water-main, the plane also knocked down telephone and power lines, and cut off a number of gas meters and risers -- gas pipes above the ground. These breaks caused natural gas leaks which fed the fire until workers could shut the supply off.

Crews were on site within minutes as the power company worker who was in the area at the time of impact immediately notified his dispatcher, who operates in the same room as the gas company dispatcher.

Damage to the telephone system was minimal. Most of the phones affected were within a block of the crash.

This did cause some problems, however, when families in the area could not call out, and friends and relatives could not contact them to find out if they were safe. The Red Cross handled

more than 800 queries from persons unable to reach friends and relatives.

Although actual damage to the telephone system was limited, the system did run into other problems. There were so many calls to key agencies that they found it impossible to operate. Even station X could not get information, partly because the private ambulance company's lines were jammed.

Despite these problems, the telephone company did not institute line load control, a system which gives priority service to pre-designated agencies.

The power problems were more widespread. Impact knocked out power in a wide area, leaving about 10,000 homes without electricity. Firemen didn't know this -- they had to assume downed power lines throughout the site might be live, and carefully avoided them while fighting the fire.

Lines to the area were quickly separated from the main system by the first responding power worker. Power was then restored to all but the handful of homes surrounding the area of impact.

The power worker then notified his dispatcher that downed lines in the area were not dangerous.

This information, however, was not reported to anyone at the scene. Since the power worker could not discern who was in overall command of the incident, he didn't know where to report in. Shortly thereafter he did relay the information, along with what he felt was the responsibility to pass it on where needed, to his supervisor who by this time had also arrived on site.

Nearly two hours passed before the fire dispatcher, on request from the fire crews on site, could get in touch with the power company dispatcher and notify those on site that the downed power lines were safe to handle.

14. The Cessna

Several persons who either saw the two planes collide or heard the impact -- the bang was big enough to be recorded on seismometers -- saw the jet hit the ground first. The Cessna came down much more slowly.

But even those who knew two objects had hit the ground responded almost exclusively to the jet crash site.

Many police and firemen at the scene, including some of those in charge, either didn't know about the Cessna or forgot about it as events developed at the PSA crash site.

Half an hour after the incident, the Cessna lay in the middle of a street, nine blocks from what remained of the PSA jet. Just one police officer and a small group of about 50 to 70 spectators responded.

There are a number of reasons why the Cessna attracted so little attention. Compared with the carnage brought about by the PSA crash, the loss of life caused by the Cessna was limited to two bodies, one of which remained trapped in the wreckage, while the other was thrown clear to a nearby roof.

The smoke rising from the PSA site was visible for miles, attracting the attention of all those responding to the incident. The Cessna crash did not cause any damage, start a fire, or disrupt telephone, power, gas or water services, thereby leaving few signs to indicate its existence.

Those signs which were visible, such as the debris found in the middle of the street, could not be seen from a distance further than a block or two, and were completely overshadowed by the highly visible smoke, and later convergence, at the PSA site. The jetliner crash was simply more dramatic than the Cessna crash.

That drama was heightened when news about what happened, conveyed by the media and by word of mouth, focused on the jet crash and not on the collision between the two planes.

Lindbergh tower did not report for some time that there had been a collision. Controllers knew the jet was down - the pilot had made this clear before impact. They knew the planes had been on a collision course, and they knew the Cessna had not acknowledged its last radio message.

But they did not know for certain whether a collision had occurred or whether both planes had gone down.

Persons going to the scene - whether for official reasons or just because they had heard of the crash - went to the jet crash site. The Cessna crash site was largely ignored.

15. The Media

Members of the media, as with all other organizations, converged quickly at the crash site, some in advance of most officials and onlookers.

Reporters and camera crews attending the gas vapour recovery system demonstration at a nearby service station simply ran or hopped into their vehicles and were among the first to arrive on site.

Within minutes media relations personnel from the police and Sheriff's departments also began arriving on site.

As the day progressed they experienced many problems, largely as a result of police problems with overall perimeter control.

Reporters continually walked in and out of the police command area, hampering operations.. On site, they walked all over the impact area, disrupting evidence, getting in the way of firemen, and upsetting residents with their questions and often aggressive attitude. Television crews persisted in shooting video tape of the carnage, asserting what they called a right to do so.

Some media personnel were eventually arrested and charged with refusing to leave the scene of an incident. The Police Department later followed through on these charges, and they stuck.

By noon the police media relations personnel did manage to rope off an area near the main impact site and opened it to the media. It was at this location that they began releasing information when it became available.

But it was impossible to manage the media in this way for two reasons. Because of the problems with perimeter control, media personnel were relatively free to wander throughout the site, talking to officials and witnesses along the way. They weren't forced to rely on the media relations officers for information.

Second, the roped-off press area was simply too small for the vast influx of media personnel. The officers eventually responded by setting up a second briefing site by the police command post at the high school. However, this site was too far away from the area of impact for most reporters and camera crews.

The outside media caused special problems. Unlike their local counterparts, they tended to arrive after the initial confusion had abated somewhat, and after overall organization had begun to fall into place.

They arrived after efforts to set up a perimeter had been initiated, and as such had more difficulty accessing the impact area. Television crews in particular wanted the same footage their local competitors had already been able to secure.

A Sheriff's Department media officer responded to the problem by organizing a media bus trip through the impact area to give all those who wanted it a clear view of what had happened.

A tour through the temporary morgue was also organized. One card giving access to the high school gym was issued to the press corps, who took turns using it to get the material they needed.

Rumours were also a problem. The media reported the Governor had been on the jet, and later stated it had been his son instead. Both stories proved to be untrue.

A police ambulance driver became distraught when informed by a reporter the infant he had transported to the hospital had died. It wasn't until he checked the hospital that he found out the story wasn't true.

The media published and broadcast reports of looting at the scene, describing how people were stealing watches, jewellery and other valuables belonging to the victims.

The rumour was actually verified by one of the police PR men whose confusion originated with another officer who had logged seven arrests under police code 459. That number should have been 409 -- failure to disperse. Code number 459 indicates looting.

Some first responding plainclothes and off-duty officers decided to pick up valuables scattered around the site, feeling this would help the Coroner and prevent possible looting.

Without uniforms to identify them, the unsuspecting media thought the officers were citizens stealing the valuables, a conclusion easily reached as the appearance of several men suggested they might be hoodlums, not officers working undercover for the Drug Squad.

Personnel at the on site police command post heard the looting rumour. It prompted them to issue an order requesting all such information be immediately reported to the command post.

The ECC at Headquarters set up a rumour control board, and actively monitored the media to correct any false reports.

Although some persons had been seen taking paper, debris and plane parts from the site as souvenirs of the incident, no one was ever seen taking personal possessions belonging to the victims.

The looting reports, however, received international attention. San Diego is still trying to live down its image of a city inhabited by unfeeling residents.

Media relations during the incident raised another problem.

At the time of the crash, San Diego's Fire Department did not have media relations personnel, but the Police Department did.

The media, therefore, received most of their information from the two on site police media spokespersons -- a police officer and a former newsman in full-time police employ.

As a result, the media depicted the incident and its ensuing response from a police perspective, making it sound as if the police ran the entire incident.

Even now, nearly seven years later, some police officers still don't know firemen also picked up body parts. The media's image of the incident has coloured memories of what happened, and has become a public account of the truth for most people.

Firemen, however, are a notable exception. They remember feelings of frustration upon learning no one talked about their hard work in containing the fire to prevent further damage and injury, and their cleanup efforts which further exposed them and others to the grisly horror of the crash.

San Diego's Fire Department has since discovered the value of public relations, both for its own public image and for the morale of its members, and now has a full-time media relations section.

16. **Relatives**

Although the media supplied constant bits of information on the crash, their accounts could not settle the demand for information from the relatives of victims in the planes and on the ground.

The information was also not detailed enough to allow many relatives to exclude as victims family members flying on other PSA flights, or living, visiting or travelling within the surrounding yet unaffected area on the ground.

PSA flew about 60,000 persons that day. Relatives of these passengers often knew they were flying PSA, but did not know the flight number or even whether they made their flight, and as uch, whether or not they were safe.

The airline could not immediately determine who was on the jet. As is normal with most flights, some passengers arrived too late, others not at all, and still others disembarked at Los Angeles, deciding at the last moment not to go on to San Diego.

This movement rendered the computerized passenger list unreliable. PSA officials had to go through ticket stubs by hand before being able to accurately determine who had been on the final and fatal leg of the jet's flight that morning.

The volume of calls into the airline's San Diego office, for information, jammed its telephone system. The company's security officer, a former San Diego policeman, was forced to call upon friends in the police departments to bring in radio telephones and vehicles equipped with radios to establish communications with the outside world.

Similarly, relatives of those living within the area of impact began calling the police, who referred them to the Red Cross which had set up an enquiry service to deal with just such calls.

One man, fearing his wife and young son had been hit, described them as having been enroute to a day care center at Dwight and Nile when the jet impacted.

A woman telephoned about her sister who lived in the area, and with whom she had been speaking when the phone suddenly went dead at the time of impact.

The Red Cross, through its investigators on site, soon established the mother and son, and the sister, were among the victims on the ground.

It normally informs people if they are sure persons are all right, but asks the Coroner to verify whether a family member has actually died.

17. Sccial Services

The Red Cross was also active in providing shelter, comfort, support and sustenance to residents who lost their houses, relatives of the deceased and officials having to cope with the emotional impact of the crash.

It set up an evacuation centre at a local rollerskating rink, a counselling service at the high school, and an on site rest area.

Only a handful of families lost their homes, leaving the evacuation centre unused.

Red Cross counsellors at the high school, however, were busy. They made use of classrooms to provide comfort and privacy

for the many grief-stricken relatives who turned up at the temporary morgue in search of family members.

The counsellors provided support and guidance to those residents who lost their homes, and arranged for them to receive money, clothes, shelter and other necessities such as medication to help them through their ordeal.

One couple arrived at the high school wearing only robes and slippers. All their other possessions had burned in the fire.

Another woman arrived wearing a kerchief. Undergoing chemotherapy treatment for cancer, she had lost her wig in the fire. Red Cross workers, noting the emotional significance of such an item, quickly provided her with a replacement.

The on site rest area became a haven for many exhausted officials and volunteers. It was well stocked with food and drinks. Red Cross workers administered first aid to those who suffered from minor injuries. And counsellors became a sounding board for those who found it difficult to cope with the grisly horror of the crash.

The Red Cross was not alone in providing support services.

The Salvation Army provided assistance on site.

A psychologist phoned the ECC, offering his help, although the department did not realize the necessity of his services until several days after the incident.

PSA arranged for a local hotel to stand by as an evacuation centre.

18. The Coroner

Once the fire was out and it became clear problems at the PSA crash site were with the dead and not with survivors, control of the area fell to the Coroner.

He began accessing personnel and resources from other agencies throughout the County of San Diego.

The planes collided and crashed over the City of San Diego, which maintains a number of its own agencies such at the police and fire departments.

Surrounding the City are other municipalities, some of which also maintain agencies exclusive to them. Others are serviced by agencies, such as the Sheriff's Department, which have jurisdiction in those areas of the county where there is no parallel local organization.

The Coroner's Office, however, has county-wide jurisdiction.

There are some peculiarities in this structure. Although Station X serves mainly those agencies lying outside the municipalities, it provides the medical radio link between both municipal and county hospitals, and between ambulances and hospitals throughout the county.

The only disaster plan available at the time of the crash was an overall county plan. The crash involved only one small section of the City of San Diego, which itself is only a portion of the county.

At the crash site most of the police and firemen, who often deal with sudden death, were well acquainted with the Coroner and his staff, and were well aware of his responsibilities.

One of the Coroner's deputies had been attending the death on Nile when the crash occurred, and was one of the first to reach the site.

The Coroner also became quickly involved. As a county official with an office radio link to Station X, he found out as soon as the hospitals were alerted.

The Coroner's office, however, like other agencies, soon ran into communications problems. The office's six telephone lines, with sequenced numbers, became completely tied up as soon as persons started calling. The Coroner and his staff were unable to call out for more information.

Neither the Coroner nor his staff carry radios, so once at the scene of impact they could not communicate with the office. Once mobilized on site, however, they quickly took control.

Realizing the casualty clearing station in the high school's gym would not be needed, they converted it to a temporary morgue.

Using county staff, they brought in vehicles and body bags, and with help from the Police Department and county

disaster office, they procured six refrigerated vans from a local grocery outlet to store the bodies both at the site and later at the County Morgue by the Coroner's Office.

Given the magnitude of the Coroner's task, policemen were recruited to help his small staff in recording any information at the site about various body parts. Firemen also helped by moving debris to find and expose any buried pieces.

Once these parts were tagged and transported to the gym in body bags, one of the Coroner's staff prepared a detailed description of each bag's contents. It was a huge task -- 350 bags were used for the 151 victims.

The Coroner also worked closely with the airline to gather information about passengers on the ill-fated flight. It was particularly helpful in providing information about the crew and dead-heading employees (PSA employees flying as passengers).

A pilot and stewardess, well acquainted with many of the victims, worked with the teams and the Coroner's Office, and provided such details as whether any of the passengers had worn jewellery, if they had any birthmarks or scars, their blood type,and whether any of the women wore IUDs. One stewardess was identified by the way she tied her scarf.

The Coroner and his staff also worked closely with the Federal Bureau of Investigation and with several dentists who matched fingerprints and dental records with the bodies.

Eventually, the seven persons killed on the ground, the Cessna's two pilots and all but three of the jet's passengers and its pilot were identified.

Although the teams found evidence that these four persons were on the aircraft, they could not identify their remains, a problem caused in part by over-enthusiastic policemen who picked up wallets and jewellery to avoid looting, but did not record where these items were found.

Despite this success in identifying most of the victims, the Coroner's staff were not able to determine the identity of many body parts. Four coffins were eventually filled with most of these pieces and with what was believed to be the remains of the four unidentified victims. These were buried in a common grave in San Diego. The remaining parts were cremated.

It's quite clear that search and rescue must take precedence over any other activity at a crash site. Such activity must be carried out even if evidence is destroyed.

But the experience at San Diego suggests that once it is determined there are no further survivors or injuries, failure to take immediate care that nothing is disturbed can hamper the later identification and investigation process.

19. Psychological Impact

The Coroner's staff was far too small to take care of the immense job of picking up body parts.

Police officers, mainly detectives, were therefore assigned to the job of picking up and bagging body parts. Firemen were also involved and helped by moving debris to expose hidden body pieces. Most of their work was concentrated in a small area where a heap of debris contained 51 bodies.

Many of them did this hour after hour. Some had reactions to the task that still give them nightmares.

Most retain vivid image of the scene. For once it was two hands clasped together, one with a wedding band, one without.

For another it was the image of a priest saying the last rites over a remnant of a body.

For another it was the endless bugs hovering over pieces of human flesh, and crawling up his arms.

For another, the smell of burning flesh lingers on.

One man can still not eat meat.

While a few policemen and firemen suffered emotional stress problems at the scene, most carried on. But after the incident, nine policemen resigned as a result of stress related to the incident.

The Fire Department did not run into similar problems. This appears to be related to relief and to the nature of what happened.

Firemen arrived on site with something to do. They were immediately busy, and had little time to think. Once the fire was out, they left.

More important, they left not to go home but to go back to their stations where they could sit and talk about their distress with co-workers, people with whom they live 24 hours a

day while on duty, and with whom they feel comfortable -- people who saw and worked within the same horror they had faced themselves.

It is perhaps significant that one fireman who still remembers the incident with some horror was assigned to clear the hoses of human remains that night, while most others were allowed to rest at their home stations.

The police, however, had a completely different experience. While firemen fought the fire, they stood by helplessly, watching and unable to help.

When their duties at the scene ended, they either went back to their one-man patrol cars or to a home where they found it difficult to relate their feelings to spouses and families. They didn't know how to even begin talking about the fingers and eyes and piles of human flesh they saw, and later helped collect for the coroner.

In 1978, most policemen felt they had to maintain a macho image, and were reluctant to admit they had problems. They tended to bottle their feelings up inside.

Shortly after the crash, the San Diego Police Department set up special counselling arrangements to help police and their families recognize and cope with the stress of dealing with such events.

The program proved particularly helpful when San Diego police dealt with the 1984 MacDonald's Restaurant massacre in San Ysidro.

Although this incident was in some ways more horrible than the PSA crash, and although many policemen did suffer emotional strain after seeing parents and children lying in pools of blood, no one was lost to the Department.

Counselling was immediately available for the policemen who were no longer as reluctant to admit their need for help.

20. In Retrospect

There were many problems at the 1978 PSA crash site.

Perimeter control was ineffective. As long as some sort -- any sort of identification was shown, persons were let through police lines. Control points where access could be monitored were not established.

The situation inside the perimeter was therefore chaotic. Hundreds of persons not necessary to the response moved freely about within the perimeter.

Outside, the situation was, if anything, worse. Vehicles were routed in circles. Streets and highways were blocked. There were no clear entrance and exit routes to and from the site.

Communications, within and among agencies, were inadequate. Though the police initiated the emergency medical response, they did not maintain communication with that system. Hospitals were not briefed about the incident.

The original medical centre -- destined to be a casualty clearing station -- was not established at one of the pre-designated schools. Instead, it was located at a school where supplied were not stockpiled.

Communications with other key agencies, such as those responsible for social services, were either inadequate or non-existant. No central, multi-agency Emergency Operations Centre (EOC) was ever established. And no one assumed overall command.

In some ways, little of this mattered. All the persons in both planes had died on or before impact. And except for two persons, those on the ground were either dead or safe.

Excepting the fire, the incident was over by the time those first responding arrived.

Although the problems with response had no effect on the handling of victims, they did create unnecessary strains on institutions such as hospitals, which had disrupted surgical and other procedures to stand by for a medical emergency which those on site knew would not happen.

They also left emotional scars on many of those who responded to the scene, but who stood by, helpless. These people never should have come.

The one question which comes to mind is what would have happened had there been mass casualties? Suppose many of the passengers on the PSA jet had survived and that many persons on the ground had been injured.

Under these conditions, the response would not have been acceptable.

Fighting the fire and treating the injured would necessarily have been simultaneous operations, involving consultation between the agencies responsible for the operations.

The decision to access a high school as a casualty clearing station, without medical supplies, would have been a serious error. The failure to establish entrance and exit duties would have been equally serious.

And the failure to establish a communications link with the emergency medical system would have been unacceptable

Given a situation involving victims, cooperation and coordination among various agencies -- police, fire, medical, social service -- would have been essential. Without this type of inter-agency integration, such a situation could not have been properly managed.

Experience indicates this type of integration, imperative to a successful response, occurs immediately only when an emergency plan has been drawn up and has become second nature to all agencies and personnel involved.

Initial response to any disaster will always be chaotic until the plan falls into place. At this point operations will become systematic and organized. Without a plan, however, the response remains chaotic and unorganized for some time.

Given no survivors, the handling of the PSA crash is understandable. But given survivors, it should have been -- and we believe would have been -- dramatically different.