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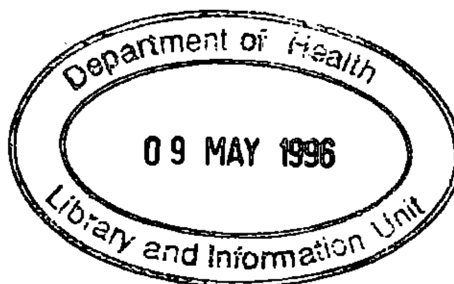

Report of the Advisory Committee to Government on The Monitoring and Medical Treatment of the Survivors and Victims of Future Disasters

This report is not confidential - checked with Ray Smyth, FoI officer, FK 7/2/2000

March 1992

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Foreword

I have pleasure in submitting the report of the Advisory Committee to Government on the monitoring and medical treatment of the survivors and victims of future disasters. The Committee, recognising the existing major emergency plans and the provisions made in them for the management of major disasters, both organisational and medical, concentrated on the psychological and post-traumatic stress problems associated with such disasters.

However, the Committee has made some general recommendations which it considered would further improve the existing arrangements in relation to major emergency planning.

I would like to express my personal appreciation to the other members of the Committee. Dr. Ita Killeen, Professor Robert Daly, Professor Muiris Fitzgerald, Mr. Matt McHugh for their dedication and co-operation. I would like to thank, in particular, Mr. Larry O'Reilly for his excellence as Secretary to the Committee and his patience and skill in drafting the report.

Dr. Niall Tierney
(Chairman)
Chief Medical Officer

Background

In the early morning of 14 February, 1981, a fire broke out during a function in the Stardust Disco, Artane, Dublin. As a result, 48 young people died, 128 received in-patient treatment and 86 were treated that night in hospital accident and emergency departments.[1]

On 15 February, 1981, the Government announced that a Public Inquiry would be held into the disaster and that this would take the form of a Tribunal to be established under the provsions of the Tribunals of Inquiry (Evidence) Acts, 1921 and 1979. The report of this Tribunal was published in September, 1982.

On 25 September, 1985, the Attorney General issued a statement on behalf of the Government announcing that, having considered ways in which they might act to alleviate the terrible ordeal of the victims of the Stardust Disaster and their families, and having consulted with some of the interests involved, they had decided to set up a Tribunal with powers to award ex gratia compensation assessed under the provisions of the Civil Liability Acts, 1961 and 1965.

The Report of the Stardust Victims Compensation Tribunal was submitted to Government in December, 1989. Among its recommendations, the Tribunal suggested that the Government might form a small committee representative of the doctors who had the most experience of treating Stardust victims with a view to advising the Government on the monitoring and medical treatment of survivors and victims of future disasters, in the post-disaster period.[2]

Establishment of the Advisory Committee to Government

Following consideration of the Report of the Stardust Victims Compensation Tribunal, the Government decided to accept the Tribunal's suggestion in relation to the establishment of an Advisory Committee. In October 1990, the Minister for Health nominated the following members to serve on the Advisory Committee:-

Dr. Niall Tierney (Chairman), Chief Medical Officer, Department of Health

Dr. Ita Killeen, General Practitioner, Mountjoy Square, Dublin.

Professor Robert Daly, Department of Psychiatric Medicine, Cork Regional Hospital

Professor Muiris Fitzgerald, Department of Respiratory Medicine, St. Vincent's Hospital, Dublin

Mr. Matt McHugh, National Burns Unit, St. James's Hospital, Dublin

Mr. Larry O'Reilly (Secretary), Higher Executive Officer, Department of Health

The terms of reference of the Advisory Committee were:-

"To advise the Government on the monitoring and medical treatment of survivors and victims of future disasters. The Committee's recommendations should be based on the direct experience of the medical members of the Committee who have experience of treating survivors and victims of the Stardust Disaster. The Committee's recommendations will be incorporated into the major accident plans in which the Department of Health and the Health Boards have a direct input."

The first meeting of the Advisory Committee was held on 30 November, 1990 and in all the Committee met on 5 occasions.

Disasters

Disasters are tragedies that overwhelm our communities, destroy our property and harm our population. Disasters are the results of natural or man-made events, each is unique, each is of extreme urgency and each places a tremendous burden on the community to minimise death and destruction. Unfortunately, it is virtually impossible to prevent most disasters; nevertheless we can forestall or alleviate many of their worst effects by anticipating them and by being prepared.

Irish Disasters

The type of disaster that has occurred in Ireland has changed over the past quarter of a century. Before this, two types of disasters were common in Ireland: fire and drowning. However, in the past 25 years, with the massive changes in industry, high technology and transport, the type of disaster has changed considerably:-

Tusker Air Crash 1970
Dublin bombings 1972 and 1974
Whiddy Oil Terminal Explosion 1979
Fastnet Yacht Race 1979
Buttevant Rail Crash 1980
Stardust Fire 1981
Cherryville Rail Crash 1983
Air India Air Crash 1985
Ballsbridge Gas Explosion 1987

Foreign Disasters

The pace of technological advances is again reflected in the type of disasters occurring around the globe:-

Saveso Chemical accident
Bhopal Chemical accident
Chernobyl nuclear reactor accident
Chelybinsk rail crash
Alaskan oil spillage
Ramstein air crash

U.K. Disasters

Closer to home, the U.K. has had its share of major disasters in recent years:-

The Flixboro Chemical Explosion
The sinking of the Herald of Free Enterprise
The Bradford City Fire
The King's Cross Fire
The Piper Alpha Oil Rig Fire
Clapham Rail Crash
The Kegworth Air Crash
The M1 Air Crash
The Hillsborough Football Stadium Disaster
The Lockerbie Air Crash

The Physical and Psychological Sequelae of Disasters

Because of the number of disasters in recent years, much general attention has been given to the aftermath of disasters, in particular, to the psychological impact on survivors, victims and personnel involved. The nature of the disaster and of the injuries sustained influence the physical and psychological sequelae.

After extraordinary events, people tend to have major difficulties in returning to normal routines. These events usually take a heavy toll on the individual in terms of stress and emotional upsets are common. Sometimes feelings are held back for a period and this may be followed by angry outbursts. Survivors may be physically scarred but sometimes they are also mentally scarred. Some individuals may show no emotion at first but may exhibit the symptoms of emotional distress at a much later stage. Rescue workers also may suffer from this problem. Grief and the inability sometimes to reconcile themselves to the death of friends or relatives is unfortunately a by-product of such disasters and for some survivors there is also the problem of guilt.[3]

There is a major role here for health service workers which is not always appreciated. This role concerns the provision of psychological support services for survivors and victims. This particular role is low profile and lengthy as opposed to the emergency medical service which is high profile and of short duration.

The Psychological Consequences of the Stardust Disaster

In the case of the Stardust disaster, the burn injuries of many of those who died, the necessity to use items of jewellery or forensic examinations to identify some of the bodies, while five of the bodies were unidentified, would be expected to increase the psychiatric morbidity among the bereaved. The parents of those who were injured had other children to care for, both in the aftermath of the disaster and when attempting to support injured children who suffered long-term physical and/or psychological effects.

However, those affected by the disaster cannot be narrowly defined. Of those admitted to the Stardust Disco on the night of the disaster, the majority were in the 18-25 age group. Because of the age group affected, some of those who died or were injured were engaged to be married. Many others were involved in stable relationships with boy or girl-friends. Some of the young women were pregnant. Many of those present at the disco were friends and neighbours of the dead and injured. Thus, the circle of people affected by the death or injury of a significant person in their lives was wider than might at first appear.

The Physical Consequences of the Stardust Disaster

In all, 48 young people died as a result of the disaster - 25 males and 23 females. Forty-four of those who died did so immediately at the time of the fire. Four of those injured (2 males and 2 females) died following admission to hospital. A

further 124 people were admitted to hospital and 86 were treated in hospital A & E Departments. The Tribunal of Inquiry was told that 846 people were admitted to the disco. Thus, approximately 30% of those admitted either died or received some form of hospital treatment. Of the 124 people who were admitted to hospital, 88 had at least one impairment. The most frequent type of impairment was scarring following burn injury which occurred in 48 patients. The other large category was respiratory impairment which occurred in 25 patients. In addition to the psychological symptoms which may arise in the post-disaster situation, symptoms may also be expected as a result of sustaining scars from burn injuries. The extent and duration of such psychological impairments would be expected to increase in the age group affected by the Stardust fire, who were at the stage of establishing their personalities.

Treatment of the Survivors by Medical Consultants

There were 19 hospital consultants who carried responsibility for those admitted to hospital following the fire, either because the patients were admitted under them or were later transferred to their care. In addition, some patients were under the joint responsibility of two or three consultants e.g. a physician, a surgeon and possibly one other specialist. There were 11 surgeons, including specialists in plastic surgery and 8 physicians. Some patients were also referred to 2 ear, nose and throat specialists and one ophthalmologist. A number of patients were also referred to a consultant psychiatrist.

Issues relating to the provision of medical care (excluding psychological support) to the survivors of future disasters[4]

1. The type of specialist care required for the survivors will be significantly influenced by the nature of the disaster e.g. fire, explosion, gas/chemical vapour release, radiation, major impact collisions, air/rail crash, building collapse or flood/hurricane. The special requirements for each type of disaster should be identified e.g. plastic surgery facilities in fires, acute surgical services in trauma collisions etc.

2. The scale of the disaster will have important implications in relation to the magnitude of the medical problems that ensue and disaster planning should take this into account.

3. The geographical location of the disaster will have a significant influence e.g. length of time before assistance arrives, accessibility etc.

4. Secondary dispersion phenomena (e.g. radiation clouds, chemical vapour clouds) will have a bearing on preventive strategies that require to be adopted for populations contiguous to and even remote from the disaster. There is a need to identify preventive/anticipatory strategies required for secondary dispersion phenomena to wider populations outside the target disaster area (e.g. advice about staying indoors, going outdoors, evacuation/non-evacuation etc.).

5. Medical care must include:-

(a) acute emergency care, both at the scene and in hospital.

(b) follow-up care, in-patient, out-patient, G.P. care.

(c) preventive strategies.

Issues relating to the provision of psychological support to the survivors of future disasters

Victims of civilian disasters are not accustomed to the idea of needing psychological help nor that unexpected severe emotional stress can have serious, protracted and possibly intractable psychological consequences. Although the death toll from technological disasters are not usually high when compared with natural disasters, there is increasing awareness of the psychological damage which they inflict. The quality and appropriateness of the help provided in their wake depends on our understanding of the way disasters affect people psychologically, within the context in which they occur.

Crisis intervention immediately after a disaster is effective in reducing immediate distress and hopefully will help to prevent delayed responses and chronic conditions. Brief insight orientated psychotherapy has also been advocated as an immediate treatment procedure and as a way of preventing chronicity. It has been suggested that people with more stable backgrounds are less liable to develop Post Traumatic Stress Disorder. It is also true that, given a sufficiently severe stressor, most people are likely to develop symptoms which will be chronic.[5]

Post Traumatic Stress Disorder

Such has been the level of psychological reaction to disasters that Post Traumatic Stress Disorder has become recognised, since 1980, as a recognisable set of symptoms caused by traumatic events which can be assessed for purposes of treatment.[6]

Vulnerable Groups

Some groups are particularly vulnerable to Post Traumatic Stress Disorder (P.T.S.D.): children, old people, those with psychiatric disorders, whose who have been multibly bereaved and those who see themselves as responsible for the disaster. The levels of P.T.S.D. vary with the severity of the disaster, the experiences of the individuals involved and previous stressful events in their lives. Certain physical injuries, particularly burns which are disfiguring or disabling, may lead to higher levels of post traumatic stress. Persons who have to give evidence before subsequent tribunals, committees of enquiry, etc. are also prone to suffer from P.T.S.D.

Effects of P.T.S.D.

The effects of P.T.S.D. can be felt in a number of ways, each of which has implications for physical and mental health. Physical reactions include nausea, headaches, fatigue and difficulty sleeping. Psychological reactions include anger, irritability, phobias, depression, anxiety and nightmares.

Research has been carried out in the United Kingdom on the types of counselling and support which are most effective in treating those suffering from P.T.S.D. There is evidence that early intervention which is pro-active and includes elements of debriefing and supportive counselling alleviates prolonged levels of stress.[7] The basic reason for providing psychological support services following a disaster is to alleviate the effects of the stress caused by the disaster on the individuals involved. For most people involved in a disaster, help may only be needed in the immediate aftermath or for a short period of time thereafter. It is difficult to determine the timescale over which a service must continue to be provided once people's need for support in the immediate post-disaster period has been met. New referrals may arise after weeks, months or even years following the disaster. People who had initially either not required or not sought help may have found that they needed support at a later stage. It should be envisaged that a psychological support service which can be expanded or contracted as appropriate would, if necessary, be established for a period of at least 1-2 years following a disaster.

Support Services

The following types of support services may be found useful in a post-disaster situation:

1. Immediate Support - helping survivors and relatives to identify bodies, make funeral arrangements and comfort the injured.

2. Initial contact of a preventive nature - to make contact with all those who were directly involved in the disaster, to explain that their feelings and reactions are normal in these circumstances and to advise them that help is available, if required.

3. Individual Counselling and/or psychotherapy - people who were directly involved in the disaster are given an opportunity to discuss their experiences individually.

4. Family Counselling - the family as a unit discuss any difficulties that have arisen as a result of the disaster.

5. Self-help Groups - people who have shared the same experiences can relate to one another and support each other.

6. Community Work - helping the community at large to cope with what has happened, the deaths or serious injury sustained by members of the community and the association of the community's name with the disaster e.g. Lockerbie.

After the Stardust disaster, there was a need for follow-up counselling to help people to come to terms with the terrible reality that had beset them. Many of those who were injured were visited by social workers and many of the families of the bereaved and of the injured were visited by public health nurses.

It is important to ensure that support services are offered to all survivors/victims on a personal basis and that such support is offered in a co-ordinated manner in order to avoid duplication.

The Role of the Family Doctor

The family doctor has an essential role in the ongoing care of both survivors and victims following a disaster. This care may well be required over a period of years. The family doctor's special knowledge of his/her patients is very beneficial in helping them to recover from their injuries and/or come to terms with their situation. He/she is at the hub of a medical caring wheel and is in a position to arrange the various specialist spokes which have become necessary in the continuing care of both the injured and the bereaved.[8]

Psychological Support for Service Personnel

While the psychological impact on the survivors and victims of disasters has received considerable attention, less well documented is the effect on human service personnel who provide care in the immediate aftermath of disasters. It is difficult for these personnel not to react to the disturbing scenes following a disaster. They need to be well prepared and supported if they are to be effective. Proper training and emotional preparation are essential. Pain, introspection and talking are the usual means by which we try to cope with terrible events. This is why psychological debriefing has been found to be an important tool in "helping the helpers".

Psychological Debriefing

Psychological debriefing helps groups of service personnel to relate and share their experiences and emphasises that powerful emotional reactions are normal. This process aims to help recovery, prevent the development of the entrenched psychological reactions associated with Post Traumatic Stress Disorder and ease the return to normal duties.[9] All staff should be made aware of the psychological effects of disasters and support structures should be developed or established, where they are not already provided.

Furthermore, psychological debriefing should be seen as routine, without stigma and be provided for all staff as a matter of course after any distressing major incidents.[10]

Burn-out Syndrome

The search for bodies, the rescue and treatment of the injured and the provision of assistance to the survivors, their relatives and friends places staff under considerable strain, particularly if they are not well trained to deal with these situations.

The combination of all the work, stress and fatigue can lead to what is now called burn-out syndrome, which particularly afflicts human service personnel in disasters.[11]

The symptoms of burn-out syndrome include:

1. Thinking - Confusion and slowness.
2. Psychological - Depressed, irritated, excited
3. Somatic - Physical exhaustion, loss of energy, diminished appetite, sleep disturbance, tremor.
4. Behavioural - Hyperactive behaviour, fatigue, withdrawal.

Another unusual characteristic is the lack of insight i.e. VICTIM IS USUALLY UNAWARE of the symptoms and his contribution to the growing problem.

The following procedures may help to minimise the level of stress on personnel and thus reduce the possibility of burn-out syndrome developing:

1. More attention should be paid to the selection of staff.

2. Staff training should be improved and should incorporate sessions on stress management.

3. Arrangements for staff counselling should be developed and full use should be made of all other existing support services.

4. Arrangements should be put in place to obtain the assistance of additional support services, if and when required.

The Incorporation of Counselling/Psychological Support Into the Health Boards Major Emergency Plans

Experience has taught that there is a long-term dimension to the health care response to situations requiring the implementation of a major emergency plan. Social Work Departments and Psychiatric Departments should play a lead role in the provision of psychological support services following a disaster.

Each Health Board should nominate a person who would be responsible for co-ordinating the long-term response for both victims and carers. In the co-ordination of such a response, it is important to realise that many victims will not seek psychological support or may reject such support initially. It is also important that some contact be made at an early stage with those involved so that follow-up care can be provided later.

In co-ordinating such a response, it is important to remember that victims or carers from outside of the health board area may be involved and special arrangements will be needed to ensure that any follow-up care required will continue to be provided when they return to their own area.

In the provision of this service, it is important to ensure that the correct balance is achieved. Nobody should feel pressurised into accepting counselling, nevertheless, people who have had the experience of surviving a disaster should not have to deal with the subsequent problems on their own. The long-term support

service should include personnel with adequate experience of counselling in cases of psychological distress. These support services should also provide the necessary psychological support for service personnel dealing with the disaster.

It is the intention that the co-ordinator of long-term support services would be alerted at an early stage. However, mobilisation of these services would be at the discretion of the Chief Executive Officer of each Health Board and the timing of such an intervention would be a matter for the C.E.O. Each nominated co-ordinator of long-term support services should be asked to prepare a plan to cater for a response to major emergencies in their area. The plan should include information on personnel, alert procedures, support services etc. It is a matter for the C.E.O. of each health board to nominate a co-ordinator of long-term support services. It is envisaged that the Programme Manager for Special Hospital Care would be a suitable nominee. The assignment of responsibility for the various aspects of the psychological support plan, both short-term and long-term, would be a matter for decision by the co-ordinator.

It is recommended that the provision of support services be planned initially for between one and two years after the disaster and that they should be capable of being increased or stepped down as required during that period. An especially high level of support will be called for in the first two/three months.

It is recommended that initial contact with these support services should be pro-active and that these services should make full use of all available voluntary and professional resources. It is essential that proper training and preparation be provided for those who will be involved in the provision of psychological counselling/care.

It is particularly important that those who do not seek help or those who do not return for further counselling, if this has been agreed, are not allowed to go unnoticed.

Recommendations

The Committee recommends that:

1. Health Boards should incorporate structures into their major emergency plans to ensure that any help, advice or support that might be required, either by survivors, victims, or personnel dealing with the disaster, can be provided.

2. The Chief Executive Officer of each Health Board should nominate a co-ordinator of psychological support services. It is envisaged that the Programme Manager for Special Hospital Care would be a suitable nominee.

3. Each nominated co-ordinator of psychological support services, in consultation with the Clinical Director of Psychiatric Care, should be asked to prepare a plan to cater for a response to major emergencies in their area. The plan should include information on personnel, alert procedures, support services, etc. This plan should be incorporated within the existing major emergency plan for that health board area.

4. Arrangements for incorporating psychological support into a hospital's major emergency plan are a matter for the Clinical Director of Psychiatric Care, in consultation with the co-ordinator of support services.

5. The assignment of responsibility for the various clinical aspects of the psychological support plan, both short-term and long-term, would be a matter for decision by the Clinical Director of Psychiatric Care or his/her nominee, in consultation with the co-ordinator of psychological support services.

6. Social Work Departments and Psychiatric Departments should play a lead role in the provision of psychological support services following a disaster. Psychological support services should include personnel with adequate experience of counselling in cases of psychological distress.

7. It is recommended that initial contact with the psychological support services should be of a preventive nature and that these services should make full use of all voluntary and professional resources. It is considered essential that proper training and preparation be provided for those who will be involved in the provision of psychological support.

8. It is important to ensure that psychological support services are offered to all survivors/victims on a personal basis and that such support is offered in a co-ordinated manner in order to avoid duplication.

9. Nobody should feel pressurised into accepting counselling, nevertheless people should not have to deal with subsequent problems on their own.

10. It is envisaged that a psychological support service, which can be expanded or contracted as appropriate, would be established, if necessary, for a period of at least 1-2 years following a disaster.

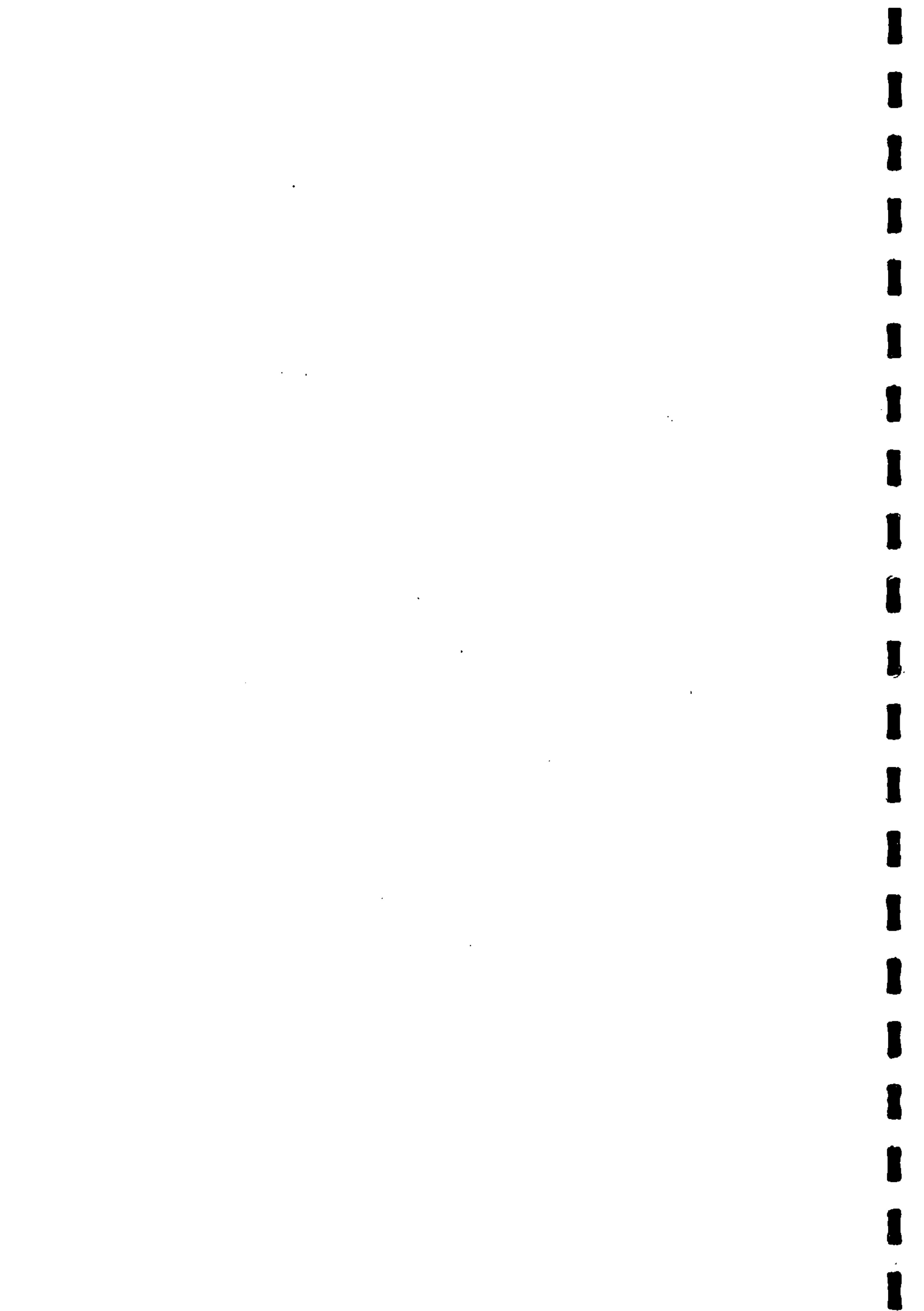
11. Proper selection, training and counselling are essential for human service personnel. In addition, the assistance of existing support services should be called on, if required.

12. Psychological debriefing sessions should be provided for all staff after dealing with a disaster. These sessions should be seen as routine and without stigma.

13. All necessary steps should be taken to ensure that the possibility of burn-out syndrome developing in personnel dealing with a disaster is reduced to a minimum.

14. The essential role to be played by the family doctor in the ongoing care of both survivors and victims following a disaster should be recognised and developed.

15. The Health Boards should introduce a means of notifying family doctors of emergency situations/disasters that have occurred. In addition, Health Boards should make arrangements to inform family doctors when any of the doctor's patients have been involved or injured in a disaster, especially if these people are from outside that particular Health Board area. This also applies in relation to the provision of follow-up psychological support.



16. Each Health Board should provide family doctors in its area with a copy of its major emergency plan.

17. Medical care, excluding psychological care, must include:-

    (a) acute emergency care, both at the scene and in hospital
    (b) follow-up care, in-patient, out-patient, G.P. care
    (c) preventive strategies.

18. The types of specialist care required for each type of disaster should be identified by the Health Boards e.g. plastic surgery facilities in fires, acute surgical services in trauma collisions.

19. Attention is drawn to the benefits of the Advanced Trauma Life Support and Cardio-Pulmonary Resuscitation training programmes which are already in existence.

Recommendations, outside the terms of reference of the Committee, which were made by the Committee in relation to major emergency planning

1. It is considered essential that the Health Boards should identify the major hazards and associated risks in the area being covered by their emergency plans. The Health Boards should assess the suitability of their plans for dealing with these hazards and should consider the ability of their services and of the community to respond effectively.

2. The Health Boards' major emergency plans should be capable of providing for various levels of medical response, depending on the nature and scale of the disaster concerned.

3. In the event of a major emergency, arrangements should be made, where possible, for the establishment of a temporary mortuary near the casualty collection point, but in a separate location well protected from public view. Access to the mortuary should be strictly limited and, unless absolutely necessary, bodies should not be removed to hospitals.

4. Health Boards should develop a system of record keeping for use in emergency situations which is simple, familiar and requires minimal duplication. This is important in order to identify patients and their location and to provide an ongoing records of the patient's care and condition. Initial information should, if possible, be completed prior to the patient arriving at the hospital.

5. It is considered essential that each Health Board/Hospital should test its emergency plan on a regular basis and should ensure that all relevant members of staff are familiar with it.

6. Emergency planning by the Health Boards should give consideration to the use of all modern methods of telecommunications which are at their disposal.

7. It is important for Health Boards to ensure that factual and timely information regarding a major emergency is provided to survivors, victims and the media. This will require the appointment of an experienced public relations/information officer.

8. Some Health Board emergency plans provide for the use of volunteer helpers under the supervision of the Chief Ambulance Officer. The use of such volunteers needs to be co-ordinated and consideration must be given to the possibility that they may develop psychological symptoms as a result of their role.

9. Access to the site of a disaster should be strictly limited to authorised personnel.

10. Each hospital should, in a disaster situation, assign a member of staff to compile a list of admissions and to pass this information on to the public relations/information officer, through the co-ordinating group.

11. Each hospital should prepare a list of staff working in various specialties whose expertise could be called on, if required, in an emergency situation. The lists could also incorporate medical and nursing staff from outside the hospital.

12. Health Boards and general hospitals should arrange for the erection of visual display charts of their major emergency plans outlining structures, procedures, contacts, telephone numbers etc. and this information should be updated on a regular basis.

13. All staff should be informed of any amendments, additions, deletions or updates which are made to the Health Board/Hospital emergency plan.

14. Major passenger services should consider providing their staff with additional training in communications, especially in regard to an emergency/disaster scenario.

15. Members of the clergy should be made aware of the content of the Health Boards' major emergency plan and should be alerted once the plan is put into effect.

16. Attention is drawn to Ireland's co-operation with its EC partners on emergency planning issues and to the fact that EC assistance may be requested by Ireland in a disaster situation, if required.

Conclusion

No country or community expects a disaster to befall it, but disaster do occur e.g. the explosion at a chemical factory in Bhopal, India which killed over 2,500 inhabitants of the city and injured 150,000 others. Adequate advance preparation and planning helps those expected to cope with the disaster to do so in a much more efficient and effective way. The ready availability of the required medical care and counselling services helps the survivors, the victims and, indeed, the carers to recover from any physical or psychological injury which they may have undergone as a result of the disaster. It is the hope of this Committee that this Report will help to ensure that the medical services, particularly the psychological support services, which will be provided following any future disaster will meet these requirements.

Appendix A

Definition of Terms

Aftermath - period of disaster which follows the ending of the rescue phase.

Counselling - psychological support and/or advice given by individuals who have been selected and trained to do so.

Impact - period from the onset of a disaster to the end of the rescue operation.

Injured - people present at a disaster who have been physically injured but not killed.

Long term - refers to a period following the impact phase which may continue for approximately two years.

Major Emergency - a "Major Emergency" is any event which, usually with little or no warning, causes or threatens:-

- death or injury,
- serious disruption of essential services, or
- damage to property

beyond the normal capabilities of the Gardai, local authorities (including fire authorities) and health services.

Survivors - people present at a disaster who have not been killed.

Victims - all disaster-affected persons.

Appendix B

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16. Medical Aspects of Disasters - Dr. I. Killeen.

17. Coping with a major personal crisis - leaflet prepared by Nottinghamshire County Council.

18. Mirrors of Pain - M. Stewart, Crisis Counselling, February, 1989.

19. Order from Chaos - responding to traumatic events. Marion Gibson.

20. Radioactive Substances Decontamination Exercise. B. Heaton, A.B. Matheson, J.G. Page. B.M.J., 28 April, 1990.

21. Disaster Planning and Response. Joseph F. Waeckerle, Review Article New England Journal of Medicine, Vol. 324, No. 12, 21 March, 1991.

22. The Disaster at Lockerbie. A paper presented to the Committee by Dr. Ita Killeen.

23. Major Chemical Disasters - Medical Aspects of Management - Proceedings of a meeting arranged by the Section of Occupational Medicine of the Royal Society of Medicine, London.

24. Disasters - Planning for a caring response - Parts 1 and 2. Report of the D.H.S.S. Disasters Working Party.

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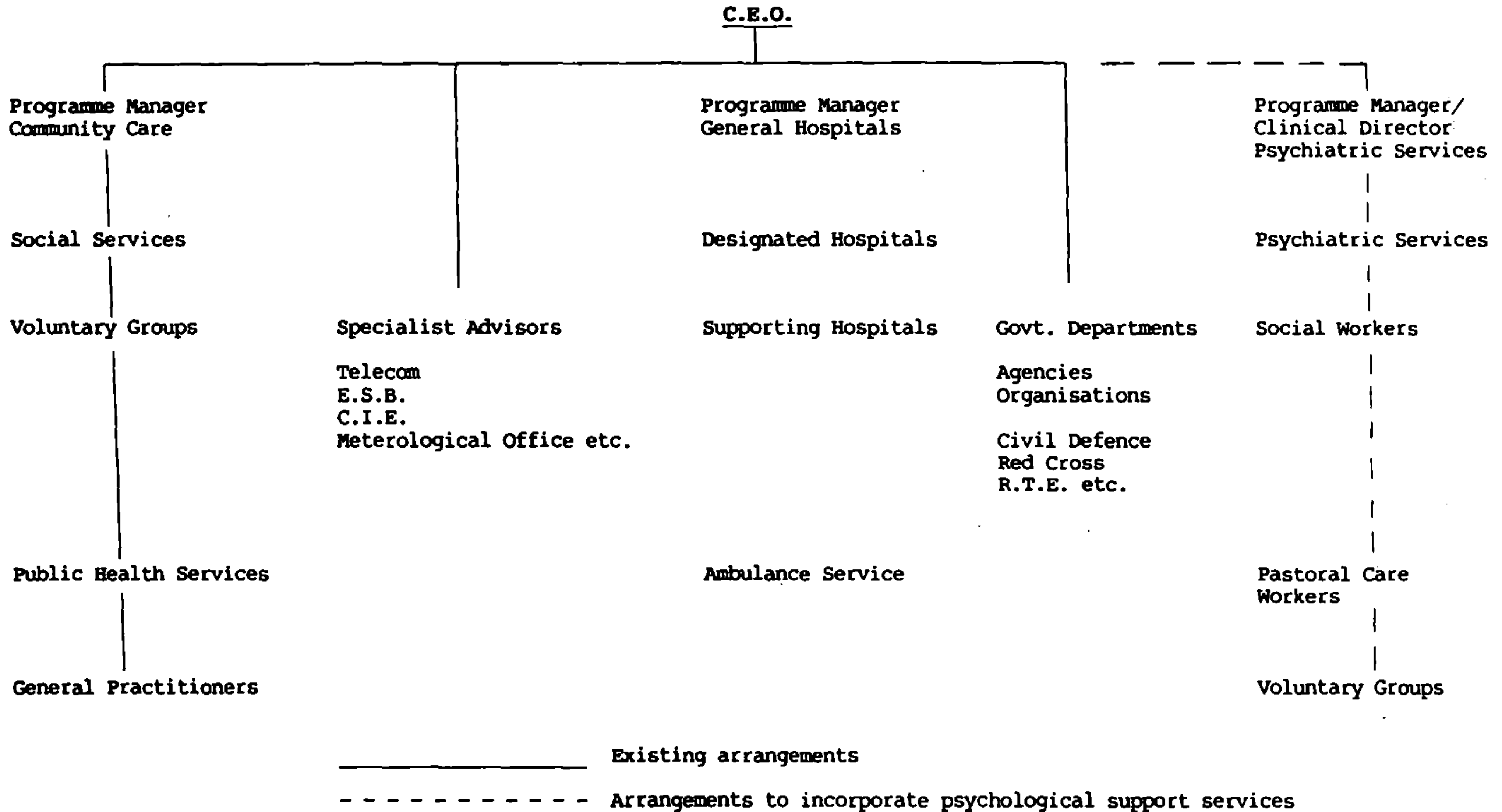
Model for the implementation of a health board Major Emergency Plan



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Appendix 3

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