

A STUDY OF EMERGENCY MANAGEMENT PROCEDURES  
IN THE UNITED KINGDOM

REPORT ON VISIT TO THE UNITED KINGDOM  
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## ACKNOWLEDGMENTS

Emergencies are a fact of life and whilst there are many situations which are beyond our control to prevent, when they do occur, the response by all organisations involved is magnificent.

There will never be an emergency situation from which lessons cannot be learned. There will never be an emergency situation in which everything will function to perfection. We can only learn from each situation and continually strive to improve our performance.

The purpose of this study tour was to learn from those who have been involved in major emergencies throughout the United Kingdom and my thanks must go to the Emergency Services Foundation for making the scholarship available and to my employer, Victoria Police for allowing the trip to be undertaken.

My special thanks to Inspector Sandra WILKINSON of the Police Requirements Support Unit, Home Office, London, for her assistance in arranging my itinerary, both business and social, throughout the United Kingdom, in addition to providing a network of excellent contacts prior to and during my trip.

Without the frankness and honesty of all those spoken to on this tour, little would have been achieved. Without exception, my sincere thanks to all those with whom I had contact, for their preparedness to discuss openly and without reservation the respective emergencies with which they were involved.

The author also expresses his appreciation to Leanne van Rees for the typing of correspondence and this Report.

## INTRODUCTION

It is quite often said that the emergency management arrangements in Victoria at the present time are among the best in the world. Whilst this may be the case, it should be stated that since the inception of the Emergency Management Act, 1986, and the new Displan 1987, these arrangements have not been fully tested. When compared with recent events in the United Kingdom, Victoria has remained relatively unscathed from major emergency situations. The list of emergency situations in the United Kingdom in recent years, has covered a wide range of incidents including the Zeebrugge Ferry Disaster, the Lockerbie and Kegworth plane disasters, the London Underground Fire and the Hillsborough Soccer Stadium crush to name a few, and so it was an opportune time to undertake a study tour to evaluate the extent and effectiveness of the emergency management arrangements involved in some of these incidents, but more importantly perhaps, to identify lessons learnt from each of the situations.

Having been awarded the scholarship by the Emergency Services Foundation to undertake this tour, it was my intention to seek out personnel who were involved in incidents at the "coal face" rather than those who might provide "filtered" accounts of the incidents. By adopting this approach, I believed that many of the operational issues, which have particular relevance to personnel from all emergency services involved in emergency incidents would be more easily identified. I consider this was achieved through the frankness and honesty of those spoken to.

It is apparent that each incident produces its own problems and as has been proven in this State, the manner in which an emergency is handled, will depend largely on the personnel who are working at the time it occurs.

This report will identify a number of emergency management areas studied during the tour and discuss various aspects of each. It would be fair to say, that many of the problems identified at incidents in the United Kingdom are no different to those encountered here. However, because of the greater number of resources available within that country, some of the problems are magnified. A more detailed paper on the London Underground Fire and Kegworth Air Crash, operational issues, are attached at Appendices "E" and "F".

### 1.0

#### LOCAL GOVERNMENT INVOLVEMENT

##### 1.1 Emergency Planning "v" Civil Defence Planning (England)

Planning for emergencies seems to be a fairly recent innovation within the United Kingdom at this time. There does not appear to be any legislation similar to the Emergency Management Act which requires local government and agencies to prepare plans for countering emergency situations.

There is not a similar document to our State Disaster Response Plan and in fact, a great deal of interest was shown in the procedures and structures we have developed. The main thrust of the planning process throughout the United Kingdom has been aimed at the civil defence requirements, rather

than emergency planning as we know it. At this point in time, there does not appear to be any general requirement upon municipalities to prepare plans for, or get involved in planning for anything except civil defence. However, greater emphasis is now being placed on counter disaster planning by the Counties themselves, rather than as a requirement under legislation. As a result, some Counties are further advanced than others and it would seem that the extent of counter disaster planning undertaken, is largely dependant on the appointed County Emergency Planning Officer and the interest of the respective County personnel. This was evident in both the County of Cumbria and the County of Dumfries and Galloway, both of which are fully involved in counter disaster planning at a very high level.

### 1.2 Counter Emergency Planning Officer

A Counter Emergency Planning Officer is appointed to each County by the Home Office. The appointee and his staff are funded by the Home Office, but employed by the respective County. In fact, the Home Office selects the appointee, who whilst working for the County is still responsible to the Home Office. This position has existed for sometime now, with the role of civil defence planning. The terms of employment are based on civil defence planning, however, due to what has recently been seen as a diminishing likelihood of war, Emergency Planning Officers have turned their planning skills towards Counter Disaster Planning. This change in role has been accepted by the Home Office with the proviso that essential civil defence planning is not neglected.

In many instances, they have taken on the function of writing and managing training exercises within the County and to some extent, are similar to our Emergency Response Development Officer (ERDO) in the planning area.

The appointment of a full time Emergency Planning Officer within each County, certainly has its rewards in the level of preparedness it can maintain and the necessary education of the public, should an emergency situation occur.

### 1.3 Public Information

Counties are heavily involved in the provision of public information to the community, particularly in areas where an installation which handles specified amounts of hazardous substances is located. These specifications are detailed in the "Notification of Installations Handling Hazardous Substances Regulations 1982".

Further requirements are placed upon such installations by the "Control of Industrial Major Accident Hazards Regulations". These Regulations require companies to provide information to the community on the industrial hazards which exist within the area and the action the public should take in the event of an accident occurring.

Companies are required to fund the production and circulation of information leaflets every two years, however, in a recent survey conducted by Cumbria County Council, it was revealed that public apathy was such,

that many discarded the leaflet in the rubbish and the general reaction of the public living in the area was not as great as expected, when advised of the installation located in their community. The survey also revealed the information contained in the leaflet was ineffective after eighteen months due to a number of reasons, including the transient population and general lack of interest. A copy of such a leaflet is attached at Appendix "B".

Cumbria County Council have produced "School Action Cards" to advise those in schools of action to take in the event of an emergency at an installation within the Sellafield District. See Appendix "C". This information is provided to the schools and contains a comprehensive document for teachers to assist them in ensuring correct procedures are followed during an incident.

#### 1.4 Public Information Centres

In Cumbria County, the responsibility for the establishment and maintenance of public information centres belongs to the County. Public information centres are generally located at public libraries and police stations. Librarians and library staff are trained in methods of providing the relevant information in conjunction with police, who are always in attendance at such centres. This system seems to work effectively and releases police to perform other more pressing and necessary functions. In times of emergencies, the public are advised to attend at these information centres to obtain relevant information on the emergency which is occurring. It provides a location away from the actual scene where the community can obtain information either in person or by phone.

#### 1.5 Emergency Planning - Post Lockerbie (Scotland)

Following the Lockerbie air disaster, when a Pan American Boeing 747 exploded over Lockerbie claiming the lives of 259 passengers and 11 residents of Lockerbie, a major report was produced by the Chief Executive of Dumfries and Galloway Regional Council, Mr. Neil McIntosh. The report titled, "Lockerbie - A local Authority Response to the Disaster", is a very comprehensive account of the Council's role and the lessons learned from the disaster. It identifies the commitment that local government must have in emergency planning in prevention, response and recovery phases.

The report made the following comments:-

"It is also considered that the Council should recognise in their strategic policies for emergency planning, the concepts of a unified local authority approach, total support and co-operation, delegation of responsibilities to senior management and the dedicated team approach and full involvement of the community in its own recovery with the withdrawal of the Councils' participation when circumstances so permit".

The report continues to detail the conclusions for emergency planning and provides general principles as a framework in which to further develop the "All Hazards Approach" in emergency plans. Relevant excerpts are attached

at Appendix "D".

Discussions with both the Chief Executive and his Deputy concerning the Council role, confirmed that the commitment of these two men was reflected in the Council attitude to and level of involvement in emergency planning issues.

The Council was responsible for establishing a Community Liaison Steering Group within days of the disaster, when it was seen that a need existed to involve the community in the on-going recovery process. The Community Liaison Steering Group was established at a public meeting on 27 December, when 100 people attended and representatives were nominated to the Group. Membership included representatives of the Community Council, Rotary, Round Table, Evergreens, Probus and representatives of the most severely damaged areas.

The Steering Group met on six occasions formally and several times informally, with the purpose of providing a means by which local opinion could be canvassed on the many issues which were to be addressed.

Whilst this major initiative resulted from the public meeting and proved successful, so did a number of other initiatives which were adopted, including the "Community Update", a broadsheet which complimented noticeboards and disseminated important information throughout the local areas. It was delivered by volunteers to most homes in and around Lockerbie. A copy is attached at Appendix "E".

These and other similar initiatives were vital in the process of assisting the community in recovery from such a disaster. The Council were major players and their involvement and the results they achieved, again highlights the necessity for local government to become heavily involved in planning for all aspects of emergencies which threaten their communities.

## 2.0 Major Response Problems

In any major emergency, wherever it occurs, a number of response problems will be identified in the de-briefs and inquiries that will inevitably follow. The incidents examined in the United Kingdom proves that the problems encountered in those incidents are similar to those encountered in Australia. Major response problems the world over, are generally considered to involve control structures, convergence, communications and co-ordination. These certainly created problems in the major incidents studied and some examples will be provided. A more detailed report on the London Underground Fire and the Kegworth air disaster are attached as separate Appendices, "F" and "G".

## 2.1 Control Structures

### (a) London Underground Fire - Kings Cross

At about 1930 hours on Wednesday 18 November, 1987, a small fire was first noticed underneath a step at the right hand side of the upper part of one of the escalators, which brings travellers from the tunnels to the booking area at Kings Cross Railway Station, a major station in the London rail network. It then developed into a major fire which, when eventually extinguished, had claimed thirty one lives, including one fire-fighter, who had responded in the course of his duties.

Any form of command, control and co-ordination was virtually non-existent from the first report of the fire until some considerable time after a major flash-over had occurred and whilst it could be said that this is the norm in these type of incidents, it highlights the need for some formal structure to be in place, which all organisations are prepared to work to. It is obvious that through the pre-flash-over and flash-over stages of the fire, everyone was running around in a state of confusion, doing what they believed to be the most appropriate at the time. It has been proven, that for an efficient control structure to work, there must firstly be one in place and unfortunately, it seems it was not the case in this instance and from all reports it is apparent that there is still no established structure in place to allow it to occur in the future.

One report I received, indicated that one of the problems at the scene, was the argument between police and fire brigade officers as to who was in charge of the incident.

There does not appear to have been any formalised structure for disaster response and it took sometime to establish a system of liaison officers to deal with the situation. The command and control function within the fire service was of major concern and received strong criticism from several quarters. Each time a senior officer arrived on site, he immediately assumed command with little or no briefing. This occurred on a number of occasions and created problems, not only within the fire service, but for other services trying to identify who was in control of the incident.

### (b) Kegworth Air Crash

At 2025 hours on 8 January, 1989, a British Midland Airways 737, Flight No. BD 092 from London to Belfast with 126 passengers and crew aboard, crashed into the western embankment of the M1 Motorway near Kegworth in Liecestershire. Forty seven died as a result of the crash.

Within the County of Liecestershire, emergency management arrangements require the Forward Command Post/Control Point to be identified by the flashing lights of the vehicle which has been designated that role. All other units responding are required to turn their flashing lights off on arrival at the scene. Unlike Australia, where each emergency service has a

different coloured flashing light for identification, all emergency service vehicles in the United Kingdom are fitted with blue flashing lights. Within a very short time of the plane crashing onto the motorway, in excess of 200 emergency vehicles arrived on site, many self activated and all left their blue lights flashing. It was impossible to identify the Control vehicle.

As a result of this experience, consideration is now being given to the appointment of a site marshall, who will be responsible for ensuring that all lights are turned off, radios turned down and vehicles are correctly parked or at least be able to be moved. It seems as though the proposed site marshals role would be almost impossible. One wonders how one man is going to control such a large number of vehicles all arriving within a short space of time? It seems that it would be more appropriate to continue education across all services as to the requirements and importance of establishing correct control structures at such incidents.

(c) Lockerbie Air Disaster

On 21 December, 1988, a Pan American Boeing 747, with 259 passengers and crew left Heathrow Airport at 1825 hours bound for New York. At approximately 1903 hours the plane exploded in mid-air in the Lockerbie area, killing all 259 aboard together with eleven residents of Lockerbie.

With the search extending over 824 square miles, wreckage over 35 miles and bodies over 6 miles, the control structure for the Lockerbie disaster, was by necessity, much different to what would normally be expected. To endeavour to effectively control a response of such magnitude from one control point would be almost impossible. To overcome the problems associated with the vastness of the area involved, it was divided initially into six sectors and later increased to eleven. Each sector was provided with its own control structure and a Detective Chief Inspector was placed in charge. He was assisted by a Detective Inspector, two Detective Sergeants, eight Detective Constables and two uniform personnel. The Chief Inspector, whilst having control of his sector, reported back to the Central Control Point maintained at Lockerbie. This system proved to be very effective.

2.2

CONVERGENCE

(a) Communications

In each of the disasters studied, the problem of communication convergence was identified as a major one. During the London Underground Fire the Casualty Recording Bureau at Metropolitan Police took 14,000 calls in just 4 days. These were inquiries from local people as well as from relatives and friends around the world. The telephone system was completely clogged up for sometime and made it quite difficult for emergency services.

At Kegworth, a similar situation occurred when large numbers of motorists, delayed because of the accident, used car phones and portable phones to call home. Emergency services had great difficulty in accessing the

telephone network due to the sheer volume of calls being generated. The media further complicated matters, when having obtained a telephone line, kept it open by leaving the phone off the hook and maintaining access to their offices. Again, these telephone calls were not only local. Within 20 minutes of the crash occurring, radio stations from Australia were seeking information on the accident. Arrangements are now in place for British Telecom to provide sole use of the radio telephone network system to emergency services in times of emergencies.

Lockerbie also experienced similar problems. The telephone system became so overloaded, that even local calls could not be made within Lockerbie itself. There were just no lines available until Telecom brought in mobile exchanges. At one stage all local telephones were disconnected to provide access to the system for emergency calls.

(b) People

When considering the convergence phenomena relating to people, there are a number of groups which are worthy of mention. They include emergency service personnel, volunteers, relatives and friends, and the media. Some examples are as follows:-

- (i) Kegworth. Relatives started arriving on site from Ireland and the south of England within hours of the crash. The Airline provided a flight at 1000 hours the following morning from Belfast. It contained relatives and the Rev. Ian PAISLEY. Accommodation had to be found. The Donington Thistle Hotel had been quickly booked by the media. The licensee cancelled their booking and provided accommodation to the relatives. The Irish have a tradition of remaining with the body from the point of death to point of burial. Having been brought to the scene, this created further problems for emergency services.
- (ii) Lockerbie. Within a very short time, 5000 police were in attendance. Most were self activated and had no role to play at that particular time. Civilians and other volunteer groups wanting to help, conducted their own searches for bodies and body parts. They would bring body parts into the police with little knowledge of exactly where they had been located thereby, making it impossible to photograph in situ. Lockerbie was flooded with people looking for relatives who had been on the plane.

The various culture and religious backgrounds created some difficulties. Members of the Jewish faith must have a body to bury in 24 hours. They were looking over remains at the scene and there was some fear that they may have removed a body for burial so as to comply with their beliefs. Twenty one nationalities were involved

and most had relatives at the scene within a short time, as they were flown to the United Kingdom by Pan Am.

Media also over-ran the scene and it was reported that they were moving amongst the body bags, opening them and taking photographs of the deceased.

It was also reported that a Belgian media representative had obtained a medical badge and was working in the temporary mortuary. He proceeded to interview mortuary staff and distressed relatives who were of the belief that he was a "bona fide" mortuary attendant.

### 2.3

#### COMMUNICATIONS

In all disasters studied on this tour, the recurring problem of effective communications was identified as a major problem and source of frustration. In the London Underground Fire the radios were ineffective. Wiring of the station had been completed, but was not connected due to renovations being undertaken. A similar problem occurred at Kegworth when it was found that due to the terrain and location of the crash within the cutting, UHF radios were ineffective. A sparsely equipped Land Rover was brought in as a Communication vehicle and assisted the communication, until it was removed to supplement the Forward Command Post established a short distance away from the crash site. As a result, contact from within the motorway cutting, was lost with the surrounding area. The RAYNET organisation, (equivalent of our WICEN, amateur radio operators), were available and could have assisted, but were not called. The RAYNET organisation have now been included in the planning process.

Lockerbie experienced the same problems. Police radios were ineffective due to the terrain and Army and RAF radios were limited also. On this occasion, RAYNET were activated and certainly boosted the communication capability.

### 2.4

#### CO-ORDINATION

The co-ordination role at emergency scenes is performed by the police, however, this has caused some concern among other agencies who still seem unwilling to accept that the co-ordination role is a police one.

Not only does the problem of co-ordination relate to actual emergency incidents, but it also extends to training exercises, where it seems that all training is done "in-house" and there is little training of agencies together. This varies throughout the country and seems to be less of a problem in some of the country areas. In the London Metropolitan area, there is a common view that joint training is of little value.

It was quite obvious that there is a tremendous amount of ill-feeling between the emergency services and this has resulted in many of the management problems which have been experienced at these major incidents.

The co-ordination role of the police does not appear to be formalised to any great extent and therefore, leads to a level of non-acceptance by other agencies.

In an effort to overcome, what seems to be a serious shortcoming in the management of emergencies, a Working Party on Emergency Procedures was established in 1987 and it has produced an Emergency Procedures Manual to be used as a reference and guide in the preparation of Force contingency plans. The Working Party was established by a Standing Sub-Committee on Emergency Procedures and supported by Chief Constables from the numerous Police Forces. It is evident that an attempt is being made to resolve the problems with co-ordination and control experienced in the past and the Manual makes recognition of that in its introduction:-

"Whatever the legal and professional responsibilities of other parties, who will play a crucial part in the management of major disasters, experience indicates that none of them will be effective unless there is order. Police Control and Co-ordination is simply a necessary pre-condition to enable all the other emergency service inputs to be brought into effect. Unless there is a single control at some level there will be competing and confusing interests. It is therefore just as essential that the police establish contact and liaison with all other key agencies at the earliest opportunity as it is that police mobilisation gets underway. The issue of Police Control and Co-ordination in this role cannot be over emphasised."

Whilst the need to develop such procedures has been identified, from my observations, a lot more hard work has to be done before such procedures will gain acceptance, particularly, within other emergency services.

### 3.0

#### RESOURCES

#### 3.1 Police and Emergency Services Personnel

One of the greatest problems encountered by emergency service organisations in the United Kingdom is the sheer number of organisations involved. Every County has its own Police Force, its own Fire Brigade and other respective emergency services organisations contained within its own boundaries.

Separate Police Forces are numbered in the vicinity of fifty four, each with its own Chief Constable and Command structure and each with their own very parochial views. This also applies to other agencies.

Whilst in many circumstances the tremendous amount of resources available would be seen as an added bonus, in times of emergencies, it brings with it, its own type of problems. Two which were particularly highlighted, were convergence at scenes of emergencies and lack of standardisation in forms and procedures.

The problem of convergence of emergency services was particularly highlighted at both the Lockerbie and Kegworth plane disasters. There is no restriction on emergency services moving from County to County to assist in emergencies or other incidents. The police powers for example are consistent, particularly throughout England. On the occasion of both the Lockerbie and Kegworth incidents, emergency services responded in large numbers from within the County, as well as from adjoining Counties.

The Kegworth plane crash occurred on the M1 Motorway, the main north/south arterial road, when a British Midland Airways Boeing 737 developed engine problems and failed to clear the motorway whilst attempting to land at the Kegworth Airport. In excess of 200 emergency service vehicles responded and parked their vehicles where they stopped without considering the consequences of their actions. All drivers vacated their vehicles leaving their flashing lights operating, their radios turned up to full volume and then took the keys of the vehicle with them. Key personnel had to leave their vehicles some three kilometres from the scene and proceed on foot because of the convergence problems. Ambulances were loaded with injured but were unable to leave the scene as they were blocked in by vehicles.

A similar problem occurred at Lockerbie, where in a very short time of the incident occurring, approximately 5000 police arrived on scene and it took some time to detail duties and functions whilst attempting to deal with the disaster and all the other accompanying responsibilities.

As I previously stated, County boundaries in England are not like Australian State boundaries. Police personnel in England are not restricted in their work by County boundaries. They have the ability and authority to cross boundaries almost at will and this was highlighted during the Hillsborough Soccer Stadium incident where police from Liverpool, attended at Sheffield, another County and police area, for the purpose of policing their own supporters from Liverpool.

Standardisation of procedures and forms was identified by a number of people as a particular problem. When we in Australia have difficulty in achieving standardisation of forms and procedures across seven States and the A.C.T., one can envisage the problems with attempting to achieve standardisation where, in excess of fifty Counties are involved.

An example which really highlights the problem was evident when during one particular interview, it was indicated that whilst that particular Force was attempting to have the Interpol Disaster Victim Identification Forms adopted as a standard by all Forces throughout the United Kingdom, they were continuing to use the Interpol D.V.I. forms for national incidents, but for local matters they preferred to use their own forms.

### 3.2

#### VOLUNTEER GROUPS

Throughout the United Kingdom, I found that there was little or no formal recognition of volunteer groups as a valuable resource for providing assistance in emergency situations. Groups such as the Salvation Army, Red Cross and Womens Royal Voluntary Service are not recognised in the planning processes as having any specific role to play. Most volunteer agencies

seem to become involved in disasters like Lockerbie and Kegworth, but only as an afterthought. There is no identified role and when needed they are called, hence, there is no incentive for them to be involved in training their people nor to prepare themselves with equipment which might never be called upon.

Some Counties have recently recognised the value of involving volunteer groups in their County plans and are now in the process of formalising their roles. Cumbria County Council is one such Council who indicated, that following Lockerbie, they are now in the process of developing plans similar to our State Disaster Response Plan which will formalise the roles of volunteer groups within that County.

Registration of evacuees is a police responsibility and undertaken by them. They have found in the past that volunteer groups have been unreliable in these areas and they prefer to perform the function themselves. The Police Forces are much larger than Australian Police Forces and have the resources to fulfil these roles.

There was an obvious reticence by emergency services to call out volunteer groups to assist at emergencies. There is little acknowledgment of the role they can play as comforters to distressed families and it is now an accepted practice that a police officer is assigned to the family of the deceased in major emergencies, to provide the necessary comfort and assistance from the time of the incident, till the inquest is concluded.

Volunteer groups have expressed the desire to be much more involved in emergency management procedures, similar to the roles undertaken by their counterparts in the Victorian arrangements, however, such acceptance by emergency services is unlikely in the short term.

### 3.3 Major Incident Box

In order that certain items of equipment will be immediately available at the scene of a major emergency, Metropolitan Police have developed a "Major Incident Box" which is maintained at each Division and must be stored in an accessible location and kept fully equipped at all times. The equipment is separated into sections and labelled to indicate the function for which it is required. The functions listed are:-

- (a) Scene.
- (b) Rendezvous point.
- (c) Marshalling area.
- (d) Mortuary.
- (e) Hospital.
- (f) Survivor Reception Centre (Evacuation Centre).
- (g) Friends and Relatives Reception Centre.

A list of the recommended contents for each section are detailed at Appendix "H".

#### 3.4 Casualty Recording Bureau

A Casualty Recording Bureau has two fundamental tasks; firstly, to gather in as much information as possible on the persons involved in the incident or has the potential to be involved and secondly, to provide accurate information to both the relatives and friends of those persons and to the Coroner or his representative.

The system is similar to our National Registration Inquiry System (NRIS) in that, a telephone number is issued via the media for relatives and friends to ring, to register their concern and provide details of the person they are concerned about.

The establishment of a bureau is standard practice when an incident occurs, however, because varying numbers of phone lines are available in different locations and procedures and documentation also varies between Police Forces, achieving a standard system is difficult.

A National Project Team is currently examining a number of issues, one of which is the inability of existing telephone systems to cope with the high volume of calls directed at one telephone number at one geographical location and via one local telephone exchange.

Following the recent Hillsborough Soccer Stadium disaster in which 95 people were killed by crushing, 1.75 million call attempts were made to the local exchange within a six hour period. Only 250,000 calls actually reached the exchange and less than 1,000 were answered by police.

A proposed new National System is now being developed, which will enable calls to be diverted to various parts of the United Kingdom where the call will be answered. By placing the information on the Police Computer, it is anticipated the problem can be overcome. A Progress Report on the National Casualty Bureau Project is attached at Appendix "I".

#### 3.5 Aide Memoirs

The Emergency Procedures Manual, previously mentioned, contains detailed Job Descriptions of designated command functions and specialist areas of responsibility. The description recommends ranks for each position identified and acknowledges that these may vary from Force to Force. The list of jobs identified includes, cordons officer(s), traffic manager, property officer (scene) and many others. The Metropolitan Police for example, have identified sixty six such positions, a list of which is attached at Appendix "J" together with a sample of the job descriptions.

In conjunction with these descriptions, they have developed a set of aide memoirs, in the form of a plasticised card, for the purpose of assisting officers who arrive at the scene of an emergency and are then detailed a specific job. They are provided with a card which details in point form, a

description of their duties. It provides advice on who they report to, their areas of responsibility and matters they should consider. I believe it would be of great assistance to personnel who are called into take charge at evacuation centres for example. Because of the rare occasions that such a centre is required, personnel are not always aware of what their responsibility is.

When handed the aide memoir, he immediately has a reference and proceeds accordingly. A sample of the aide memoirs are attached at Appendix "K".

4.0

#### CONCLUSION

It is only in recent years that the United Kingdom seems to have recognised the need to develop some comprehensive emergency management structures and procedures. The number of major situations which have occurred recently has heightened the awareness of those involved in emergency management of the requirement for a co-ordinated approach when dealing with large scale incidents and the associated planning requirements that necessarily go with it.

November 1989, saw the appointment of Mr. David BROOK as the first Civil Emergencies Adviser with the responsibility of developing emergency planning in the United Kingdom. His role encompasses all aspects of emergency planning, reporting direct to the Home Secretary.

A major review of arrangements for dealing with civil emergencies is now underway in the United Kingdom and includes the following topics:-

- (a) The role of Central Government.
- (b) Statutory requirements for civil contingency planning.
- (c) National Co-ordination.
- (d) Public Information.
- (e) The role of voluntary bodies.
- (f) Provision of aftercare.

It is encouraging to note that issues now being considered in the United Kingdom are well and truly enshrined within Victorias' emergency management procedures.

The study tour has reassured me that in this State we have developed a very comprehensive emergency management structure which is recognised overseas as one of the best in the world. However, it was also highlighted, that there is a need to continually review our procedures, to practice them together and ensure that they are flexible enough to deal with the many varied and difficult incidents that can occur when an emergency/disaster occurs.

OFFICIAL VISITS/MEETINGS

1. Police Requirements Support Unit, Home Office.
2. Metropolitan Police Communications Centre, New Scotland Yard.
3. Metropolitan Police Casualty Recording Bureau.
4. Metropolitan Police Emergency Procedures.
5. London Transport International, London.
6. Kings Cross Underground Railway Station.
7. British Red Cross Emergency Planning Section.
8. Heathrow Airport, Metropolitan Police.
9. Kenyon Emergency Services.
10. Liecestershire Police Headquarters.
11. South Yorkshire Police Training Wing.
12. South Yorkshire Police Headquarters.
13. Hillsborough Soccer Stadium.
14. West Yorkshire Police Headquarters.
15. Bradford Soccer Stadium.
16. Cumbria County Council Emergency Planning Office.
17. Lockerbie Control Centre.
18. Dumfries and Galloway County Council.
19. Cumbria Police Headquarters.
20. Whitehaven Police Station, Cumbria County.

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WHAT TO DO IN AN  
**Emergency**

AT ALBRIGHT & WILSON'S  
WHITEHAVEN WORKS

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This guide has been prepared jointly by  
Copeland Borough Council, Albright &  
Wilson Ltd. and Cumbria County  
Council's Emergency Planning Unit for  
distribution to everyone within the  
Sandwith, Kells, Mirehouse East and  
Mirehouse West Wards of Whitehaven.

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**ALBRIGHT  
& WILSON**



## Introduction

Albright & Wilson have been producing chemicals here in Whitehaven for nearly half a century and in this time there has never been an accident resulting in serious injury to members of the public.

It must be stressed that the possibility of such an accident is very remote and that the design of all plant on the site is to the highest standards of safety which are also independently monitored by the Health and Safety Executive.

Nevertheless it is important that local residents know what action to take in the event of an emergency, and therefore you are advised to study this leaflet carefully and keep it in a safe place.

The leaflet has been produced in the interests of public safety and in response to proposed new regulations\*. There has been no change in operations at the site.

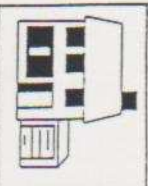
\*The Control of Industrial Major Accident Hazards (Amendment) Regulations 1988.

## Your First Actions

**IN THE EVENT OF AN EMERGENCY AT ALBRIGHT & WILSON'S WHITEHAVEN WORKS**

**IF YOU RECEIVE WARNING OF A MAJOR INCIDENT, OR BECOME AWARE OF ONE, OR IF YOU HEAR THE EMERGENCY SIREN, (A LOUD RISING AND FALLING WAILING SOUND) REMAIN CALM AND FOLLOW THIS ADVICE**

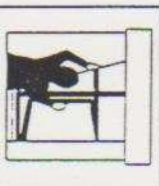
**1 GO INDOORS AND STAY THERE.**



**2 DO NOT LEAVE THE AREA.**



**3 CLOSE DOORS AND WINDOWS.**



**4 DO NOT USE TELEPHONE (except in an emergency).**



**5 LISTEN TO RADIO CUMBRIA. 206m MW, 95.6 MHz FM.**



For additional information see over .....

# Your First Actions

## EMERGENCY SIREN

If an accident at the site threatens to affect the public, the EMERGENCY SIREN will be sounded. This is a loud, rising and falling "wailing" sound and should not be confused with the site alarms which make a steady "wailing" sound.

N.B. The emergency siren will be tested periodically and prior warning given in the Whitehaven News and on Radio Cumbria.

## GO INDOORS

In order to restrict any fumes entering your home close all doors and windows. Switch off ventilation fans, air conditioning and heating systems.

## DO NOT ATTEMPT TO LEAVE THE AREA (unless told to do so by the Police)

You will be much safer indoors. If you are outside you are more likely to be affected and if you try to leave you may block the roads for the emergency services.

## DO NOT USE YOUR TELEPHONE (Except for emergencies)

The emergency services, and Albright & Wilson, will need all available telephone lines. Jamming of their exchanges would merely hinder them.

## TUNE IN TO RADIO CUMBRIA (206m medium wave, 95.6 MHz FM)

During an emergency, information and advice will be broadcast on the Radio Cumbria frequencies.

# Possible Incidents

The types of incident that might affect you are a gas escape or an explosion.

## GAS ESCAPE

Areas downwind of the site could be affected if there were a major escape of sulphur trioxide. This is easily recognised: it is a dense, white, choking gas.

## EXPLOSION

In this event, windows of buildings around the site could be shattered, and the main dangers would be flying debris and glass.

Further information on what to do should either incident occur is given in the next four pages.....

# What You May Need To Do

- ☛ The Police may ask you to:
  - ☛ Shelter from a chemical incident such as an escape of gas
  - OR
  - ☛ Shelter from a possible explosion
  - OR
  - ☛ Evacuate

## 1. SHELTER (Gas Escape)

- ☛ Go indoors and stay there.



- ☛ Close all doors and windows, and switch off ventilation fans, air conditioning and heating systems. Put out open fires and where possible block up chimneys.



- ☛ Do not go outside, where you could be in danger of being caught in a gas cloud.



- ☛ Do not attempt to collect children from school. They will be looked after by their teachers.



- ☛ Stay tuned to Radio Cumbria (206 metres medium wave, 95.6 MHz FM).



### IMPORTANT

If there has been a gas escape, it is important that when the white gas cloud has passed all windows and doors are opened so that any gas that may have seeped in can escape. The Police will tell you when this needs to be done.

## 2. SHELTER (Possible Explosion)

- ☛ Take shelter in the nearest building, in a room on the opposite side of the building to the site.



- ☛ Close curtains and blinds, and keep away from windows to avoid danger from flying glass.



- ☛ Under no circumstances go outside. You will be much safer indoors.



- ☛ Do not attempt to collect children from school. They will be looked after by their teachers.



- ☛ Stay tuned to Radio Cumbria (206 metres medium wave, 95.6 MHz FM).

WHAT TO DO IN A EMERGENCY

### 3 EVACUATION

- If the Police advise you to evacuate from the area they will direct you to a RECEPTION CENTRE, where you can stay until the emergency is over.

The main reception centre is:  
Whitehaven School, Cleator Moor Road,  
if this school is not available the reserve reception centre is:  
St. Benedict's RC School, Red Lonning.

- Use your own transport if possible and go directly to the Reception Centre.

- Do not delay except to gather essential medicines etc.

- If you have space in your vehicle please take any neighbours who don't have their own transport.

- If you do not have transport, walk immediately to the nearest assembly point announced by the Police, from where a bus will take you to the reception centre.

WHAT TO DO IN A EMERGENCY

- If you know of anyone who is elderly or infirm, and who might have difficulty during the evacuation, please help, or if you are unable to do so, tell the Police of their whereabouts and circumstances.

- Do not attempt to collect children from schools. They will be taken to the reception centre, where you can meet them.

- If you wish to stay with friends or relatives you will of course be free to do so. However, it is vital that you register at the reception centre first, so that if someone asks the Police about you, they will be able to say that you are safe.

- If you bring pets to the reception centre in a car, leave them in the car but do not fully close all the windows. Alternatively, temporary accommodation can be made available.

# Registration Card

If an emergency occurs, it is important that the Police know who has been involved. The registration card (attached to the action card enclosed) will be used should this be necessary.

- In order to save time fill in your registration card **NOW** — complete sections A and B and leave section C blank.
- Do not detach the registration card from the action card. Put them in a safe place where you can find them quickly if an emergency occurs. You may like to pin the cards to the inside of a cupboard door.
- If the Police ask you to leave your house take the registration card with you.
- Give the registration card to a Police Officer when asked.

# Further Details

Further details of these emergency arrangements can be obtained from:

The Assistant Secretary  
Copeland Borough Council  
PO Box 19  
Catherine Street  
WHITEHAVEN CA28 7NY

OR

The Safety Department  
Albright & Wilson Ltd.  
Whitehaven Works  
PO Box 15  
Whitehaven CA28 9QQ

OR

County Emergency Planning Officer  
Arroyo Block  
The Castle  
CARLISLE CA3 8UR

WHAT TO DO IN AN EMERGENCY

# School Action Card

For use in the event of an emergency at Vickers Shipbuilding and Engineering Ltd., Barrow-in-Furness.

If you hear the Vickers Works Hooter warning signal (3 short blasts, 3 times), or if you receive warning of an emergency from the Police, remain calm and follow this advice.

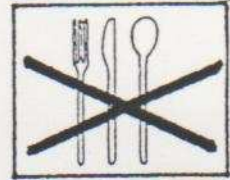
**1** GO INSIDE AND CLOSE DOORS AND WINDOWS.



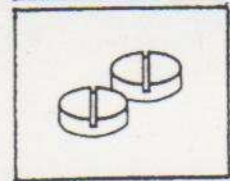
**2** MONITOR RADIO FURNESS\* AND TELEPHONE.  
(\*358m MW and 96.1 MHz, FM)



**3** WAIT FOR ADVICE BEFORE EATING OR DRINKING FOODSTUFFS.



**4** TAKE POTASSIUM IODATE TABLETS WHEN ADVISED (Infants up to 4 years, 1 tablet. Children over 4 and Adults, 2 tablets)



**5** CHECK ATTENDANCE REGISTER, and record the names of those who have not taken potassium iodate tablets.



**6** AWAIT POLICE INSTRUCTIONS.



For additional information see over .....

## CONCLUSIONS AND APPRECIATIONS

The Lockerbie Air Disaster will be remembered, sadly, as one of the worst atrocities perpetrated by international terrorism and which required the largest criminal investigation in Scottish legal history. It will be remembered too by the families and friends of those who so tragically lost their lives and by those throughout the world whose hearts were so moved by the terrible events of Wednesday 21 December 1988.

The response to the Disaster by the Regional Council has been recognised as of national and indeed international significance and a great deal of interest has been expressed by local authorities and others concerned with emergencies planning in the issues facing the Council and the lessons learned from its experiences. This report is aimed primarily at recommending to the Council how it may wish to develop its own emergencies planning in the future. It is to be hoped that others will also benefit from this publication for their own purposes and that the Council's response will be a significant contribution to the development of emergency planning elsewhere.

It is relevant therefore, in conclusion, to dwell briefly on more significant issues that arose and were developed through the many phases of the response (some of which are continuing as this report is completed) and to emphasise the main principles which were adopted.

The Council's response can be summarised as applying two main strategies - support for the Police and Emergency Services operations and support for the Community and the Bereaved.

On the first, the policy of total support to the Chief Constable in the search, recovery and investigation operations could only have been achieved by the Regional Council because it had access to the required level of resources. If, as it appears to be, it is accepted by Government that responses to major emergencies should continue to be managed at a local level then clearly the Regional Council will have the major role to play and it should therefore plan accordingly.

On the second, but equally important strategy - that of support to the Community and the Bereaved, the principle lesson learned from the Disaster is that they should as far as possible determine the manner and pace of their own recovery. It is right that the Regional Council and the other agencies work together to provide the maximum support to the Community and individuals in the process of recovery.

The Regional Council's effort was but one part of the wider response from many organisations and individuals involving international agencies, central government, the public services, armed forces, the private sector, voluntary organisations and, again, the Community at large. Little could have been achieved by the Council or each of these bodies alone and the success of the overall response is undeniably due to the mutual support, trust and understanding on the part of all those involved.

Within that context it is appropriate to conclude a report which related primarily to the local authority role with the following expressions of appreciation:

- to the local authorities throughout the United Kingdom who offered their support and assistance and to those members of their staff who gave indispensable assistance at Lockerbie.
- to the Convener of Annandale and Eskdale District Council and, in particular, the two local Elected Members who have played an integral part in the response by both authorities,
- to the Chief Executive and staff of the District Council who have shared in the task of responding to the emergency and have given of themselves so fully in the interest of the Community,
- to the staff of the Regional council who have worked in and for Lockerbie without regard to their personal circumstances and who have addressed their difficult and demanding task with commitment, determination and sensitivity,
- to our families who have also made personal sacrifices and who have given us their support, comfort and understanding,
- to the Convener, Vice-Convener and Elected Members of Dumfries and Galloway Regional Council, who have carried the ultimate responsibility and accountability for all that has been done in the Council's name, for their consistent leadership, guidance and support.

This report has not been intended to be an object lesson but rather an objective account of the manner in which the Council, working along with many other agencies, has responded to the Lockerbie Air Disaster. Many aspects of that response could, inevitably, with hindsight, have been carried out differently and to even greater effect. Many lessons have been learned which will, hopefully, benefit others in their own emergency planning. If this report assists in any way to ease the pain and anguish of those affected by future disasters and to promote the process of recovery and renewal then it will have served its purpose.

Neil McIntosh  
Chief Executive

November 1989

- **Development** - Plans will require to be developed over time and reviewed and updated regularly. This process should involve not only key personnel from the Council but also from other agencies. Trials and exercises should be held to test the effectiveness of the plans and those who will be involved in their implementation. The existing Emergencies Planning Consultative Group is a valuable forum to discuss matters in general. Consideration could be given to holding regular meetings with key personnel in smaller specialised working groups to consider individual elements of the planning process in greater detail.

**Recommendation Sixteen** - *That the Council agrees to pursue development of their emergencies planning in terms of the policies, strategies and framework outlined above and receive further reports as to progress.*

## 2 Emergencies Planning in the National Context

Many of the recommendations made to the Council relate to what can be considered as local emergency planning issues which can be developed through discussion and trial involving the Council's own departments, the Emergency Services, public agencies, the voluntary sector and representatives of the Community.

However, the experiences gained at Lockerbie are also of relevance to emergencies planning nationally and indeed internationally. Prior to this report being prepared Central Government undertook a review of the current arrangements for dealing with civil emergencies. It is considered that the Council's own experiences as detailed in this report can make a contribution to the continuing debate.

It is proposed to refer to each of the conclusions drawn from the Government's review and to comment on them in light of the Council's experiences as follows:

- **The Role of the Local Authority** - The review concludes that the basis of the response to particular disasters should remain at local level. This should be supported. While it is accepted that a response should be co-ordinated and delivered at "local" level it is felt that further comment is required as to the particular role of the local authority (as distinct from the Police and other emergency services) and on the question of responsibility between local authorities given the present two-tier structure of local government.
- **Further Legislation** - The Government's review concludes that the powers available to local authorities in terms of Section 84 of the Local Government (Scotland) Act 1973 are sufficient for their emergency planning purposes and use of resources and so it was considered that there was no immediate requirement for additional legislation to cover planning for peacetime emergencies. It is considered that this view can be supported given the Government's intention to keep its position under review and that clarification of the responsibilities and duties of local authorities is clarified in further guidance. In addition clearly defined responsibilities should be allocated to ensure a fully co-ordinated and integrated response is delivered. Central Government should issue guidance on which authority (civil or uniformed) should undertake liaison with other support agencies from the public and voluntary sectors.
- **National Disaster Response Team** - The conclusion of the review not to pursue the concept of a National Disaster response team is to be supported given the view that responses must be managed and delivered at local level, a view which has, hopefully, been substantiated at Lockerbie.
- **Civil Emergencies Adviser and Emergencies Planning College** - The proposal to establish a post of Civil Emergencies Adviser whose aim will ensure that local plans are compatible and that best practices are drawn up and made widely available is to be supported. It is important to support the view that such an adviser would not have operational role in any disaster but would be concerned with general questions of forward planning and training. In addition the proposal to widen the remit of the Emergency Planning College to embrace civil as well as war time emergencies planning (implemented in June 1989) is to be supported.

**Recommendation Seventeen** - *The Council is asked to accept the proposals and recommendations for furthering their own emergencies planning and relating to such planning within the national context.*

## SECTION FOUR

### CONCLUSIONS FOR EMERGENCIES PLANNING

#### Introduction

This final section seeks to address the broader issues in Emergencies Planning generally which are based on the experiences gained in responding to the Lockerbie Air Disaster. The Council will wish to take this opportunity to review its emergencies planning arrangements within the Region generally to ensure that the lessons learned in the response are fully developed and implemented through close liaison with the public and voluntary sectors.

The Council will also be aware of the significant interest shown by many other organisations involved in emergencies planning and disaster response both at national and international level. It is important therefore to consider these issues particularly at national level and to comment on the powers, responsibilities and functions of local authorities generally in that context.

#### 1 Local Emergencies Planning

Peacetime Emergencies Planning is perhaps a concept which requires identified aims and policy objectives as much as any written documentation. It requires a commitment both in terms of physical and human resources and of mind. This commitment exists in the region not only within the Council but in the many other agencies and organisations that responded to the Disaster. It is considered that the Council should take the lead in harnessing that commitment and ensuring its further development in terms of its own main aims and strategic policies.

It is also considered that the Council should recognise in their strategic policies for emergency planning the concepts of a unified local authority approach, total support and co-operation, delegation of responsibilities to senior management; and the dedicated team approach, and full involvement of the community in its own recovery with the withdrawal of the Council's participation when circumstances so permit.

The Council may also wish to accept the following general principles as the framework in which to further develop their emergency plans in terms of the 'All Hazards Approach' :

- **Format** - Plans should be flexible. It is clearly not possible to provide detailed arrangements on how a response should be implemented in any written format. Written plans should include all necessary data bases regarding contact points in the Council and other key agencies, call out responsibilities and arrangements, resources such as available types of accommodation and appropriate uses, equipment and other supplies. This would enable those directly involved in making preliminary and longer term arrangements to have as much relevant information as possible at their fingertips.
- **Implementation** - Plans should identify which organisations should be called out as a matter of course in different situations and which others might be put on standby until required. Plans could be designed on a "menu" basis through which identified needs could easily be matched to known existing resources. "Key/prompt" cards could be developed for central control staff as aide memoires covering all standard issues that ought to be addressed in any situation.
- **Staffing** - A core team of Regional Council officials could be identified as an Emergency Planning and Response Team. The role particularly of emergency planning staff in operational circumstances should be addressed and clear distinctions drawn between their responsibilities for planning and for implementation.
- **Liaison** - Each agency or service should have clearly defined roles and lines of communication. Their resources and abilities should be identified in the planning process. All of these issues should be agreed and recorded within any written plan. Arrangements for liaison with the community should be included as far as possible.
- **Training** - of key personnel in the use of communications systems, logging procedures and generally responding to emergency situations will be important. Training in other aspects of a response not least in media relations, stress handling and related personnel issues will also be required.
- **Phased Approach** - Plans could address in some detail the specific requirements of a immediate response including the roles of the emergency and other support services, those of the voluntary sector and the local community. For later phases, written plans may be less appropriate other than as 'aide memoires' of the policies and strategies agreed by the Council as so important.

# Additional Information

## ● SHELTERING

If sheltering is required, remain calm - under no circumstances go outside. The Police will tell you when it is safe to do so.

## ● FOODSTUFFS

Uncovered food and water may be contaminated with radioactive particles. Advice on foodstuffs will be broadcast on the radio or passed by the Police.

## ● PARENTS

Advise any parents arriving to collect their children to remain with them in school until the emergency is over.

## ● EVACUATION

If an evacuation is required, the Police will organise transport. All staff, pupils and any parents present must go to a Reception Centre to be registered. Take the School Attendance Register with you.

## ● FURTHER INFORMATION

For further advice consult the booklet  
"EMERGENCIES IN THE VICINITY OF YOUR SCHOOL"  
which is held by



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**Volunteers**

After Wednesday 4th there will be no daytime Youth Club for primary school age youngsters. The children have all asked if they can have a club in the evenings. There is equipment available for a Youth Club so volunteers please, to put on a one night a week club for primary school age.

Teenagers 12 yrs upwards have been asking about an evening Drop-In Club starting next week. Again volunteers please and we can get this going either one or two nights a week.

**Drop-In Cafe**

Remember the Community Cafe is open at the Ebenezer Hall, Park Place, on weekdays from 10 - 12 noon and 2 - 4 pm.

**Toddler Group**

The Parent and Toddler Group which normally meets in the Town Hall hopes to restart on Tuesday 10th Jan. in the Guide Hall. Watch out for more definite news!

**Citizens' Advice Bureau**

We now have a temporary base in the Ebenezer Hall, Park Place. We will be available at 2 pm on the days that the Drop-In Cafe is open. We hope to have use of a shop in the town shortly.

**Resident's Meeting**

The residents of Sherwood Park are arranging a further meeting for those affected in the Sherwood Park/Crescent area on Thursday 5th at 7 pm in the Queen's Hotel Function Suite.

**Low Flying Aircraft**

George Younger, Secretary of State for Defence, has given an assurance to Sir Hector Monro MP, that there will be no low flying at all in the Lockerbie area for the present and that the position will be reviewed when the Air Crash Investigation is complete.

**Clearance of Debris**

Would anyone who still has debris in their garden please inform the Community Liaison Office on the number below.



COMMUNITY LIAISON OFFICE  
LOCKERBIE LIBRARY 30-32 HIGH STREET LOCKERBIE 4241/4242

## APPENDIX THREE

**COMMUNITY UPDATE**

Number Two

31st December 1988

**Social Work Department**

The Social Work Department is, at present, located in Holy Trinity Church Hall. It will be open Monday to Saturday, starting Monday 2nd January, from 9 a.m. to 5 p.m..

Help with immediate material needs is available now **WITHOUT PREJUDICE** to insurance claims.

Telephone numbers      Lockerbie 4175 for normal calls.  
    Lockerbie 4244 - HOTLINE NUMBER

**PLEASE CONTACT THESE NUMBERS AND LET US HELP YOU**

**Memorial Service**

A Memorial Service will be held in Dryfesdale Church on Wednesday 4th January at 2 p.m.

The service will be relayed to Dryfesdale Hall, Mid Annandale Comrades Club and probably All Saints Episcopal Church.

Local people are requested not to bring their cars to the church as traffic will be heavy and parking will be very limited.

**Youth Club**

The Youth Club in the Scout Hall has been very successful over the last two days. There will be further sessions on Monday 2nd 2-4 pm, Tuesday 3rd 10 - 12 noon, 2 - 4 pm, Wednesday 4th 10 - 12 noon. On Wednesday there will also be a trip for 5 - 9 year olds to Puddle Lane Play Centre in Carlisle leaving at 9.30 and back at 12 noon. There will be 45 places available for this trip so get your name in quickly; there will probably be space for parents should they wish to go.

There will hopefully be an outdoor adventure day for secondary school age youngsters on Thursday so watch out for news of this.

Children please remember to bring back consent forms, no-one can go on a trip without one.

## APPENDIX FOUR

**COMMUNITY UPDATE**

Special Edition

16th May 1989

**SPECIAL EDITION**

The first Community Update came out on the 29th of December 1988. It provided all of us with vital information following the Air Disaster.

For many people the immediate problems have been resolved and day to day routines have been resumed successfully. This may not be so for everyone. Problems may crop up months or even years later. Information from other areas shows that long-term damage to people's lives will only happen when distress is not recognised and dealt with. Disasters and the difficulties they create can be overcome.

Community Support is using this Special Edition of Update to let you know of the work being done, to look at what still needs to be done, and to invite you to take part.

1.



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### Clean-up, Repair and Restoration

The Works Section set up within the Regional Council's Lockerbie Emergency Unit is co-ordinating a clean-up, repair and restoration programme in close co-operation and liaison with the District Council, Public Utilities, Tradesmen, Contractors, etc..

Using local volunteers the Sherwood Park and Crescent, Ivy Place, the children's play area at Rosebank, King Edward Park and Mains Meadow areas have been substantially cleaned up.

As soon as the Police release the remainder of the Rosebank area and any other areas, the local volunteers will carry out cleaning up work.

Urgent repairs are being carried out to the Sherwood area by local tradesmen and contractors under local volunteer supervision.

The sewer in Alexandria Drive which was damaged by a jet engine has now been repaired.

Anyone requiring either clear-up or urgent repair work should contact the Community Liaison Office at Lockerbie Library.

### Personal Problems

At the meetings which have been held with members of the local communities, various problems have been raised in connection with legal issues, property surveys, financial assistance etc.. So far as property surveys, independent insurance advice and financial assistance are concerned, investigations are being carried out to find the best way to provide a "professional" service to the community. Further details will follow, however, in the meantime, if you have any questions or you require financial assistance, please contact the **COMMUNITY LIAISON OFFICE (Lockerbie 4242)** or the **SOCIAL WORK OFFICE (Lockerbie 4175)**.

In regard to legal problems, The Law Society of Scotland recommends that you engage your own solicitor. If you have difficulties, you are advised to telephone the Law Society's "Lockerbie representative" on 031 226 7415. The Law Society will thereafter engage a solicitor for you. When you do employ a solicitor please ask him to notify the Law Society that he is acting for you.

### Clubs

Lockerbie Dog Training Club will not meet until further notice.

The R and I Ladies Club will meet as usual on Thursday 5th Jan. at the Blue Bell Hotel.



COMMUNITY LIAISON OFFICE  
LOCKERBIE LIBRARY 30-32 HIGH STREET      LOCKERBIE 4241/4242

### Home Baking

This is still required for the Rescue Services and the Drop-In Cafe. It should be brought to the Central Collection Point at Lockerbie Library between 9 and 11 am daily.

### School Opening - Official Dates

Lockerbie Primary School will open on 5th January.

Lockerbie Academy (Secondary) The Regional Council has advised us that they are working towards an opening on Monday 9th January.

### Community Liaison Office - New Year's Day Opening

The Community Liaison Office will be open between 12 noon and 4 pm on New Year's Day. Any questions or problems which you may have will be dealt with outwith these times if you telephone Lockerbie 4260.

### Physical Planning Department

If you want any advice on Planning or Building Control matters then Gordon Mann, the Director of Physical Planning can be contacted through the Community Liaison Office at Lockerbie Library. Building Control staff can also inspect your property if you are worried about its safety. This, however, is not a replacement for a full structural survey by a chartered surveyor.

Every individual circumstance will be different, but in general, there is no need for anyone to make a Planning or Building Warrant application for repairs to a building. Where a house has to be completely rebuilt then it will be necessary to apply for both Planning Permission and a Building Warrant.

If you have any questions come in and see us at the Library.

### Addresses

A list of addresses of people temporarily rehoused is available at Lockerbie Library.



COMMUNITY LIAISON OFFICE  
LOCKERBIE LIBRARY 30-32 HIGH STREET LOCKERBIE 4241/4242

## COMMUNITY UPDATE ...

**YOU CAN HELP US**

There are bound to be other things which have been overlooked. They may not have seemed important at the time, but it's not too late to look at them again. It would help us if you gave some thought to the following questions.

1. Some people think that everything should be alright now, but do **YOU** think you need more help ?
2. Relatives or friends may still be relying on you more than usually. Can we help you to continue supporting them ?
3. There may be particular problems in some places throughout the area, those who live there need the chance to work these problems out. Can we help ?
4. Many of you offered help wherever it was needed day or night in the weeks following the disaster. Do you feel you have been forgotten since ?
5. A lot has happened in Lockerbie since the disaster. Do you know of things which have been missed or forgotten about ?
6. Do you have any ideas or suggestions which you think would be helpful for the people of Lockerbie in the future ?

4.



**COMMUNITY UPDATE ...****CAN COMMUNITY SUPPORT HELP YOU?**

As time passes, we may expect to get back to normal. Experience from other places shows that problems can last much longer than we anticipate.

If you know what to expect then you will be able to

1. recognise a problem in yourself or a friend
2. offer a friend the help he or she may need
3. decide when help from others is needed
4. take an active part in the future

You may think you are the only person in Lockerbie still feeling upset. This is not so. Don't let pressure from other people stop you from asking for help.

**SELF-HELP**

In other places which have been affected by disasters, groups of friends, neighbours, class-mates etc., have met regularly in an informal atmosphere. These self-help groups can be very successful. If you would like to organise one, we may be able to help you by :

- arranging to meet people to discuss the possibility
- making a meeting place available
- helping with the running of the group, if you want us to.
- making resources, such as copying facilities, background information and talks available.

3.



**COMMUNITY UPDATE ...****COMMUNITY SUPPORT**

Community Support is a group of people who are working together.

So far Community Support has been helping with :

- ★ relocation of residents and restoration of property
- ★ personal and family support
- ★ election of street representatives, forming of Residents Associations and Community Groups
- ★ establishing and continuing an information service to the community,
- ★ liaison with Pan Am, insurers and solicitors when asked for
- ★ dealing with holiday offers and other events
- ★ matters concerning the Trust Fund
- ★ dealing with the media

Some of these issues are still going on. Through time fresh questions will come up. We would like you to suggest the best ways we can help you..



## **CORDONS OFFICER**

### **RANK:**

Inspector or Chief Inspector.

### **ROLE:**

1. Responsible to the Incident Officer.
2. Liaise with the Incident Officer on the siting of the inner and outer cordons and access points.
3. Liaise with Incident Control Post re issue of passes.
4. Divide manpower into units and allocate areas of responsibility.
5. Brief sector supervisors.
6. Requisition equipment (e.g tapes, ropes and barriers) to reinforce the boundary as necessary.
7. Arrange for regular rotation of staff for rest and refreshment.
8. Ensure that all entry and exit points are manned.
9. Maintain radio contact with the Incident Control Post.
10. Perform other duties as directed by the Incident Officer.

## INCIDENT OFFICER

The role of the Incident Officer is extensive and exacting and it is therefore recommended that the Commander of the division in which the incident occurs should assume this responsibility. However, until his arrival at the scene, the senior police officer present will assume interim command. Consequently a succession of officers may assume the role. If this is the case it is suggested that each remain as staff officer to his successor until the Divisional Commander arrives.

The Incident Officer's responsibilities are such that he must be free from administrative functions to act as an operational forward commander, controlling and co-ordinating the on site operation. He must be easily identifiable to others and should therefore wear a fluorescent jacket or tabard with 'Incident Officer' thereon.

He will be resourced by the Incident Control Post, through which manpower, technical and material support will be requested as required.

### RANK:

Divisional Commander.

N.B. The first officer at the scene and successive supervisors will assume this function until the arrival of the Divisional Commander.

### ROLE:

1. Responsible to the Overall Incident Commander.
2. Establish and maintain Police control and co-ordination at the scene.
3. Assume command of all police operations in the "controlled area".
4. Declare the incident a 'major incident'.
5. Ensure that action has been taken to organise:
  - (a) Priority traffic routes for essential services;
  - (b) Rendezvous points;
  - (c) Diversions;
  - (d) Incident Control Post;
  - (e) Casualty Clearance;
  - (f) Cordons with manned entry and exit points;
  - (g) Protection of Property;
  - (h) Documentation Teams;
  - (i) Parking for essential service vehicles;
  - (j) Press Liaison Point.
6. Instigate the establishment of a temporary mortuary.
7. Activate the Casualty Bureau.
8. Co-ordinate the response of the emergency services.
9. Consider the need for evacuation.
10. Ensure the provision of adequate communications.
11. Request specialist equipment as necessary.
12. Request assistance from voluntary and support services as necessary.
13. Assess staffing levels and request additional manpower as required.
14. Ensure that provision is made for canteen and rest facilities for use by the on site workforce.
15. Ensure regular situation reports are transmitted for the information of the Overall Incident Commander.
16. Liaise with on site representatives of other emergency and support services.
17. Provide information for the Identification Commission as required.
18. Submit full report (but see Section 7—paragraph 1.4).

## JOB DESCRIPTION

## INDEX

- |  |  |
|--|--|
| (3) Overall Incident Commander.                            | (34) Friends & Relatives Reception Security.               |
| (4) ‡ Incident Officer.                                    | (35) ‡ Casualty Bureau Officer in Charge.                  |
| (5) Investigating Officer.                                 | (36) ‡ Casualty Bureau Deputy.                             |
| (6) ‡ Incident Control Post Co-ordinator.                  | (37) ‡ Missing Person Enquiry Unit Supervisor.             |
| (7) ‡ Major Incident Control Room Co-ordinator.            | (38) Missing Person Enquiry Unit Operator.                 |
| (8) ‡ 1st Officer at Scene.                                | (39) ‡ Casualty Information Unit Supervisor.               |
| (9) Logistics Officer/Team (Major Incident Control Room).  | (40) Casualty Information Unit Operator.                   |
| (10) Communications Officer (Major Incident Control Room). | (41) ‡ Casualty Bureau Collator.                           |
| (11) Operations Officer (Major Incident Control Room).     | (42) ‡ General Message Unit Supervisor.                    |
| (12) Cordons Officer.                                      | (43) General Message Unit Operator.                        |
| (13) Press Liaison Officer (Scene).                        | (44) Casualty Bureau Administrator.                        |
| (14) Property Officer (Scene).                             | (45) General Duties Officers.                              |
| (15) Traffic Manager.                                      | (46) ‡ Mortuary Documentation Officer.                     |
| (16) Rendezvous Point Officer.                             | (47) Mortuary Duty Officer.                                |
| (17) ‡ Survivor Reception Centre Supervisor.               | (48) ‡ Ante Mortem Co-ordinator.                           |
| (18) Survivor Reception Documentation Officer.             | (49) ‡ Ante Mortem Liaison Officer.                        |
| (19) Survivor Reception Liaison Officer.                   | (50) Relative Liaison Officer.                             |
| (20) Survivor Reception Security.                          | (51) ‡ Officer in Charge of the Identification Commission. |
| (21) Casualty Receiving Station Officer.                   | (52) Identification Commission Administrator.              |
| (22) Ambulance Loading Point Officer.                      | (53) ‡ Post Mortem Preparation Team.                       |
| (23) ‡ Body Recovery Teams.                                | (54) ‡ Post Mortem Examination Team.                       |
| (24) ‡ Hospital Documentation Team Supervisor.             | (55) ‡ Property Team (mortuary).                           |
| (25) Hospital Documentation Officer.                       | (56) ‡ Clerk/Observer to the Odontologist.                 |
| (26) Hospital Documentation Liaison Officer.               | (57) ‡ Photographer (mortuary).                            |
| (27) Hospital Documentation Property Officer.              | (58) ‡ Fingerprint Officer (mortuary).                     |
| (28) Hospital Radio Communications Officer.                | (59) ‡ Reception (mortuary).                               |
| (29) ‡ Evacuation Officer.                                 | (60) Stretcher bearers (mortuary).                         |
| (30) Rest Centre Liaison Officer.                          | (61) Security Officer (mortuary entrance).                 |
| (31) ‡ Friends & Relatives Reception Centre Supervisor.    | (62) Police Media Spokesman.                               |
| (32) Friends & Relatives Reception Documentation Officer.  | (63) Site Clearance Manager.                               |
| (33) Friends & Relatives Reception Liaison Officer.        | (64) Property Recovery Teams.                              |
|  | (65) Body Recovery Officer.                                |
|  | (66) Plotter.  |

- 5.5 Fortunately the solution to this problem exists, in that it is possible to place the information onto the Police National Computer (PNC), which ALL police forces have access to, and thus make it available very quickly to the force dealing with the incident. (NOTE: PNC is currently being upgraded to PNC2)
- 5.6 The option proposed requires three elements to be in place :-
- An integrated telephone diversion network, using Advanced LinkLine
  - Standard documentation and procedures, and
  - A Missing Person Database on PNC2. (Police National Computer 2)

All of these, and hence a full national system, can technically be in place by early 1991; this, therefore, is the target time being pursued by the Team.

## 6. CASUALTY INFORMATION

- 6.1 The system described so far has concentrated on the collection and processing of information obtained from public enquiry telephone calls, concerning persons who might be involved; to make any use of this information it is necessary to also collate information on those actually involved, and this means getting fast, accurate details of casualties from the scene, the hospitals and the mortuary.
- 6.2 As with the forms used for logging public enquiry calls, the documentation for logging casualty information is not standard throughout the country, or even in many cases throughout individual Police areas. Procedures also vary, with some hospitals allowing Police officers to take details direct from casualties and others insisting on this being done by hospital staff.

## 7. FUTURE OF THE PROJECT

- 7.1 The Project aims to produce a full, working system by about April 1991 and is, therefore, engaged in the final consultation stages with outside agencies who are affected by the proposals put forward to date; this consultation includes such agencies and groups as the Health Service and the media.

*Should you have any questions with regard to the project please contact the Project Team at*

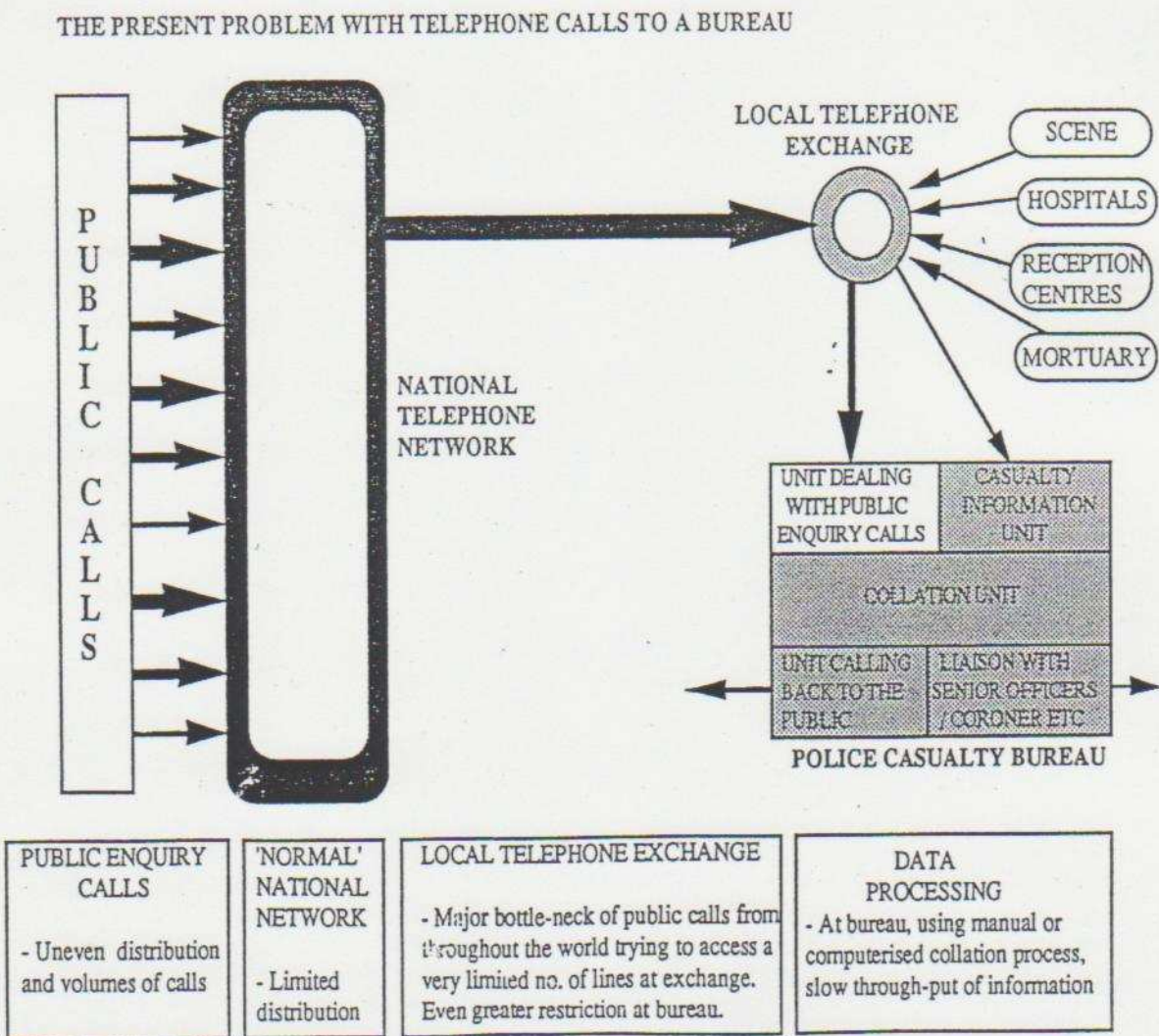
*The Home Office,  
Police Requirements Support Unit,  
Room 253, Horseferry House,  
Dean Ryle Street,  
LONDON SW1P 2AW*

*Telephone number :- 071 - 217 - 8520  
( this has an answer-phone facility when the team are away from the office)*

*Fax number :- 071 - 217 - 8619*

- 4.3 The result of this situation is to create a huge bottle-neck of calls and this means that not only do very few of the concerned callers get through, but other traffic through the local exchange, including calls from the hospitals etc to the bureau, are also very badly affected. This has the following consequences :-
- frustration to worried callers
  - unsuccessful callers start ringing hospitals, police stations etc, causing more disruption to the emergency services
  - unsuccessful callers visit the scene, hospitals and police stations in person seeking information, causing problems of manpower required to deal with them
  - information required to assist in identification of casualties fails to reach bureau
  - local industry, commerce and 'normal' telephone traffic very severely affected, often stopped altogether
- 4.4 To illustrate the bottleneck effect, following a recent disaster at a football stadium, where 95 of a crowd of 50,000 were killed by crushing, within a period of six hours 1.75 million call attempts were made to the local exchange, only 0.25 million actually reached the exchange and less than 1000 were answered by police at the bureau.
- 4.5. The main priority set to the Project Team was to solve this problem, and thus provide a way in which these calls could be dealt with.

FIGURE 1



- 2.3 The Casualty Bureau Project Team was established in August 1989 to examine all aspects of the subject, identify the main areas of problem and to produce recommendations for a standard system for casualty bureau nationally.

### 3 THE CASUALTY BUREAU PROJECT

- 3.1 The Terms of Reference of the Casualty Bureau Project are :-

" To define a user requirement for a national or regional system to receive missing person enquiries in respect of casualty bureaux. This requirement to take account of improved telecommunications technology and the need to liaise with other nations. A report to be completed by Summer 1990."

- 3.1 The Casualty Bureau Project Team was established in August 1989 and consists of two officers :-

Chief Inspector Peter Todd - Bedfordshire Police  
Inspector Sandra Wilkinson - Norfolk Constabulary

- 3.2 A Steering Committee consisting of Chief Police Officers and Heads of Home Office Departments has been established to give policy direction to the Project Team, and to take forward their recommendations, when completed.

### 4. THE MAIN ELEMENTS OF THE PROJECT

- 4.1 The Project Team have identified three main elements of bureau operation for their particular attention :-

(i). The telephony problems - to examine the options available to provide the most appropriate response to the flood of enquiry calls from the public

(ii). The standardisation of procedures - to develop a standard content and format for the data captured and the procedures for handling it.

(iii). The computerisation of bureaux - to examine the relative merits of manual and computerised casualty bureau systems

- 4.2 Of these three aspects, the greatest problems are experienced in connection with the telephony system employed to answer the public enquiry calls. The problem is that invariably when the media announce the emergency telephone number for the casualty bureau there is an immediate flood of thousands of calls. The calls are all directed at one telephone number, at one geographical location and via one local telephone exchange. Whilst the main national network is designed to be able to take a very high volume of calls, local exchanges have a very much reduced capacity. In addition, as previously outlined, there are likely to be only a small number of lines available in the bureau ( maximum of 30).

# THE NATIONAL CASUALTY BUREAU PROJECT

## PROGRESS REPORT AS AT 30TH JULY 1990

### 1. THE RESPONSE TO CIVIL EMERGENCIES

- 1.1 In the United Kingdom the response to civil emergencies such as the Lockerbie air crash, whether it be a natural or man-made disaster, is based on the principle that those best placed to take decisions are those who know the locale and the availability of local resources. Immediate response, therefore, is carried out by local emergency services, local authorities and public utilities in accordance with locally formulated contingency plans, and under the coordination and control of the Chief Constable of Police for the area within which the incident has occurred.
- 1.2 In the United Kingdom (England, Scotland, Northern Ireland and Wales) there are 52 Police Forces, each commanded by a Chief Constable. Although contingency planning and actual response are decided locally, there has evolved a degree of standardisation which one might not have expected. Government guidelines, inter-agency liaison and cooperation and, most importantly, experience have combined to produce a central body of knowledge which forms the basis of planning and hence imparts at least a degree of uniformity on emergency response.
- 1.3 The respective roles of the Fire and Rescue Service, the Ambulance Service and the Police at the scene of an incident are universally accepted, in general terms at least; the fire service have a rescue and fire-fighting role, the ambulance service are responsible for the delivery of injured persons to hospitals and the police assume the overall command and co-ordination of the operations, in particular taking responsibility for communications, protection of the site and co-ordination of all the services and agencies involved.
- 1.4 The police also have a fundamental, legal obligation to the Coroner to investigate all such incidents and to produce all available evidence for the inquest, and any subsequent criminal enquiry. In fulfilling this role, the Police have traditionally taken over all responsibility for identification of the main 'players' in the tragedy, namely those who were involved, and the central way of achieving this goal is to establish a Police Casualty Bureau.

### 2. POLICE CASUALTY BUREAU

- 2.1 A Casualty Bureau has two fundamental tasks; firstly, to gather in as much information as possible on the persons involved, or potentially involved, and secondly to provide accurate information to both the relatives and friends of these persons and to the Investigating Officer / Coroner. As part of this process a telephone number is issued via the media for friends and relatives to ring, to register their concern and lodge details of the person they are worried about. This telephone number is usually issued within an hour of the incident occurring.
- 2.2 Whilst the establishment of a bureau is standard practice, the actual format of the bureau once established, still owes much to the vagaries of local procedures, politics and finances and to the limited amount of actual experience of disasters within individual police forces. Particular areas of differences are (i) the number of telephone lines made available to answer the public enquiry calls, which at present varies from 2 to 30 and (ii) the method of matching up information gathered in, which can be any combination of manual (i.e. on cards) and / or computerised. In addition to differing procedures and methods of matching, the actual forms used to take down information from the callers are different in every force.

Message Pads  
Pens, pencils, scissors, string

8. Sports Stadia Contingency Planning

8.1 This part provides guidelines for the preparation of contingency plans for coping with incidents at stadiums. They are held at the Divisional Station with the responsibility for that ground and will form part of the divisional contingency plan. A copy of the plan should be lodged with area operations office and T020 (for CCC).

Map of Division and surrounding Divisions  
PSU Windscreen Labels (Forms 1104)  
RVP aides memoir

(c) Marshalling Area

'Marshalling Officer' jacket  
2 clipboards/paper  
PSU Windscreen Labels  
Map of Division and surrounding Divisions  
Fluorescent traffic gauntlets  
Marshalling area aides memoir

(d) Mortuary

'Mortuary Duty Officer' jacket  
'Mortuary Documentation Officer' jacket  
Blank Signs  
200 Forms 3140  
10 clipboards  
Small/Medium/Large Property Bags  
Property seals/labels  
Property Book (MIR/21)  
Mortuary aides memoir  
Message Pads  
Pens, pencils, scissors, string

(e) Hospital

Forms 3127  
Small/Medium/Large Property Bags  
Property seals/labels  
5 clipboards/paper  
Forms 3121  
Hospital Documentation Team aides memoir  
Message pads  
Pens, pencils, scissors, string

(f) Survivor Reception Centre

Forms 3125  
5 clipboards/paper  
First Aid Kits  
Survivor Reception Centre aides memoir  
Message Pads  
Pens, pencils, scissors, string

(g) Friends and Relatives Reception Centre

Forms 3121  
5 clipboards/paper

Major Incident Box

In order that certain items of equipment will be immediately available at the scene, each division maintains a major incident box which must be stored in an accessible location and kept fully equipped at all times. The equipment should be separated into sections and labelled to indicate the function for which it is required, i.e.:-

- (a) Scene.
- (b) Rendezvous point.
- (c) Marshalling area.
- (d) Mortuary.
- (e) Hospital.
- (f) Survivor Reception Centre.
- (g) Friends and Relatives Reception Centre.

A recommended list of contents for each section is as follows:-

(a) Scene.

Fluorescent Jackets:-

SILVER "Police Incident Officer"  
"Fire Brigade Liaison Officer"  
"Ambulance Liaison Officer"  
"Property Officer"  
"Police Press Liaison Officer"

10 'Police', 10 'Press' and 10 'Official' armbands  
6 rolls of ordinary incident tape (outer cordon)  
6 rolls of red/white tape (inner cordon)  
2 rolls of yellow tape (approach path)  
Aides memoir for 'scene'  
Disposable gloves  
Cosmic Crayons  
Property seals/labels  
Property bags (small, medium and large)  
Property book MIR/21  
Clipboards/paper  
Blank, stick on signs  
Map of Division and surrounding Divisions.

(b) Rendezvous

'Rendezvous Point Officer' jacket  
2 clipboards/paper

of organising the recording, security and identification of property and once initiated, functioned extremely well.

Recovery of property was undertaken in the daylight hours by a field team containing a trained exhibits officer. The task was not made easy by the rescuers who had piled property to one side and this precluded any notion of recording where property had been found.

Whilst some property was destroyed because of its condition, other property was cleaned by specialists, to assist in identification, prior to being returned to the relatives.

Audits of property were undertaken to identify and retrieve sensitive material (assumed identifies) both in the form of classified documents, which were removed for security reasons and pornography, removed on the grounds of the sensitivity of the relatives.

#### Conclusion

This incident highlighted to those involved the tremendous amount of professionalism, dedication and commitment that is required from emergency service personnel and other organisations who have a role to play in such emergency. Figures provided to me indicate that at the peak time of this operation the following resources were involved:-

- (a) In excess of 700 personnel.
- (b) 301 Police from 4 Police Forces in 59 vehicles.
- (c) 247 fireman from 4 Brigades in 37 vehicles.
- (d) 142 Ambulance Officers from 4 Counties in 73 vehicles.
- (e) 3 Hospital flying Squads.
- (f) Doctors and Nurses.
- (g) 72 Army personnel.
- (h) Others including R.A.F., Mine Rescue, Search and Rescue Dog Association, Salvation Army and many others.

It must be stated that Leicester Police and other emergency services in the area have learnt many lessons from this air crash and as a result, a much greater emphasis is now being placed on the development of emergency management structures and liaison procedures.

Whilst it is apparent that our structures are much more advanced than those in place in the United Kingdom, we cannot afford complacency. The question must be asked, "How would we have coped had this incident occurred in Victoria?"

A thorough assessment is now being undertaken to establish what equipment should be available for use in a temporary mortuary. Such items as a secure property container, protective clothing, gloves and protective suits are essential.

#### Relative Care

Relatives of the dead and injured travelled to Kegworth from the South of England and Northern Ireland, the first arriving at 2.25am. At 10.00am the following morning, a plane supplied by British Midland Airways arrived from Belfast containing relatives and the Reverend Ian PAISLEY. The Donington Thistle Hotel which was the only hotel in the immediate vicinity had previously been booked by the media within an hour of the crash. Hotel management on being made aware of the plight of the relatives, cancelled all media bookings and made the hotel available to the relatives. It was located close to the temporary mortuary and was quite easy to secure, thereby, providing a degree of privacy for the grieving relatives.

A system of multi-agency care teams were established to provide comfort for relatives throughout the identification process. The teams involved clergy, social workers and uniformed police personnel.

#### Catering

Catering for those involved at the scene identified the necessity of developing catering plans prior to such incidents occurring. The Police Catering Unit was activated quite early in the incident, but due to a conflict of priorities involving a towing vehicle, didn't arrive at the scene until 5.15am. It then provided a cooked breakfast, but those who had been working among the bodies, had no desire to partake of such a breakfast.

The Salvation Army were called upon and did much to maintain the spirits of those on site.

In an effort to further improve feeding arrangements, a decision was taken, the day following the crash, to move to the Lodborough Police Station. However, this required a 3 hour absence from the site due to traffic congestion. It was suggested to me that a marquee erected near the crash site would have been a better option.

The determination of feeding requirements was not co-ordinated and food was wasted. The Logistics Team was tasked with the responsibility of arranging feed requirements and times, but they were subjected to alteration by Incident Control at Kegworth without consultation. Catering problems were mainly as a result of people working in isolation.

#### Property

No provision existed for property handling teams. The amount of property involved required a large storage area and a nearby gymnasium was used for that purpose. A Superintendent was given the responsibility

Identification of Deceased

Passengers on this flight to Ireland included members of the Royal Ulster Constabulary, the Armed Forces and Government employees, some of whom, for obvious reasons were travelling under assumed identities. The passenger manifest therefore was not accurate in reflecting the true identities of the passengers and added to this, was the uncertainty of whether vehicles travelling on the motorway had been involved.

A passenger manifest was received by fax, but it was later ascertained that the document inadvertently had been positioned in such a manner that the bottom two names were omitted during transmission. A further problem was created when names of rescuers injured during the rescue were added to the same list but not distinguished as rescuers in the documentation. This created difficulties in ascertaining the true casualty and body count and this was further exacerbated by the quality of information from the hospitals, regarding casualties received.

At one stage a figure of 46 deceased was given to the press when in fact the correct figure was 44. Subsequently, this figure was corrected, resulting in the media naming the Leicester Police as the "Lazarus Police".

Mortuary and Identification Procedures

The East Midland International Airport emergency plan has identified the snow shed as the premises to be used as a temporary mortuary in the event of an aircraft disaster. The plane is exercised annually and on each occasion reference is made to these premises. However, the premises have never actually been trialled as part of a practical exercise. The effects of such an omission were brought home, when it became apparent that the snow shed did not have:-

- (a) Running Water.
- (b) A telephone point.
- (c) Office accommodation.
- (d) Washing and toilet facilities.
- (e) Viewing facilities for relatives of deceased.
- (f) Refrigeration facilities.

The camber of the floor was such that attempts to wash away body fluids, resulted in the liquid flowing back into the centre of the shed.

This real life situation highlighted the need for premises which are identified for specific purposes to be fully trialled and other backup facilities to be considered.

### Media Management

A massive media contingent were on site within a short time of the crash becoming public. Regular media conferences were arranged and worked effectively. The media immediately booked out all vacant accommodation in the immediate vicinity and having made contact with their respective offices, maintained the telephone line open continuously, which then created major communication difficulties for emergency services by adding to the already congested telephone system. In an effort to better manage the media group and assist them in obtaining photographs and other information, the media were provided with a viewing position which was in the flight path of the crashed plane. Whilst the idea of containing the media in a confined area worked well, the location chosen, created a number of problems. Being in the flight path, parts of the engine which were braking up prior to the crash were scattered over the area and these were trampled into the ground and made recovery of them more difficult.

Satellite dishes were brought in by the media for use by foreign journalists. These were positioned under the main airport flight path and seriously interfered with the instrument landing systems of the airport, thereby creating a serious hazard to aircraft. The airport threatened to close if they were not removed.

Uniformed police officers were allocated to marshal the press and contained them in specified locations.

Media caused concern at hospitals and relative care centres and demonstrated the necessity for a uniformed police presence at these locations.

### Traffic Isolation and Diversion

The M1 Motorway, being the main arterial north/south route throughout the County was carrying heavy Sunday evening commuter traffic. This was brought to a halt and traffic was diverted by less major roads both north and south of the incident. In many ways, this simply transferred the traffic problem to other areas. Advance motoring signage of the closure was extensive and resulted in vehicles taking alternative routes many miles from the crash scene. The scale of the traffic problem is illustrated by the fact that it was taking people on local villages, 30 minutes to cross the road at peak times.

Local and national media was used extensively to advise motorists of the difficulties and this was supplemented by high profile policing, involving the use of foot patrols, traffic wardens, special constables and police motor cyclists, to police main routes many miles distant from the crash scene.

PROBLEMS IDENTIFIED

I propose to record a number of problems which were identified in procedures and operational activities during the resolution of this incident. They are not recorded as a criticism of the people or organisations involved, but rather as a learning process for anyone of us who might be involved in a similar situation in the future.

Control

A number of matters have already been mentioned in the paper concerning the identification of the Control Point at the scene, however, some other issues are worthy of mention, relating to call back procedures and identification of personnel.

A short time prior to the crash, a training exercise had been conducted at the Airport involving all emergency services. When members were advised to attend at the location because a plane had crashed, many believed that it was another exercise and in some instances, it took sometime to convince them that a real incident was in progress.

A number of support agencies such as the Salvation Army and other volunteer groups were not called out early enough and plans are being put in place to remedy that situation.

Identification of key personnel at the site Control area was a real problem. This highlighted the need for some form of tabard identification for key personnel of each organisation, to readily identify the responsible representative from each organisation involved. The problem was further exacerbated by the numbers of personnel within the control area, many of whom did not have a specific role at the time. This really was a site security problem and was subsequently identified as an area which needed on-going liaison across agencies, to ensure that once a persons role was completed they should leave the immediate area and be stood down.

Casualty Evacuation

The nature of the incident itself and its location, was sufficient to create problems in the area of casualty evacuation. In addition to those previously mentioned, other problems included:-

- (a) Casualties were removed from the scene without being documented in any way.
- (b) Dead and injured were evacuated to two different locations. No casualty clearing area was established.
- (c) Deceased were removed to temporary mortuary by both ambulances and funeral directors. This created confusion and demonstrated a need for greater liaison over means of removing deceased.

Seating and baggage had to be removed to make space for the human chain to operate. Rescuers continued to reassure the injured that everything that could be done was being done.

The numbers of rescuers used was limited by the shortage of space available to move and work in and as a result, some rescuers were involved in reassuring and comforting the injured for sometime. This saw a number of relationships between the rescuers and the injured being developed and police and other rescue personnel did not want to be relieved as a result.

#### Emergency Service Vehicles

In excess of 200 emergency service vehicles responded within a very short time of the accident occurring and contrary to their operating procedures, all left their flashing lights operating, their radios turned on to maximum volume, removed the keys and left their vehicle where they stopped and walked to the scene. This created tremendous chaos for some distance surrounding the scene. It was impossible to identify a command post in the initial stages, ambulances which had been loaded with injured to be conveyed to hospital could not move and drivers of these vehicles could not be located to move their vehicles. The maximum volume created a tremendous noise and added to the initial confusion. One police officer who was called into attend at the scene, was unable to park his vehicle within four kilometres from the incident and then had to run the remaining distance to the crash site.

#### Rescue

As I have previously mentioned, rescue was the major priority in the initial stages but there were a number of problems identified. Some have already been mentioned throughout this paper, however, there are others which are worthy of mention. Professional rescuers from various emergency services were hindered to some extent, when personnel from those same services, not trained in rescue, continued to attempt rescue instead of performing other roles that needed to be undertaken. Subsequent de-briefs highlighted this problem and determined that those with expertise in specific areas should be able to fulfil those responsibilities, whilst others continue to perform their other necessary functions. It was a typical human response of wanting to help, despite the lack of training in that area.

Another major problem which posed serious safety concerns was the aviation fuel which was lying around the crash site. It was reported that as much as 86,700 litres of aviation fuel was in the immediate crash site and in an effort to ensure safety for rescuers and the injured, 550,000 litres of foam was used to reduce the risk of ignition. This added to the problems of rescuers who were forced to operate in the foam and the slippery conditions caused by it. Consideration had to be given to the evacuation of rescuers in the event of a threat of explosion. A whistle system was quickly developed to advise rescuers of the decision to evacuate should the need arise.

KEGWORTH AIR CRASH

Introduction

At about 2025 hours, on the 8th January, 1989, a British Midland Airways Boeing 737, Flight No. BD 092 with a passenger capacity of 400, crashed into the western embankment of the M1 Motorway, one mile south of Junction 24, Kegworth, in the County of Liecestershire. The aircraft carrying 126 passengers plus crew was on a flight from Heathrow Airport to Aldergrove, Belfast. As a result of the crash, 47 persons died and a further 82 were injured. Experts were amazed at what was considered by them, to be a low number of fatalities resulting from the crash.

The Scene

The pilot of the aircraft had reported difficulties with one engine and was preparing to land at the Airport on the western side of the Motorway. He was approaching the runway from the east and initial reports indicated that a decision was taken to shut down the engine which was breaking up. On doing so the wrong engine was shut down, causing the aircraft to crash. Subsequent investigations revealed that the wiring from the control mechanism to the engines had been installed in reverse, causing the pilot to shut down the operating engine instead of the damaged one.

The plane hit the field on the eastern side of the Motorway, struck a number of trees and then continued across the M1. The undercarriage of the aircraft became entangled in the central safety barriers of the motorway before impacting among trees on the western embankment. The aircraft came to rest across the M1, the fuselage breaking into three sections, with the rear section rotating through 90 degrees to a vertical position.

The M1 is the major traffic route from the north to the south of England and continually carries extremely heavy traffic. The first emergency personnel to arrive on scene were unable to determine whether the aircraft had landed on cars, coaches or other pedestrians on the Motorway. Police were amazed to later find out that the only contact with any other vehicle on the Motorway was a reported incident of a car aerial being touched as the plane crashed.

On impact, passengers were trapped by collapsed floors and baggage lockers, seats had concertinaed forward and also trapped passengers. The first responders were confronted with an horrific scene of live but injured persons trapped with those who had been killed on impact. A major rescue operation was put in place with human chains organised to remove the dead and injured. Due to the embankment on the western side of the M1, steps had to be cut into it and ropes installed to enable rescuers access and footing. Medical teams had to be called in with amputation kits to assist removal of the dead and injured.

General

In studying this particular incident and then drawing a comparison between procedures in Victoria and the United Kingdom I am re-assured that in the emergency management area, this State is well advanced on procedures applicable in the United Kingdom. In recent times, a Civil Emergencies Adviser has been appointed to address a number of the issues that came out of this and other incidents and the indications are that they are moving towards a variation of the procedures that are in place in Victoria.

Conclusion

The Public Inquiry subsequently made a number of recommendations which were wide ranging and covered many areas including training and awareness of station staff, the need for greater liaison between all involved in any similar incident, an improved communications system in underground stations and the need for a review of the command and control procedures of the London Fire Brigade.

Whilst it could be said that we in Victoria appear to be somewhat advanced in our emergency management procedures when compared to those that were in place during this incident, it must always be remembered that whilst the structure sets out the roles and responsibilities of the various agencies and provides guidelines to assist, the entire success of any operation will be dependant on the people at the coalface, their knowledge of the structure and procedures in place and the ability of all concerned to work in co-operation with each other.

References

"Investigation into the Kings Cross Underground Fire"  
Department of Transport - London 1988.

"The Fire at Kings Cross Underground Station"  
G.D. CLARKSON - London - November, 1987.

task. The Fire Brigade took a decision to remove bodies to a place where they could be checked for any signs of life. No live casualties were found in this manner and in fact it is reported that all the bodies were removed and placed in a passageway without any tagging or other procedure to establish where the body was removed from. This did create some problems for the police in later establishing the identity of the deceased. It was also believed that it contributed to a major mix up in blood samples which were taken to assist in establishing cause of death. I was advised that the bodies were not only moved on one occasion in this fashion, but several times, one occasion being to remove them from the view of the media.

I was quite surprised to find that there are no formalised Disaster Victim Identification Teams in the United Kingdom. However, Metropolitan Police at Heathrow Airport are in the process of training a team for that purpose.

There were several other interesting aspects related to me concerning the identification processes. In one instance a black man was not identified for sometime because the extreme heat had blanched his skin white. His relatives could not identify him. He was not recognised as having black skin.

In another instance, a male was not identified until fourteen months after the fire. No record could be found of him anywhere despite the fact that there were a number of points which would have caused one to think that identification would have been relatively easy. It was first considered that the man may have been a vagrant living in the underground but on checking the body, initials were found on his false teeth, he had a rotary flap inserted in his head as a result of surgery and his body did not appear to have been badly treated or abused as would be expected in a vagrant type person.

The mans identity was eventually revealed as a result of an annual check of lockers at the station, when it was discovered that the man was either a Russian or Yugoslav sailor who had gone AWOL. He had no relatives and it was necessary to do a complete face reconstruction to assist with positive identification.

#### Cause of Death

Whilst there was some dispute over the mix up of blood samples and the testing procedures involved by the police pathologist and a special pathologist employed specifically for the purpose, it was the Coroners finding that all people in the ticket hall died from the effects of toxic gases which were generated when the flashover occurred and burnt the paint on the ceiling. The area had just been re-decorated and painted with anti-graffiti paint (polyurethane). I am advised, that when burnt, this gives off hydrogen cyanide which is very toxic and causes people to become disoriented. It also causes hyperventilation which then draws more of the gas into the body.

I have already mentioned the ineffectiveness of the radios underground but in addition, it was subsequently established that the entire telephone network at the station was still operating but was hardly used.

A number of issues concerning communication between agencies and the accuracy of information communicated have since been highlighted in subsequent de-briefings and inquiries. Some of those issues are:-

- (a) Because there is no formal structure for establishing liaison officers, it took sometime before a system was up and running.
- (b) There was no effective communication between those inside the station and those outside.
- (c) London Underground staff took sometime to recognise the importance of providing a liaison officer to the emergency services. They were rightly concerned about accounting for staff and keeping trains running that the importance of providing accurate information to the emergency services was overlooked.
- (d) London Fire Brigade did not provide a liaison officer until 2120 hours, almost 2 hours into the incident.
- (e) Not only were there difficulties with communication across organisations, but also within organisations.
- (f) Whilst no-one from the London Underground made themselves available to provide information on lay-out of the station and to liaise with the Fire Brigade, it should also be said that the London Fire Brigade made no request for someone either.
- (g) Communications between those at the top of the escalator and at the bottom of the escalator was not assisted by the fact that the firemen at the bottom of the escalator did not take their radios with them.
- (h) The inquiry made the point that "...there had been a breakdown in communications at command level between the emergency services. Each diligently pursued its own duty but there was a lack of liaison between them".

#### Disaster Victim Identification

In all, thirty one people died as a result of the fire and some criticism was levelled at the fire brigade over the removal of bodies from the scene. Whilst it is the responsibility of police to take charge of the identification of bodies, because of the prevailing conditions in the ticket hall on this night, police were unable to enter to perform their

Command, Control, Co-ordination

Any form of command, control and co-ordination was non-existent from the first report of the fire until some considerable time after the flashover had occurred and whilst it could be said that this is the norm in these type of incidents, it really highlights the need for some formal structure to be in place to which all organisations are prepared to work to. It is obvious that through the pre-flashover and flashover stages of this incident everyone involved was running around in a state of confusion doing what they believed to be the most appropriate at the time, but whilst being cognisant of the time sequence in this incident, I wonder if the final outcome would have been different had some form of command and control function been quickly established in the early stages of the fire. Having made that point however, for this to be achieved, there needs to be a system of command, control and co-ordination in place which all organisations have agreed to and are prepared to work in co-operation with other organisations, to achieve. Sadly, it seems this was not the case in this incident nor is there any established structure in place to allow it to occur in the future. In fact, one report I received indicated that one of the problems at the scene was the argument between the police and fire brigade as to who was in charge of incident. It was described as a real problem in this incident and remains an on-going source of ill-feeling between the emergency service organisations in the United Kingdom generally.

There does not appear to be any formalised structure for disaster response and it took some time to establish a system of liaison officers to deal with the situation.

When some form of command was finally established within the fire service it was 2015 hours, however, it seems that each time a more senior officer arrived on site he immediately assumed command with very little briefing and in some instances, no briefing at all. This occurred on several occasions.

Both the British Transport Police and the Metropolitan Police were involved during the evening. The British Transport Police were on duty at the station because of a visit by Prince Charles. When the fire commenced, their major role was within the station complex. Whilst there seemed to be a lack of command and control within the station environs, an Inspector from the Metropolitan Police quickly established a rendezvous point for ambulances and commenced traffic isolation and diversion procedures in accordance with their major incident procedures.

Communication

The London Underground Fire at Kings Cross again showed the often identified deficiencies in communication, not only in areas of technological communication facilities, but more importantly in the areas of inter-agency communication.

Whilst awaiting the arrival of the Fire Brigade, police had ordered an evacuation of the area and made a 999 call to request that trains on the Piccadilly and Victoria Lines be ordered not to stop at Kings Cross. Despite the request, trains continued to stop and allow passengers to disembark.

Already, things were starting to become confused. The relieving Station Inspector, being preoccupied with other matters forgot about the water fog equipment and it wasn't turned on. A train on the Piccadilly Line and another on the Northern Line stopped and let passengers out. No-one advised the people in the Bureau de Change or the public lavatories of the fire incident.

Passengers continually ignored the fire and continued to use the escalators. When the Fire Brigade arrived and the fire was quite visible, they found people still using the escalators and took immediate steps to prevent people using the escalator.

#### Flashover

At 1945 hours, fifteen minutes after the initial report of fire, flashover occurred resulting in the entire ticket hall being engulfed in intense heat and dense black smoke. As people had been directed upwards to the ticket hall from the Victoria Line, there were a number of people congregating in that area many of whom began screaming in the darkness and heat. Firemen and general public alike ran for their lives. The heat was such that the digital clock at the top of the escalators stopped at 1945 hours, the time of the flashover. Flames shot up from the escalator and quickly enveloped the entire concourse in a violent fireball. Some reports stated that the temperatures at ceiling level were about 600 degrees centigrade.

Severely burned and injured persons were carried and dragged from the ticket hall area and in the darkness it was difficult to determine where other screams for help were coming from. Firefighters who had been donning breathing apparatus had no time to operate the set or don the face mask and in some instances they found their protective gloves beginning to melt.

Several trains proceeding through the station at walking pace after receiving the order not to stop, were in fact stopped and used to evacuate passengers from the lower sections of the underground. This continued until all passengers on the lower platforms had been cleared from the area.

Prior to the arrival of the Fire Brigade, it seems that no-one put any water onto the fire to extinguish it. Extinguishers and hoses were available in close proximity to the seat of the fire, but they were not used because a sign read "not to be used on electrical:..

Commuters ignored the advice of staff and continued to use the escalator. In one instance a staff member saw people push past him and start to ascend via the escalator to the ticket hall. He could only watch as these people caught fire at the top of the escalator as flashover occurred.

Within one minute of that initial report, a police officer attended and observed smoke and single flame about three to four inches high, located about one third of the way down the escalator. He attempted to radio through a report of the fire and request the attendance of the Fire Brigade but found that this radio was ineffective below the surface. He then moved up to the surface where his radio would operate and advised of the fire. He then waited at the top of the stairs on Euston Road to await the arrival of the Fire Brigade. On arrival of another police officer to wait for the Fire Brigade, he then went below to the fire area. At 1936 hours, London Fire Brigade despatched the first of its firefighting equipment to the fire.

It is appropriate at this time to mention the importance of "Murphys Law" and the role it played in the initial stages of the fire.

- (a) Each of these stations is under the control of a Station Inspector who has good local knowledge of his station and is available to provide advice to emergency services involved in such an incident. On this occasion a relieving Station Inspector from another area was on duty and this was his third time at Kings Cross Station.
- (b) Two other staff who knew the Station, had left for meals one hour earlier than rostered. In fact, one admitted that whilst only entitled to half hour break, it was accepted practice to take an hour and a half meal break when on late shift.
- (c) The police radio failed to work underground, however, wiring to overcome this difficulty had been installed but was not connected because of renovations which were being undertaken.
- (d) There was no direct line between the British Transport Police and the Fire Brigade. Contact had to be made via the 999 System through British Telecom.

On arrival of the Fire Brigade at the Station they did not proceed to the Euston Road entrance where police were waiting to direct them in. They proceeded instead to the Pancras Road West entrance which was some distance from the seat of the fire. There has been some argument as to whether a rendezvous point was given to the Fire Brigade or whether they attended at that entrance in accordance with laid down procedures for attending a fire at Kings Cross.

The fire units positioned closest to the station were unable to respond immediately as they were attending another fire call in the area. The first fire unit arrived on scene at 1942, six minutes after receiving the initial call to find what they described as a fire about the size of a large cardboard box but with flames licking up the handrail on the left hand side.

In various locations around the main entrance, there are pine entrances which lead commuters into the network. Some of these are located in streets around the Station and lead into a further complicated system which covers five different levels. The Piccadilly line is situated on Level-4 with the main access route being via Piccadilly Line escalators. Further access is also available from the Victoria Line and the Northern Line.

Within the inner concourse a temporary hoarding had been constructed which blocked off access to a fire hydrant and hose and a London Fire Brigade box containing plans of the Underground. These boxes had been installed following a fire at the Oxford Circus Station in 1985. Subsequent to the fire, it was revealed that some conflict had been on-going between the London Fire Brigade and London Underground Ltd, over two particular issues:-

- (a) Should the Fire Brigade be called to every suspect fire?
- (b) Should the Fire Brigade be advised of any construction work which was scheduled for the Underground Network?

These issues had arisen following the Oxford Circus Fire and were still being debated at the time of the Kings Cross Fire in 1987. The argument on the second issue degenerated into issues of definition as to whether "a concrete hole in the ground" was a building structure and was notifiable or not.

The Escalators

The three escalators at Kings Cross which conveyed commuters between the Piccadilly Line platforms and the central ticket hall were of wooden construction and were installed in 1939. They were inclined at 30 degrees and the distance from top to bottom was 17.2 metres. Cleaning of the escalators running track was done manually, but to do it properly, would require the dismantling of the escalator. It seems that this was never undertaken. Water fog equipment was initially used to damp down the escalator of a night, but it was found that this caused corrosion of the machinery and even though this procedure was successful in removing some of the build up of inflammable fluff it became the practice to damp down once a fortnight only. However, for a number of years prior to the fire the water fog equipment was not used on a regular basis, thereby allowing a build up of inflammable material.

The Fire

In many respects, the timing of the fire could be said to have been quite fortuitous. It was first sighted and reported at about 1930 hours, only fifteen minutes after the completion of the peak rush which ended at approximately 1915 hours. Had the fire occurred thirty minutes earlier, the loss of life may have been much greater due to the increased numbers of commuters using the network at the time.

LONDON UNDERGROUND FIRE - KINGS CROSS

Introduction

At about 1930 hours on the evening of Wednesday, 18 November, 1987, a passenger travelling up escalator at Kings Cross Underground Station, noticed a small fire underneath a step at the right hand side of the upper part of the escalator. He immediately reported the fire to the booking clerk in the ticket office, who then contacted the Station Inspector on duty at that time. This was the first report of the fire which was to take the lives of thirty one (31) people, including one London Fire Brigade, Fire Officer who attended to combat the fire.

Kings Cross Underground Station

Kings Cross Underground Station is one of the busiest in London and is the major interchange station for the Victoria Line, Northern Line, Piccadilly Line, Circle Line and Metropolitan Line in addition to two other British Rail Lines. In excess of 250,000 passengers pass through the station per day, 100,000 during each peak hour and the remaining 50,000 off peak. It is situated about two miles from the centre of London and is surrounded by a road system which carries heavy traffic throughout the day, but particularly in peak hours. Both the Kings Cross Station and the surrounding area is a popular place for vagrant types and prostitution flourishes in the area. Kings Cross Underground Station is a labyrinth of shafts, tunnels and passages which connect the five different levels which have been built underground. At the time of the fire, the escalators servicing the Piccadilly Line were constructed of wood and provided access between the central booking office and the Piccadilly Line platform.

Some form of firefighting equipment was available on all platforms within the Underground. All platforms had fire extinguishers and sand buckets provided in addition to a cupboard containing a fire hose and hydrant with a nozzle and adaptor to fit London Fire Brigade equipment. Fire extinguishers were also located at the top and bottom of each set of escalators and in the machine room.

A London Fire Brigade Plan box was also installed on the central booking office level for the purpose of storing comprehensive plans of the Underground complex. Plans were provided to the Fire Brigade to enable them to gain some knowledge of the Underground system before placing the plans in the box provided. It was believed that the box would provide ready access to fire brigade personnel called to any fire at the station.

The maze of passages, tunnels and shafts which make up the Kings Cross Station, highlights the necessity for extensive pre-planning, the value of local knowledge and the need for emergency services to involve themselves in gaining a thorough knowledge of areas within their locality, which for whatever reason could pose difficulties for persons responding to an emergency situation.

## COMMUNITY UPDATE ...

**YOU CAN CONTACT US BY :-**

Writing : Our address is 49 High Street , Lockerbie

Phoning : Our phone numbers are Lockerbie 4143 / 4144  
/ 4242 / 4281 (after hours Lockerbie 4143)

Visiting : Our office is above the Royal Bank of Scotland.  
Opening times are 9am to 5pm Monday to Friday

And  
Asking For :

- Alex McElroy
- Mike Combe
- Alan Ritson
- Jodie Robson
- Margaret Johnstone

We will be happy to meet you anytime. Your feelings and opinions are valuable to us, and may also be helpful to others who will face tragedy in the future.

5.



Form 3321C

CORDONS OFFICER(S)

(a) General

1. Responsible to SILVER.
2. Liaise with SILVER on the siting of the inner (and outer cordons) and access points.
3. Liaise with SILVER COMMAND re issue of passes (where appropriate).
4. Divide manpower into units and allocate boundary areas of responsibility.
5. Brief sector supervisors.
6. Requisition equipment (e.g., tapes, ropes and barriers) to reinforce the boundary as necessary.
7. Arrange for regular rotation of staff for rest and refreshment.
8. Ensure that all entry and exit points are manned.
9. Maintain radio contact with SILVER COMMAND and CONTROL.
10. Vet all persons requesting access. (Non emergency staff require SILVER's authority.)

(b) Inner

Establish immediate security of site, treat as 'scene of crime'.

(c) Outer

- (i) Log arrival and departure of emergency services, specialist and support staff.
- (ii) Specialist civilians e.g., Air Accident Investigation Branch may require police escort to get to scene.
- (iii) Alert senior officers of media and sightseers trying to gain unauthorised access. Bona fide media representatives should be directed to the Press Liaison Point or media centre.

- As each sector is cleared, the plot is to be updated and the sector secured.
  - Withdraw to perimeter upon completion.
  - Maintain security and create a sterile area.
12. Upon completion of initial evacuation, in co-ordination with local authority commence dispersal to rest centres.
  13. Ensure a police liaison officer is nominated for each 'Rest Centre', ensure they:-
    - Liaise with the Local Authority Officer in charge of the Rest Centre.
    - Ensure that a comprehensive index is maintained of all persons brought to the Centre (Local Authority forms).
    - Obtain regular situation reports from the scene for the information of the evacuees.
    - Perform other duties as required.
  14. Inform C.C.B. of areas evacuated and location of rest centres. C.C.B. will direct all enquiries to the local authority who are to maintain an index of evacuees and their location, for enquiries by friends/relatives and for interviewing at a later stage.

Form 3321P

## EVACUATION OFFICER

1. Responsible to SILVER (requires good local knowledge, minimum rank Inspector).
2. Assume responsibility for the implementation of all aspects of the evacuation process when directed by SILVER.
3. Familiarise yourself with:—
  - the perimeter of the evacuation area
  - premises to be evacuated
  - reasons for evacuation
  - timescale allowed
  - appropriate numbers to be evacuated.
4. Liaise with SILVER and the Senior Traffic Officer on the method of evacuation and safe routing from the area. Consider using officers to direct evacuees.
5. Identify suitable Evacuation Assembly Point(s), (a building or covered area within easy reach of the scene, arranging signing where possible).
6. Consider sectorisation and definition of perimeter, a large scale map is essential to plot the progress of evacuation.
7. Arrange for necessary manpower and transport to be made available for conveying evacuees from assembly point to rest centre.
8. Liaise with the Local Authority regarding:—
  - location of rest centres;
  - transportation of evacuees;
  - rest centre liaison officers;
  - evacuation teams.
9. Brief officers ensuring that they are aware of:—
  - reasons for the evacuation;
  - timescale;
  - assembly point locations;
  - method of evacuation and routes;
  - sectors, if applicable.
10. Inform public by either:—
  - Personal call by officers
  - Telephone—commercial premises
  - Loudhailers
  - PA systems
  - Radio/TV broadcast.

Do not alarm the public but provide information where possible.
11. Ensure that the following is carried out:—
  - Mark each building, log details of persons refusing to leave.
  - Make enquiries of unoccupied buildings in case of deaf or bed-ridden occupants. Forcible entry may have to be used.

P.T.O.

## TRAFFIC MANAGER

### RANK:

Inspector.

### ROLE:

1. Responsible to the Incident Officer.
2. Ensure that the following have been designated, if required:
  - Rendezvous Points;
  - Marshalling Areas;
  - Access and Exit Routes for essential services;
  - Emergency routes to hospitals;
  - Diversions for non essential traffic;
  - Turning areas.
3. Ensure that adequate signing, barriers and manpower are made available to facilitate traffic arrangements.
4. Arrange for diversion information and traffic information to be passed to the media.
5. Maintain radio links with the Incident Control Post/Major Incident Control Room.
6. Perform other duties as directed by the Incident Officer.

# EVACUATION OFFICER

## RANK:

Chief Inspector.

## ROLE:

1. Responsible to the Incident Officer.
2. Assume responsibility for the implementation of all aspects of the evacuation process.
3. Familiarise himself with:
  - The perimeter of the evacuation area;
  - Premises to be evacuated;
  - Reasons for evacuation;
  - Timescale allowed;
  - Approximate numbers to be evacuated.
4. Liaise with the Incident Officer on the method of evacuation and safe routing from the area.
5. Identify suitable Evacuation Assembly Point(s).
6. Consider sectorisation and definition of perimeter.
7. Arrange for necessary manpower and transport to be made available.
8. Liaise with the Local Authority regarding:
  - Location of rest centres;
  - Transportation of evacuees;
  - Rest centre liaison officers;
  - Evacuation teams.
9. Liaise with the District Health Authority with regard to:
  - Moribund patients;
  - Renal dialyses;
  - Geriatrics' etc.
10. Brief officers ensuring that they are aware of:
  - Reasons for the evacuation;
  - Timescale;
  - Assembly point locations;
  - Method of evacuation and routes;
  - Sectors, if applicable.
11. Ensure a police liaison officer is nominated for each "Rest Centre".
12. Inform Casualty Bureau of areas evacuated and location of "Rest Centres".
13. Maintain security of the sterile area after evacuation is complete.
14. Establish and maintain communications with:
  - Incident Control Post;
  - Evacuation Assembly Point(s);
  - Rest Centre Liaison Officers;
  - Evacuation Teams.
15. Liaise with R.S.P.C.A. with regard to animals/pets'.
16. Ensure a supervised return after the 'all clear' is given.