well, cooperation was almost flawless, and that didn't surprise any of us in the EMS system.

Coordination with the *hospital emergency departments* throughout the area had been the subject of disaster planning and disaster exercises for years. At the hospitals things apparently went very well, after some initial difficulty in bringing up all the hospitals on the HEAR system. However, our review of the events indicates that the periodic polling of emergency departments, as provided for in most traditional disaster plans, did not always provide the triage officer and transporting crews with sufficiently up-to-date information to properly direct patient flow. There was simply

entered the hotel. "God damn," I thought as I saw a head and an arm, neither connected with a torso. After a moment I reconsidered... "No, not God damn...My God...How? Why? This isn't supposed to happen...not in my home town...not in Kansas City...not to Kansas Citians..." I then prayed for a moment...for the injured, for the loved ones, but most importantly at the time for the ones we had yet to see...the living ones trapped with no relief in sight.

Inside the hotel I found my partner who seemed understandably wound up. My partner and I joined forces on the north end of the collapsed walkway. That segment was being lifted and we checked for any signs of life. We pulled lifeless torsos out...some intact, some not. In the process of removing those awful sights, I noticed I was standing in a pool of blood two inches deep. At this point I asked myself, "what am I doing here?" I found no answer. I looked up from the sights below and saw a priest giving last rites. He also was standing in that pool. I looked behind me and saw Kansas City's Mayor Richard Berkley, not more than three feet from me. I looked to one side and then the other. What did I see? People working steadily and persistently — determined people hoping the next body pulled out might be talking or at least moving in the slightest way.

The jackhammers quit hammering and saws quit gnawing. A hush came upon us and all of a sudden...cheers and applause. We got one out. "We" ... it's an easy word to use in this case. It was a team effort... as was everything that happened that dreadful evening. The cheers and applause occurred two times later in the early morning hours, which made the gruesome chores of the evening almost bearable.

Darkness turned to only dim. Rain came and went throughout the night. The rain seemed somewhat symbolic. It fit into the gruesome atmosphere that we had been exposed to for the previous ten hours.

At last, the final segment of the walkway was being removed...the center. The cranes and fork lifts had the segment lifted about two feet off the floor. Everyone squatted down to look and listen for the smallest movement or the tiniest whimper. No such luck. Firemen looked for their missing chief, known to have been present at the dance the previous evening. As the segment was lifted higher and secured, the body count rose. Bodies were being removed rapidly. The bodies were frozen in the most awkward positions...the positions they were in some 12 hours earlier when their entombment was forced upon them.

The final body was taken to the make-shift morgue. It was over...no need to hurry, no need to run, only recollect. Could I have done this? What if we had done that? Then after all the "could I's" and "what if's" died down, there was the one question that will remain... why?

Now everyone is looking for blame and fault. I guess that's to be expected. However, I can only look back at all the volunteers, all the off-duty police, fire fighters, and paramedics, the doctors, nurses, the Red Cross, and the Salvation Army ... all those people. This City is full of people with an overwhelming concern for each other. We did well. □

About the Author: Gary S. Frank is an EMT with 15 months field experience in Kansas City, Missouri. He is currently working toward paramedic certification, as well as a B.S. in Administration. He was on one of the first two cars to arrive at the Hyatt. He performed initial triage outside the building and gradually assumed responsibility for liaison between the triage officer (outside area), the communications officer, and transport units. He provided liaison with the Police Department, prepared patients for transport, insured that the triage officer's directives were carried out as patients were prioritized for transport, and coordinated assignments of hospital destination between communications officer and drivers. After the outside triage area was cleared, he assisted inside with excavations. Gary arrived at the Hyatt on Unit 105 at 7:12 p.m., about four minutes after receipt of the first call. He departed the scene at approximately 8:00 a.m., after the last body was removed.

14 Hours

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scene, and in fact is ordering taxicabs into the area to transport the walking injured. All Code 3 (nonemergency) calls are suspended for the night, including calls requested by the VA Hospital requesting transfers to Topeka and Leavenworth. (In the Public Utility Model, all nonemergency transfer work is temporarily suspended during a time of extreme system overload, and the health care community is expected to understand and support this occasional inconvenience, as did the VA Hospital during the Hyatt disaster.)

8:00 PM to about 7:00 AM

Sometime shortly after 8 p.m., all 14 ASI units, and two additional ASI units brought into service, are working the disaster, along with several ambulance units from neighboring communities. By 8 p.m. most of Kansas City is being covered by ambulance units furnished by neighboring EMS services which, in some cases, is a problem since not all of these ambulances have direct radio contact with the Kansas City Dispatch Center, making it difficult to provide directions to drivers unfamiliar with Kansas City streets. Even so, neighboring providers handled 12 to 15 emergency calls throughout the City while the disaster was in progress. Later that night, as one of these neighboring units would clear a Kansas City hospital, having dropped off its patient, the Dispatch Center would start them en route to the Hyatt. Then, when an ASI car left the Hyatt with patients and cleared the hospital, the dispatch Center would pull the ASI car out and use it for city coverage, since the ASI drivers are obviously more familiar with the City and could be better used in that capacity. As the night progressed, ASI gradually restored its own city coverage, and providers offering mutual aid were increasingly utilized at the scene of the disaster, though ASI units worked throughout the night.

As nearly as we can determine at this writing, assistance was supplied by Blue Springs EMS, Lee's Summit Fire Department, John Knox Village, Liberty Fire Department, Raytown Ambulance, Medact, Merriam and Mission, Kansas, Huckaby and Sons Ambulance out of Kansas City, Kansas, North Kansas City Fire Department, Children's Mercy Hospital, Osteopathic Hospital, Transfer Service, Inc. of Odessa, Missouri, KARE from Kansas City, Kansas, and the Shawnee Fire Dept. In addition, essential standby coverage was provided by Gladstone, Gold Cross Ambulance (from Independence), Grandview, Claycomo, and Raytown. In all, it appears that approximately 16 ASI ambulances plus 15 ambulances from mutual aid providers were involved. □

too much happening too fast to rely upon the traditional polling method. As a result, the Dispatch Center became actively involved in helping to coordinate the assignment of patients to hospitals. In retrospect, it seems that hospital communications would be more effective if carried out from the Dispatch Center — rather than from the disaster site, and the person carrying out this important function probably should have medical, rather than administrative, skills — paramedic, emergency nurse, or equivalent credentials.

However, even though we did learn something about how to improve the process of assigning patients to hospitals, the fact is that process worked very well at the Hyatt disaster, due more to the cooperation which developed than to any preplanned systems or procedures. The Hospital Association's Ron Norman, Communications Officer Steve Thomas, Triage Officer Allen Askren, Gary Frank, Dispatch Center personnel, and hospital emergency department personnel somehow made it all work. The success was in the people — not in the plan.

Acquisition and disbursement of *field supplies* and *equipment* was one area that could be improved upon substantially. There really was no plan for establishing a field supply inventory and distribution system. As a result, each triage area created its own supply inventory in any way it could. Throughout the night, people working in various areas would require a piece of equipment or some supply item, and there was no organized way to get it. For Example, Jim Taylor, having benefit of megaphone, might ask for an item and either get 50 of them or none, depending upon who happened to hear it, what they were doing at the time, and if they knew where they could find the item.

Field supply inventory and distribution turned out to be one area of need which really required prior planning to be handled most effectively. A disaster supply inventory should be developed and maintained, and some means of transporting that inventory to the scene should be available. Furthermore, a field supply officer should be identified, and a distribution mechanism (i.e., runners) set up immediately, along with means of communicating between the extrication site, triage areas, ambulance loading site, etc. and the field supply depot. Even though none of this had been done, people somehow managed to obtain what was needed through cooperation.

Coordination of medical personnel between tasks was a function that, frankly, we had never thought about. But it proved to be necessary, and ASI's training officer, Doug Klote, saw the need and filled it.

Whether handled formally or informally, well or not so well, these are the 11 areas of functional responsibility that had to be dealt with in order to effect an adequate response at the Hyatt disaster. For the most part, and with only a few exceptions, each of these areas of need was handled extremely well. What is hard to explain is how each of these areas was handled, and how an on-scene organization was rapidly developed to make everything work. Let us discuss each of those above-listed 11 areas of performance.

The 11 Areas of Performance

We have already discussed how the *Dispatch Center* worked, and how mutual aid providers cooperated fully with Dispatch Center directives. The success of Dispatch Center operations during the disaster was probably enhanced considerably by the fact that all of Kansas City's ambulances are *always* under the control of one Dispatch Center. Kansas City EMS routinely maintains about a four-minute average emergency response time, furnishes ALS capability on every run, handles 95 percent of its emergency calls with a response time under eight minutes, and provides nearly equal response time performance throughout all of the six councilmanic districts of the City. And it does this at a total cost, emergency and nonemergency service combined, of less than $4 million per year, including fees collected and a per capita local tax subsidy well under $1.50 per year.

Of course, none of this "routine performance" would be possible without complete coordination of all production capacity from a single dispatch facility. So in some ways it is not surprising that in the face of a huge disaster overload, that same dispatch facility is also capable of diverting the City's entire response capacity to a single location, while relying upon mutual aid providers to

handle the emergency "business as usual." In other words, a control center accustomed to managing all of the City's ambulance resources every day is better equipped to manage those same resources, plus mutual aid when disaster strikes.

Medical operations at the rescue site somehow came under the control of Paramedic Jim Taylor and Dr. Joe Waeckerle. How? It needed to be done and they did it. And everyone else saw that it was necessary, saw that Waeckerle and Taylor could do it, and gave them the support they needed to operate. This wasn't part of any plan, and neither Jim Taylor nor Joe Waeckerle occupy any special position which would make them more likely than anyone else for the task. Nonetheless, there was never any question about who was in control of medical operations at the rescue site. In fact, persons directing fire department operations in the lobby area conferred with both Dr. Waeckerle and Jim Taylor throughout the night, and we believe it is not inaccurate to say that most strategic decisions made at the rescue site were made almost by a consensus process involving Waeckerle, Taylor, fire officials, and occasionally the construction people.

As for the operation of the *two triage areas*, the outside triage area was set up and operated basically in accordance with the disaster plan recently developed by ASI's Doug Klote. The field supervisor acted as triage officer, and his partner acted as communications officer. Ron Norman from the Area Hospital Association arrived and established hospital communications. The important role played by Gary Frank at the outside triage area seemed to evolve out of necessity and capability. Things needed to be done and Gary Frank could do it, so he did. The job description was written after the job was done.

But the inside triage area, developed primarily under the direction of Dr. Bill Robinson, was not part of any disaster planning. It needed to be done, Dr. Robinson knew how to do it, so he did it. Execute the plan and then go write it.

As the night progressed, it became automatic for ambulance personnel to complete a task and then return to a sort of "staging area" where Doug Klote was re-forming and re-equipping three-person teams which were then sent into the extrication area at Jim Taylor's direction. Again, this operation wasn't part of any plan — it just developed. And it worked well.

Traffic control, crowd control, and site security was handled, as expected, by police. There was some initial confusion and traffic congestion which was quickly brought under control, and probably there will be some opportunity to prevent or reduce these problems in the future by additional planning and training. The one-way traffic corridor could have been established a little earlier, and some congestion could possibly have been avoided. But this confusion was brought under control with surprising speed, and a very orderly process was developed and maintained throughout the night. The secret was not so much in any plan as it was in the ability of a few individuals to see the problem, map out a solution, and implement it with the cooperation of others.

Coordination of body removal was handled so well that we really don't remember any significant problems in that area. In Kansas City, most body transfer work is done by a private company, Morticians Transfer Service, owned by Shannon Holcomb. Holcomb and his crews arrived on the scene, along with at least one official from the County Coroner's Office, and a temporary on-site morgue was set up. As bodies were removed from the extrication site, they were taken to the makeshift morgue where they were processed and eventually transported. We spoke with Holcomb sometime in the early morning hours and observed the body removal operation. There seemed to be no major problems, except the problem of identifying the bodies of female victims. Purses were scattered and most of the women carried no other identification.

Although there had been much controversy in recent months concerning the body transport business in Kansas City, including a lawsuit over the matter, these authors have been supportive of having most of this work performed by equipment and personnel other than our advanced life support ambulance units. ASI owners have occasionally, but not forcefully, disagreed with us on this point, and for reasons we don't fully understand, Mortician's Transfer has even sued Stout