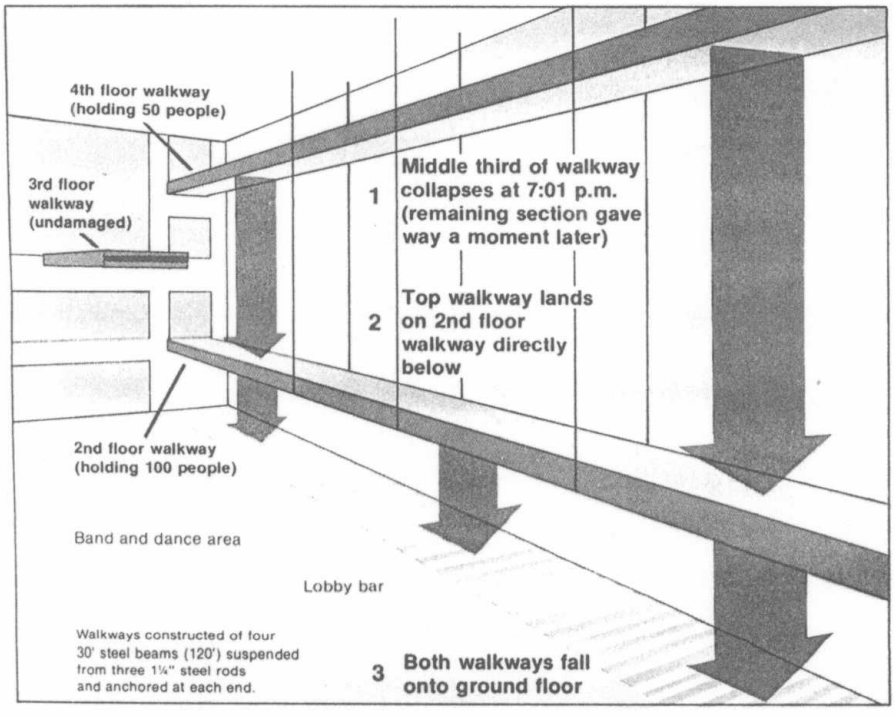
as they do in the books, an inside triage area is being established, and one hour after that, the whole system is starting to look like it's been there functioning that way for years. How did it happen?

First, we'll talk about the things we can explain:

The ASI Dispatch Center The Dispatch Center functioned amazingly well. In spite of some communications deficiencies, an antiquated dispatch console scheduled for replacement, and a recent takeover by a new Director of Dispatch Operations, the Center functioned beautifully. Only days before, Jack Morasch had written disaster protocols for the Dispatch Center and had in-service training for his dispatchers. But it also must be observed that the dispatch personnel responded resourcefully on their own. Finally, we believe it is reasonable to assume that a single dispatch center having continuous, complete, and exclusive control over every ambulance serving the City — emergency and nonemergency — greatly enhances the probability of superior coordination under periods of extreme stress.

Ambulance Disaster Response One of the reasons the system could place 14 paramedic ambulance units at the scene on a Friday night is that the system had 14 paramedic ambulance units that Friday night — it does every Friday night. If Kansas City utilized a different management model, it is likely that a two-tiered response would have resulted in some ambulances arriving at the scene with full paramedic capabilities, while others accustomed mostly to nonemergency work would have taken the place of additional paramedic units. We have always felt that a two-tiered system is undesirable, both financially and medically, for urban areas. And, if we had any doubts about this before, they are gone now.

The fact that all ambulance personnel serving Kansas City work for the same company and participate in the same in-service training program also contributed to the smooth response. As noted before, Doug Klote's disaster planning efforts and the associated in-service training programs have only recently been instituted at ASI, but the fact is that virtually every ambulance crew member serving Kansas City has been trained in the same procedures by the same instructors. Furthermore, these people work together every day. They do not work for competing private companies, and they do not work for one public agency trying to outdo another for the public relations limelight. At the scene, they knew each other by sight, understood each other's capabilities, and that probably contributed to the relative ease with which natural leadership patterns developed. More on that a



14 Hours

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also have been received, and it is clear to the dispatch center that a major emergency is in progress. All administrative people have been ordered in by the Dispatch Center, including MAST and ASI people, as well as personnel from MARCER, the regional EMS agency. The Hospital Association has been notified and is preparing to issue the standby for a Type 2 alert. Four ambulances are on the scene, with three more en route. A command post has been set up, an emergency physician is inside at the disaster scene, and ambulance units from neighboring communities are beginning to respond with offers of assistance.

At the scene, ambulances arrive to find hundreds of persons in the street, some with torn clothes, horrified expressions on their faces, many covered with blood. As ambulance personnel arrive, people surround them, begging for help for their friends, relatives, and sometimes themselves.

Inside the Hyatt, a walkway seven feet, two inches wide and approximately 120 feet long, suspended approximately 45 feet above the lobby floor has fallen onto a similar walkway suspended 30 feet beneath it, and both have fallen onto the floor. Apparently both walkways and the floor beneath were crowded with people attending a tea dance. Initial reports counted 110 dead and 188 injured. Our guess is that the system was faced with 80 to 100 critically hurt patients.

7:19 PM

Dispatch Center Director Jack Morasch, about five minutes away from the Dispatch Center, hears Unit 110 respond to a question from Car 1 (Patrick Smith) indicating that there may be as many as 100 injured parties. Jack Morasch radios Dispatcher Barbie Culli to call Johnson County EMS to get assistance from Medact, and also to request one unit each from Lee's Summit, Blue Springs, and North Kansas City. At this time, Unit 110 is trying to establish order outside the building, and is requesting that all ambulance units responding to the scene pick up patients at Pershing and Grand.

7:20 PM

Unit 110 orders two more ambulances, and Ambulances 141 and 120 are dispatched from separate locations. Unit 151 offers its services and is advised to stand by. At this point, all city ambulances except one were at the scene or enroute, leaving the city wide open on a Friday night. The Dispatch Center therefore asks for standby coverage of the rest of the City from Raytown to the east, Grandview to the south, Gladstone and Claycomo to the north, and Johnson County to the west. (Readers may note

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little later.

EMS/FIRE/EPF Cooperation Even though Kansas City's ambulance crews all work for a private ambulance company, Kansas City's ambulances are mostly based at fire stations throughout the City. Ambulance personnel and fire personnel in Kansas City generally have a good working relationship. When problems do come up they are usually small and easy to correct. Kansas City's fire and ambulance personnel work together daily, and share the same post facilities. This, we believe, contributed to the ease with which work was coordinated at the disaster site.

Similarly, the members of the Emergency Physician Foundation have worked closely with ambulance personnel over the past several months in the development of the new medical protocols, on-board equipment specifications, in-service training requirements, and in the conduct of routine medical audits. For the most part, ambulance personnel are beginning to feel that these emergency physicians know them and their capabilities, and the physicians in turn have learned to feel comfortable in providing medical leadership throughout the ambulance system. Again, this is another example of a situation in which people who deal with each other effectively on a routine basis are likely to interact more effectively during a crisis.

Regional Response From Mutual Aid Providers We believe

A Paramedic's Perspective

We were at our station Friday afternoon when I heard the first alarm go out for "some type of structural collapse at the Hyatt Regency Hotel." Battalion Chief 102, two pumpers and one truck company were sent. At this time I had no idea that my next 12 hours would be spent at the hotel undergoing the experience of a lifetime, and one I'd surely never forget.

About 45 seconds after Pumper 8 arrived, he came back on the radio, absolutely beside himself, screaming for ambulances, extra fire companies, and the deputy chief. At this time, my partner and I and Paramedic Unit 110, the Supervisor's car, were sent. Unit 105, being only four blocks away, was already en route.

Approaching the hotel, we could see over the traffic jam and fire trucks, hundreds of people running up and down the street, some with torn clothes, many with horrified expressions, many covered with blood.

Unit 110 arrived at the same time we did. The paramedic with Unit 105 was already treating patients in the street.

When I got out of the ambulance, there were people lying everywhere. Police officers were carrying people out of the front door of the hotel, bystanders were helping others out; and many people were just running into each other trying to get out of the hotel. It was absolute pandemonium.

I could see about 200 people outside. Half of them were lying in the grass and the parking lot driveway. Then a police captain ran up to me and said there were about as many more still inside the hotel.

I went back to my ambulance and put all lactated ringers, normal saline, and D_5W IV solutions in the street directly behind my unit, along with IV needles, tubing, spine boards, "C" collars and dressings. This way all needed equipment from our unit would be readily accessible rather than have someone have to rifle through all my cabinets. I had the other units do the same — a stockpile of equipment located in one place. When we completed this, I then went into the hotel. At about this time, Car 1 (MAST-Patrick Smith) arrived and ordered all available ambulances, activation of mutual aid, the Red Cross, and the Salvation Army.

by Jim Taylor

When I walked into the hotel, people began pulling at me wanting me to help their wives, husbands, or friends. I had to decline because I had to find out just what we had in there. Approaching the skywalks, I could not believe my eyes. There were people chopped in half, just torsos lying about; people with limbs sheared off, people crushed flat, ones that were still trapped, screaming for help. There is no way I can explain the helplessness that overwhelmed me when I saw this. There must have been more than 100 people still in that hotel dead and in major trauma — and there I stood not knowing what to do next.

Immediately I began directing the bystanders to take the untrapped people out to the ambulances as quickly as possible — we needed to establish as much order as possible as quickly as possible, so we could start removing the trapped victims. The whole place looked like a bomb had gone off in the middle of all these people. Intestines, brains, bones, were everywhere. It was shocking.

I went to the street to get IV solutions and dressings and briefly told the street triage officer, Allen Askren, what we had inside. He was already overloaded with what he had. I also requested extra doctors and paramedics inside for stabilization of the trapped victims.

Going back inside, the Hurst tools and Quickie saws were already fired up and at work. There were about 75 to 100 firemen trying to free the victims. Those victims who were trapped with gross injuries and were probably going to die had to be overlooked to help those who had a chance. There just weren't enough medical personnel at this point to care for everyone.

You had to blank out their cries for help, their agony. You knew they weren't going to live, there was too much on top of them, most of their bodies couldn't be seen. It would take too long to move all of the tons of steel and concrete to save them — they were going to die, and I could not look at them because I would

Paramedic Jim Taylor, megaphone in hand, directs rescue efforts of ambulance personnel from atop the fallen catwalks. (Photography was difficult due to extreme dust and fumes from small engine exhausts).

Photo by Ken Paton

that the history of the regional MARCER organization contributed substantially to the speed and smoothness of the mutual aid response from surrounding communities. In fact, the previous MARCER regional dispatch center, now taken over by ASI, provided primary and secondary emergency dispatch, as well as assistance in obtaining communications equipment for the entire region.

Perhaps just as important to this response was the recent activity carried out by the area Regional EMS Administrators Committee (REMSAC) which has resulted, in large part, from concern on the part of regional providers over the changes taking place in the Kansas City EMS System. Because of this concern, EMS administrators from throughout the area have recently taken an active role in helping to develop and formalize regional EMS dispatching protocols, including disaster planning efforts. Controversy has been an important con-

have gone to pieces myself. We had to help the ones who had a chance, or at least give them that chance.

A woman's arm was amputated to get her out. Because of other serious injuries she had to be transported at once. We had to take off a 26-year-old man's leg at the hip to get him out. (The section of catwalk trapping his leg couldn't be moved until 7:30 the next morning.)

It took about two to three hours to remove the victims trapped between the first and second catwalks — then there were those between the first catwalk and the floor. The catwalks had false bottoms, so it seemed very likely that there were people alive between the first catwalk and the floor. When all victims from the first rescue were removed, we made voice contact with a few people under the first catwalk. We couldn't see or touch them, but we surmised at least four to six people were alive under there.

At this point we turned the rescue over to the fire department, crane operators and iron workers. It was about ten or eleven p.m. During this time, ambulances were still transporting victims from the triage area and it gave me a chance to organize medical teams again — three to a team, a paramedic, two EMTs with L.R. IV sets, "C" collar and full spine board per team. When a victim was freed, the designated med team would advance, treat emergency problems and remove their patient to the triage area. I told them to hold off on treatment at the site unless absolutely necessary. When a victim was removed, another medical team was brought up into the staging area. This way we could keep the extrication site as clear as possible. We did not need the medical people getting in the way — everyone had a purpose.

During our rescue of the last trapped victims, we were talking with one male victim. He was telling us where to cut through next, and so on. Then he became silent. When we finally reached him, he was dead.

Going down into the holes we had cut in the concrete walkways was a horrible experience. Dead victims had to be dismembered to get to the live ones — and by this time, about 2 a.m., the smell was overwhelming. The possibility of another live one drove us on. An entire book could be written about that night

It went well, very well. I feel good about it.

I can't say enough for all those who went above and beyond the call that night.

You experience this and you learn, and you learn well.

I feel sad about those who had to die but I think more now about those who lived, who got a second chance.

When we used to make shift changes, in leaving, someone would say, "See ya at the big one" — well, a lot of us think a little before we say that, now.

***About the Author:** Jim Taylor is a senior paramedic in the Kansas City EMS System. He was working Unit 901 the night of the disaster. He prefers to work as a field paramedic, rather than in a management capacity, but has been an active participant in the recent development of the Kansas City System, assisting with the development of system status management plans, on-board equipment standards, and vehicle specifications. Taylor's clinical capabilities, control, and leadership qualities combined the night of the Hyatt disaster to thrust him into a role as coordinator of rescue operations. Working side-by-side with Dr. Joe Waeckerle at the site of rescue operations, Taylor could be seen throughout the night, often standing atop the fallen catwalks, megaphone in hand, directing and coordinating the ambulance personnel operations. We knew things were bad when Taylor, famous for his neatness and attention to detail, was seen with his shirt partially unzipped — a severity indicator never before witnessed. Taylor's firm and steady leadership throughout the night brought confidence, inspiration, and pride to us all.*

14 Hours

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that 13 Kansas City ambulances are now at the scene or enroute, but not all 13 have been dispatched. At the moment, we are unable to reconstruct the sequence to account for this discrepancy.)

7:23 PM

Unit 110 is calling for the Dispatch Center, asking the Center to contact the Red Cross to ask for assistance. 110 also requests three more physicians at the scene, plus additional assistance from the EPF. The Dispatch Center gets one more doctor from Truman Medical Center, and from Baptist Hospital, Dr. Joe Waeckerle. Unit 140, is clearing Truman Medical Center after dropping off a patient, and advises that they will pick up the doctor at Truman and deliver him to the scene

7:27-7:30 PM

Approximately 20 minutes after arrival on the scene, 110 experiences problems with traffic and advises that they are blocked in by fire trucks. The Dispatch Center calls the Fire Department for assistance Traffic control is becoming a serious problem. Ambulances are being routed past the outside triage area in a single lane running south to north, but occasionally congestion requires an alternate flow. (Unit 310 has started to the scene of the disaster, but is diverted to handle a Code 1 police request while en route to the disaster scene.)

7:34 PM

Supervisor Allen Askren on Unit 110, acting as Triage Officer, is requesting region-wide response of all providers to the scene to assist with the operation

7:38 PM

Unit 101 departs from the scene enroute to the hospital, apparently with the first patient transport.

RECAP at the scene

Initially, chaos But soon, an order begins to develop. Paramedic Jim Taylor begins to coordinate rescue efforts inside the lobby Soon, Dr. Joe Waeckerle assumes control of rescue activities in the lobby area, with Paramedic Jim Taylor, often standing on top of the fallen walkways with a megaphone, coordinating the execution of Waeckerle's directions. Fire personnel on the inside of the building coordinate their efforts smoothly and effectively with the work of the medical personnel. As the night wears on, construction personnel, fire personnel, and ambulance personnel will all work together as an effective team under the general leadership of Dr. Waeckerle. Many of the decisions to be made, both medical and nonmedical, would be

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