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April 13, 2009

To: Supervisor Don Knabe, Chairman
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Supervisor Zev Yaroslavsky
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From: William T Fujioka
Chief Executive Officer

CHATSWORTH TRAIN DERAILMENT – LOS ANGELES COUNTY OPERATIONAL AREA AFTER ACTION REPORT

This report is in response to the Board's September 16, 2008, action that:

1. Instructed the Chief Executive Officer to evaluate the initial disaster response, in close cooperation with Los Angeles City management and staff and with the support of the County Coroner (Coroner), Directors of Mental Health (DMH) and other County departments, and report on the findings, conclusions, and recommendations for at least the following subjects:

   a) Timeliness;

   b) Speed and effectiveness with which incident command and control was established and maintained;

   c) Suitability and sufficiency of resources to safely extract and rescue victims;

   d) Adequacy and effectiveness of communications, including means to respond to concerned family members, press, and public; and

   e) Prior to submission, the report should be reviewed by the Emergency Preparedness Commission for the City and County of Los Angeles.

2. Instructed the County Emergency Medical Services Agency, with oversight and review by the Emergency Medical Services Commission, to provide findings, conclusions, and strengthening recommendations on all aspects of the pre-hospital and hospital-care response; including on-scene responders, supplies, equipment,

communications, triage, hospital emergency stations, operating rooms, beds, medical specialists, and other patient care personnel; and

3. Request the leaders of these respective evaluations to coordinate their efforts and submit their reports to the Board as a single package within 90 days.

SITUATION SUMMARY

On September 12, 2008, at 4:23 p.m., Los Angeles City Fire Department (LAFD) and County Fire Department (LACoFD), Los Angeles City Police Department (LAPD), Los Angeles Sheriff Department (LASD), local trauma centers and hospitals, private ambulance providers, DMH, Coroner, and other supporting agencies responded to a major Mass Casualty Incident (MCI) involving a Metrolink commuter train and a Union Pacific freight train.

The Metrolink commuter train, #111, consisting of a 250,000 pound locomotive pulling three (3) bi-level coaches, departed Union Station in downtown Los Angeles at 3:35 p.m. heading westbound to Moorpark in Ventura County. The westbound commuter train, with 222 passengers aboard, departed the Chatsworth Station and traveled 1.25 miles when it collided head on with an eastbound Union Pacific freight train traveling on the same track at approximated 40 miles per hour. The freight train was led by two (2) locomotives weighing more then 500,000 pounds each. This collision resulted in the worst multi-casualty train incident in California in 50 years. The cause of the collision is under separate investigation and is not within the scope of this report.

The train collision occurred just east of Topanga Canyon Boulevard and about a quarter of a mile south of the 118 Freeway, within the City of Los Angeles and near the Ventura County line (Attachment I). The initial 9-1-1 calls into LAFD dispatch described a train accident. At 4:30 p.m. LAFD responded to the private home from which the first 9-1-1 call had originated. Upon arrival into the area, LAFD personnel observed the train collision and, due to the complexity of the situation and extent of the observed damage, immediately summoned additional resources.

LAFD observed the derailed trains with the Metrolink locomotive telescoped back into the compartment of the first passenger car. The Metrolink locomotive and three (3) of the attached cars were affected by the collision. A fire ignited by the collision added to the complexity of the scene and was quickly extinguished by LAFD. Following the Incident Command System protocol, LAFD was designated the Incident Command Agenda (ICA) and established command and control of the scene.

This concludes the situation summary. The following represents the findings and recommendations from the DHS, Coroner, DMH, Fire, and LASD to improve interagency coordination and communication in response to a MCI.

DEPARTMENT OF HEALTH SERVICES

Findings

In a large scale MCI, supplies, equipment, and personnel must be brought to the scene and staged in unfamiliar environments. In this incident, the natural time delay to set up equipment and post personnel contributed to the initial disorganization.

There were adequate emergency medical technicians (EMT) and paramedics on scene.

The LAFD physician who was on scene added a valuable resource. This is not expected at all MCIs. The Emergency Medical System (EMS) utilizes paramedics and EMTs to provide the initial triage, limited treatment, and rapid transport of critical patients during a MCI.

Law enforcement is critical at MCIs to control bystanders and ensure the safety of the scene. In this incident, law enforcement actually aided in removing victims from the train.

There was confusion by the Medical Alert Center (MAC) as to which hospital has the approved Hospital Emergency Response Team (HERT) and when the team should be utilized. The hospital personnel sent to the scene, at the request of the MAC, were unsure of their mission and may have been better utilized at their hospital of origin. Though LAFD found volunteers to be helpful, there is concern about using medical volunteers without prior review of qualifications and credentialing.

Recommendations

- Ensure EMS providers and MAC are familiar with Ref. No.1126 – Multiple Casualty Transportation Management, and Ref. No. 817 – HERT.
- Reconvene the MCI taskforce to review all policies related to MCI and revise as necessary.
- Assign the MCI taskforce to address the use of volunteers in the MCI policy.
- Continue to support provider agency MCI drills.

SUPPLIES AND EQUIPMENT

According to triage personnel, basic life support supplies were readily available from a large cache in the staging area; however, there was no Medical Supply Coordinator to access, distribute, or request replacements as needed.

There were adequate amounts of bandages, but advanced life support supplies such as glucometers and intravenous supplies were also needed, particularly maxi drip tubing and intravenous replacement solutions. Other advanced life support equipment such as Electro Cardio Gram monitors, defibrillators, pulse oximeters, automated external defibrillators, and medications were not available. According to witnesses, ambulances had this equipment but were needed for patient transport.

LAFD has mobile disaster caches stored at various locations, some of which were brought to the scene upon request. In addition, there are three (3) Disaster Medical Support Units assigned to WestMed/McCormick and Schaefer Ambulance Companies and the DHS, EMS Agency. The Disaster Medical Support Unit is a large box truck containing backboards, trauma supplies, cervical collars, and medical equipment. Other disaster caches are maintained at many of the fire departments and ambulance companies. None of these resources were requested.

Findings

During large scale MCIs, patients are triaged and provided only critical life-saving treatment and rapid transport. Though comments were made regarding glucometers and automated external defibrillators, this equipment is not normally necessary for a large scale MCI.

There was delay in assigning roles based on the ICS and inadequate use of identifying color/labeled vests (i.e. Medical Supply Coordinator).

Recommendations

- Ensure that each provider agency has internal policies in place for activation of there own disaster caches and Disaster Medical Support Unit (Attachment 2).
- Ensure that assignments of ICS positions are made early and identifying vests distributed.

COMMUNICATIONS

The MAC is equipped to communicate with multiple medical facilities simultaneously and can rapidly assess hospital status through the Rapid Emergency Digital Data Interface Network (ReddiNet) system. Additional equipment used to facilitate communication between the incident, MAC, and hospitals are the Hospital Emergency Administrative Radio (HEAR) system, landlines, and cellular telephones. The MAC is equipped with a television monitor so staff may view what is occurring at the incident scene.

When notified of a major incident, MAC personnel alert the Administrator on Duty, who also is the Medical/Health Operational Area Coordinator and the Medical Officer on Duty for the EMS Agency. In this case the Administrator on Duty responded to the MAC to provide support, field questions, and act as a resource to the staff. In addition, LAFD, as the Incident Commander, sent a field captain to the MAC as a liaison for the incident.

Reconstruction of MCI response, patient care, destination, and outcome are critical to the EMS for quality improvement, legal issues, and analysis for future policy changes. Unfortunately, there is not a system in place to allow for timely and complete patient tracking from the incident scene to the hospital and discharge, and rapid data return to the EMS Agency for analysis and quality improvement. Individual provider agencies and hospitals must be contacted to obtain bits of information about patient outcome. Gathering any information after the fact for analysis is labor intensive, inaccurate, and hindered by Federal law, Health Insurance Portability and Accountability Act.

Findings

The early notification of the incident by way of the television monitor and call from the first rescue unit was very helpful in preparing the hospitals to receive potential patients. Some hospitals were slow to respond to the ReddiNet poll, taking up to 15 minutes, and a few hospitals had to be called by MAC personnel to request a response.

The MAC provided hospital bed capacity to the field personnel, but the medical communication did not provide the MAC with patient destination and mode of transport as per Ref. No. 519 - Management of MCIs. Thus, hospitals did not receive information on the level of acuity and number of patients being transported to their facility. This information allows the receiving hospital to prepare for the patient which includes sending appropriate staff to meet the air ambulance arriving at the helipad. HEAR communications were not clear and frequently overridden by a taxi service in Mexico.

Having administrative staff and the field liaison respond to the MAC is critical to assisting the MAC staff during a large MCI.

Recommendations

- Continue to drill with hospitals on the use of the ReddiNet.
- Reconvene the MCI taskforce, review all policies related to MCI and revise to ensure that:
    - Field medical communication reports patient destination.
    - AOD reports to the MAC during a large scale MCI.
    - ICA provides a liaison at the MAC during large scale MCIs.

- Work with Internal Services Department to address solutions to the HEAR radio interference.
- Investigate methods and funding sources to improve pre-hospital patient tracking; such as electronic patient care record or scanners used not only during an MCI, but on a routine basis.
- Recommend the County investigate the possibility of securing a permanent phone number to be used for information and family reunification during a MCI.
- Continue to support the Los Angeles-Regional Interoperable Communications System (LA-RICS) project.

TRIAGE

Triage is a sorting system that provides guidelines for pre-hospital care personnel to rapidly classify victims so that treatment and transport are not delayed. Accurate triage is an essential tool for two (2) reasons: 1) It determines how best to match patient needs to resources, and 2) It improves the responder's ability to determine when resources are overwhelmed.

At the Chatsworth triage area, red (Immediate/critically injured), yellow (Delayed/moderately injured), and green (Minor) tarps were laid out and the patients were placed on the tarps according to their acuity level. Fire and law enforcement personnel triaged the victims and appropriately utilized triage tags for the identification and categorizing of 91 of the 98 patients. LAFD EMS Chief established a secondary triage to ensure that patients were categorized and transported to the appropriate facility. Yellow scene tape was utilized to control access, divide the triage areas, and aid in keeping patients and personnel in one location.

Findings

There were hundreds of people milling about the scene leading to confusion of patients and bystanders. The use of the yellow scene tape was a simple, but effective tool to establish a perimeter and provide organization.

Ideally, the colored tarps would be accompanied by staff wearing colored vests which would identify personnel in the ICA structure. The vests were pulled out, but misplaced during the initial confusion.

Effective triage cannot be determined without a close peer review of patient outcomes. The current system for data collection provides only limited ability to capture information on patient identification, destination, injuries, treatment, and outcome.

Recommendations

- Work with providers to ensure that an ongoing MCI drill schedule is developed. Drills should include various methods for crowd and scene control (i.e. use of yellow scene tape) and immediate designation of assignments and distribution of colored identifying vests.
- Investigate methods and funding sources to improve pre-hospital patient tracking; such as electronic patient care record or scanners used not only during a MCI, but on a routine basis.

HOSPITAL ASSIGNMENT PROCESS

Patient distribution is governed by pre-hospital care Ref. No. 519 – Management of MCI. In a large scale MCI, it is critical that not any one hospital is overwhelmed with patients nor should patients be transported to facilities incapable of providing appropriate care. Given the nature of the Chatsworth incident, the blunt and penetrating trauma that resulted from the collision ranged from cuts and bruises to major traumatic injury and death.

Twenty-two (22) hospitals are located within 30 miles of the derailed train. Four (4) facilities are located within a 10-mile radius of the incident, two (2) of which are trauma centers. Seven (7) additional hospitals are located 10-20 miles away. Eleven (11) additional hospitals, including five (5) trauma centers, are situated 20-30 miles away, one of which specializes in the care of children. A trauma center 32 miles away received patients by air ambulance. Harbor-UCLA Medical Center was the farthest away at 44 miles and received five (5) patients by air.

The most critical patients were transported to eight (8) of the 13 designated Level I and II trauma centers. The distribution of transported patients was as follows:

Destination	Immediate	Delayed
Los Angeles County Hospitals	62	19
Ventura County Hospitals	13	4
Total	75	23

Of the 62 patients classified as Immediate and transported to Los Angeles County hospitals, 55 (89 percent) were transported to trauma centers (data from ReddiNet).

TRAUMA CENTERS AND AIR AMBULANCE TRANSPORTATION

Four (4) Level I and four (4) Level II trauma centers received patients. Per ReddiNet records, 25 percent of the total number of transported patients sent to the Level I trauma centers went by air (34 patients via 16 helicopter transfers). Of these; 14 were

flown by LACoFD Air Operations, 12 by LAFD, and eight (8) by LASD. The Level II trauma centers received 39 patients by air and ground.

Findings

Patients were appropriately distributed among 9-1-1 receiving hospitals and trauma centers. Trauma centers were utilized appropriately.

Hospital disaster preparedness programs and regular drills over the past year contributed to the successful activation and response of the County's trauma and receiving hospitals.

On the initial ReddiNet poll, hospitals reported they could accept a total of 972 patients: 212 Immediate, 288 Delayed, and 472 Minor patients.

Northridge Hospital, one of the closest trauma centers to the incident received eight (8) patients. LAFD reported that because of traffic congestion, the ICA chose not to transport by ground to the nearest hospitals. Additionally, the EMS Agency policies consider that the facilities closest to an incident will be impacted by the walk-in wounded. Some patients self transported to Ventura County facilities, since these facilities were closer to their homes.

Patient distribution followed Ref. No. 519 - Management of MCI, and prevented any one hospital from being overly impacted and unable to function.

Recommendations

- Reconvene the MCI taskforce, review all policies related to MCI, and ensure that pre-established bed capacity by trauma centers is addressed.

SUITABILITY AND AVAILABILITY OF PATIENT TRANSPORT

LAFD operates an emergency ambulance transportation program and were able to provide 30 rescue ambulances to the scene within 5 - 20 minutes from initial dispatch. Because the exact number of patients requiring transport was not known, additional private ambulance companies were notified by the MAC and LAFD and requested to respond. Records indicate there was the potential for 110 private ambulances to be at the incident staging area. Only two (2) private ambulances were actually utilized to transport victims.

Air transportation was utilized in this incident, following Ref. No. 519 - Management of MCIs, to transport critical trauma patients to trauma centers around the County. LAFD air ambulances were dispatched at 4:29 p.m. and on scene at 4:40 p.m. The first patient was transported by air at 5:00 p.m. There were eight (8) air ambulances on scene, four (4) from LAFD, three (3) from LACoFD, and one (1) from LASD. LASD and LACoFD air ambulances self dispatched when their managers heard of the incident on the news stations. Mercy Air contacted the MAC and offered to send six (6) additional air ambulances to the scene.

Findings

There was a self dispatching of ambulances from several private companies. These ambulances were not requested by the MAC and were not in accordance to Ref. No. 1126 - MCI Transportation Management, leading to an excessive number of private ambulance companies on the scene.

Self dispatching is not allowed for the following reasons:

- Too many ambulances can block traffic and lead to congestion and confusion.
- Private ambulance companies do not have a mechanism for reimbursement for stand-by time at an MCI or disaster. The private ambulance providers are "a fee for service business" and are not eligible for reimbursement from government sources.

Air ambulance resources were readily available and appropriately utilized.

Some hospitals were not aware of incoming helicopters and, therefore, were not prepared to meet the patient and paramedics at the helipads.

Recommendations

- Review Ref. No. 1126 - MCI Transportation Management, with MAC staff and provide opportunity for hands-on drills.
- Support policies and State contracting with private ambulance companies which ensure coordinated response and payment mechanism.
- Reconvene the MCI taskforce, review all policies related to MCI, and revise to ensure that transportation resource allocation is addressed, including:
    - air ambulance providers are automatically dispatched for large scale MCIs;
    - define single mechanism to notify hospitals of incoming patients, including air ambulances.

HOSPTIAL EMERGENCY STATIONS

Los Angeles County had more than 498 emergency department treatment stations proximal to the event and an additional 40 treatment stations were available in the two (2) Ventura County hospitals, Simi Valley Hospital and Los Robles Hospital Medical Center. With 98 patients transported, the total number of available emergency department treatment bays (538) exceeded the need and the hospitals had surged to provide even more capacity (972 treatment stations per initial ReddiNet poll). Given the presence of air resources, more emergency department treatment bays even farther away from the scene could have been utilized if needed.

Findings

The train derailment demonstrated that Los Angeles hospitals can surge effectively for a short period of time.

When a major incident occurs, it is not uncommon for hospital personnel to converge on the affected facilities to render aide.

Each hospital assembled teams and mobilized resources to respond to their emergency departments or activated their external disaster and surge capacity plans.

Recommendations

- Continue to support hospital surge planning activities and encourage participation in the Hospital Preparedness Program (HPP). A grant offered through the U.S. Department of Health and Human Services. Participating hospitals receive grant funding to purchase emergency medical equipment, provide emergency preparedness training for their staff, surge plan development, mass fatality management, and hospital evacuation/sheltering.

OPERATING ROOMS

Surgeons and operating rooms were immediately available at the trauma centers; none of which had to request diversion due to patient overload. Trauma centers are required by written agreement to have surgical service, an operating suite for trauma patients, an operating room staff, and a post anesthesia recovery room that meets the requirements of the California Administrative Code. All of these resources were readily available and utilized. Because of the incident time, additional operation rooms were available since most elective surgery take place in the morning. As part of hospital surge planning, surgeries could be cancelled to increase operation room availability in the case of an emergency such as this one.

Findings

There was sufficient number of operating rooms available to handle the number of patients involved in this large scale MCI.

Recommendations

None

INPATIENT BEDS

There were enough hospital inpatient beds to care for the 98 transported commuters. The total number of licensed medical/surgical and intensive care unit (ICU) beds, within 10 miles of the incident (including one (1) Ventura County hospital), was 682 general acute and 44 ICU. An additional 798 licensed general acute beds and 114 ICU beds were available 10-20 miles from the scene. Further out (20-30 miles away) there were 3,158 licensed general acute beds and 393 ICU beds, including a combined total of 102 pediatric and pediatric ICU beds (Source: EMS Authority, Los Angeles Hospitals 11/27/07). This bed listing does not consider occupied and staffed beds, which would decrease the number of available beds. Bed status is dynamic and can change based on discharges, staffing, and triaging patients to alternate patient care areas of the hospital.

Findings

The Chatsworth event demonstrated that hospitals in Los Angeles County are able to surge quickly and efficiently. This is largely due to the fact that many have received funds from the HPP grant and have been working with the EMS Agency to improve surge capacity. Los Angeles County is a direct recipient of the HPP. Training, teamwork, and early preparedness were key factors to the successful response.

Some of the patients were so severely injured that they required months of hospitalization, multiple operations, and rehabilitation. All of the necessary services are available at the trauma centers.

Recommendations

- Continue to support hospitals and encourage participation in the HPP.

MEDICAL SPECIALISTS AND OTHER PATIENT CARE PERSONNEL

Medical specialists were available to treat all types of injuries incurred in the collision. Trauma centers are required to have a surgeon and a dedicated operating room for trauma patients, capable of treating adult and pediatric trauma patients in-house at all

times. Surgical medical specialists from the following disciplines were on-call and ready to respond at each trauma center:

Cardiothoracic	Vascular
Hand	Oral or Maxillofacial
Neurologic	Obstetric/Gynecologic
Ophthalmic	Head/Neck
Orthopedic	Plastic
Re-implantation/Microsurgery	Urologic

Findings

The development of the trauma system and the requirements for trauma centers to have specialists readily available provides the foundation to care for the critically injured. Establishing the appropriate utilization of trauma centers by policy ensures that patients' medical needs are met during a large scale MCI.

Recommendations

None

GENERAL FINDINGS

1. Patients were distributed equitably so that no one hospital was overwhelmed.

2. Trauma centers were appropriately utilized for the most critically injured patients.

3. The ReddiNet communication system worked as intended.

4. Patient transport by air ambulance was essential to the success of the pre-hospital response.

5. Hospitals surged successfully to provide emergency treatment bays and had ICU and medical/surgical capacity to care for the victims requiring admission.

FINAL CONSOLIDATED RECOMMENDATIONS

1. Reconvene the MCI taskforce to review and revise MCI policies, Ref. No. 519 - Management of MCI, Ref. No. 817 - Hospital Emergency Response Team, Ref. No. 418 - EMS Aircraft Provider, Ref. No. 1128 - MCI Transportation Management, and ensure the following issues are addressed:
   - Appropriate mobilization of DMSU and disaster caches.
   - Use of volunteers.
   - Communications between the MedCom/Patient transportation.

- AOD reporting to the MAC during a large scale MCI.
- Assignment of a liaison to the MAC from the ICA during a large scale MCI;
- Pre-established bed capacity assignments for trauma centers;
- Automatic dispatch of air ambulance providers during large scale MCIs;
- Define the mechanism to notify hospitals of incoming patients, including air ambulances;
- Utilization of appropriate transportation resource allocation.

2. Mandate MCI policy training program for all 9-1-1 EMS providers.

3. Continue support of the LA-RICS project.

4. Work with ISD to improve the HEAR frequency and limit interference on this critical communication source.

5. Investigate methods and funding sources to improve pre-hospital patient tracking; such as electronic reporting forms or scanners not only during an MCI, but on a routine basis.

6. Encourage MCI drills system wide, including the MAC, 9-1-1 providers, hospitals, and ambulance companies, to solidify policies and work out issues with personnel assignments, use of identifying vests, scene security, and triage.

7. Investigate the feasibility of implementing an 800 or 2-1-1 number and email address that is maintained by the County and available to all cities which could be accessed to provide information and family reunification during a large scale MCI.

DEPARTMENT OF THE CORONER

Findings

All Coroner personnel and equipment were directed by the ICA to stage outside of the operational area until all helicopter evacuations were completed. Those operations ceased at approximately 9:30 p.m. A command post for Coroner operations was established in a parking lot about 200 yards due east of the crash site. The operational area was organized and all required equipment was set up according to Coroner standard operating procedures.

This consisted of:

1. Decedent Processing Center: ZUMRO (manufacturer's name) tent for property/evidence collection, photography and preliminary decedent examination.

2. Temporary Morgue - body holding area prior to above processing.

3. Multi-Decedent Recovery Vehicle - refrigerated body storage, post-processing.

4. Mobile Command Post - communication center, crew relief area.

The Coroner recommends that its personnel have equipment at any Family Reunification Center (FRC) regardless of who is the designated handling agency. (Equipment: computers with email access so photos can be transmitted from the scene, chairs, tables, printers, and phones.)

A Coroner representative is also recommended to be present as soon as possible at any designated FRC where deaths have occurred. Due to early miscommunications with LAPD, families were sent home before the Coroner was able to collect necessary information from the next of kin. Though it did not cause a delay in a notification at this incident, it may pose problems in the future.

Also, the Ventura County Coroner's Office was unable to aid with notifications due to their limited staff. The Ventura County Sheriff's Department was at the FRC and helped with various "door-knock notifications" for several families.

Recommendations

A Deputy Medical Examiner (DME) is recommended to be at the scene of any MCI. Tissue (small and large) identification must be done quickly at the scene and a DME is vital in this process.

LOS ANGELES COUNTY FIRE DEPARTMENT

Findings

The LACoFD was quickly notified by LAFD of the incident. LAFD requested mutual aid assistance, which was immediately dispatched by LACoFD. Upon arrival, LAFD quickly established incident command. As a participating agency, the LACoFD representative quickly made contact with the ICA to provide coordination of LACoFD resources for immediate life-saving activities.

At the time of the incident, LACoFD Public Information Office received various calls from concerned citizens. Those calls were referred to LAFD Public Information Office, as lead agency for the train derailment.

Recommendations

None

SHERIFF DEPARTMENT

Findings

The location of the incident and the lack of adequate space for the placement of mobile command vehicles contributed to the difficulties in obtaining timely information on train derailment response efforts. Additionally, the train derailment accident scene was difficult to get to, due to the small residential streets and an over abundance of onlookers.

The initial law enforcement unit on scene or "patrol handle" initiated a unified command for incident command and control purposes.

As the incident expanded, it became more of a parallel command with law and fire response agencies concentrating on their own response activities at the incident scene. There was a need for more interagency briefings regarding the response to the incident.

COMBINED INCIDENT MANAGEMENT - INTERAGENCY COOPERATION

LASD is working closely with the following agencies to increase interagency cooperation and coordination in response to any major emergency or event:

- Los Angeles City Fire Department
- Los Angeles City Police Department
- Los Angeles County Fire Department
- Los Angeles County Department of Health Services
- Los Angeles County Department of Public Health

The group is developing a multi-agency/multi-discipline incident management team (IMT) for responses to any major emergency or event. The IMT will facilitate coordinated response from law, fire, and emergency medical services agencies.

Joint training and planning sessions are currently underway. The first of a series of combined agency training exercises is scheduled for April 21, 2009.

Additional multi-agency emergency response training is being planned with various cities using the Disaster Management Area law and fire mutual aid teams.

There were adequate law enforcement resources available to assist in rescue operations. This was predominantly a specialized- technical rescue for fire and emergency medical agencies, with assistance from law enforcement as requested by the ICA.

Law enforcement communications frequencies worked well.

Recommendations

None

DEPARTMENT OF MENTAL HEALTH

Findings

The primary responders from DMH were the Emergency Outreach-Field Response Operations staff. The trains collided on September 12, 2008, at approximately 4:20 p.m. Emergency Outreach Bureau (EOB) learned of the incident at 4:45 p.m. Metro Transit Authority and Mental Evaluation Team (MTA-MET) and Psychological Mobile Response Team (PMRT) were on site by 5:15 p.m. DMH services were coordinated through staff stationed at the incident command post.

A total of 16 clinicians from EOB, PMRT, and MTA-MET responded to the FRC operated by the American Red Cross at Chatsworth High School starting on the day of the incident and extending for 24 hours. Staff teamed up with the Coroner personnel and the Los Angeles City Mayor's Crisis Response Team and Chaplains to provide death notifications and offer support to family members and survivors. Approximately 17 death notifications were conducted starting Friday night, September 12, through Saturday evening, September 13. Three (3) of the death notifications on Saturday were for monolingual Spanish speaking family members. The FRC closed shortly after the final death notification on Saturday. PMRT staff remained on site at the command post until Sunday evening, September 14.

On Monday, September 15, and Tuesday, September 16, the Systemwide Mental Assessment Team (SMART) responded to the Los Angeles City Emergency Operations Center (EOC) to answer telephone calls from family members and survivors who were provided the telephone number as a resource for further information. Staff handled several distraught callers. PMRT also responded to several requests from businesses/community members who either witnessed the incident or knew someone who died in the incident and were in need of crisis counseling.

A public information announcement provided the toll-free ACCESS telephone number and advertised six (6) free counseling sessions for persons impacted by the incident at two (2) of outpatient clinics located in the San Fernando Valley. No services were requested as the majority of those on the train who died were Ventura County residents. Ventura County Sheriff's Department, in coordination with the American Red Cross-Ventura, made death notifications to the families of victims' living in Ventura County who did not travel to the FRC in Chatsworth.

DMH responded within the first two (2) hours of the incident and staffed the FRC. Command and control was coordinated through the command post.

DMH's response at the FRC was effective. DMH worked very closely with Coroner when conducting death notifications. DMH also did a press release announcing those clinics providing free mental health services to train derailment victims' families.

DMH also met with Metrolink personnel and provided mental health consultation services to them.

Recommendations

Ensure DMH receives timely notification of future accidents/incidents. DMH learned of the train derailment via media; therefore, response time to families at the FRC was delayed.

LASD and LACoFD should work closely with DMH to increase interagency cooperation and coordination in response to any major emergency or event.

When establishing a center where families are joining together for a tragic incident, consider the name of the center carefully. The center was named Family Reunification Center, yet **no** families were reunified. This provided families with false hope.

Provide additional coordination between first responder agencies and DMH in regard to the coordination of mental health related counseling services. LAFD provided two (2) phone numbers for families to call for further information during the post accident press briefing. DMH offered to provide clinicians to assist with those calls, but were told by LAFD that the clinicians were not needed. However, on Monday morning, September 15, DMH received a request from Los Angeles City Emergency Management Department to send clinicians to assist with calls due to the amount of upset callers.

CONCLUSION

The Chatsworth train derailment was a human tragedy that challenged our EMS. It is imperative that these events are fully reviewed to ensure ongoing system improvements

and preparedness for future response. Because of the County's geography, population, and frequency of major events, such as fire and earthquake, we are viewed as a National leader in disaster and MCI preparedness. When MCIs occur, Los Angeles County residents can be assured that there are systems in place to provide rapid EMS response and orderly transport of patients to hospitals that are appropriately staffed and ready to care for them.

The resources provided by the City and County of Los Angeles responded effectively to the Chatsworth train derailment. The recommendations listed in this document addressed inadequacies in the response effort and will increase coordination and communication between the emergency response agencies.

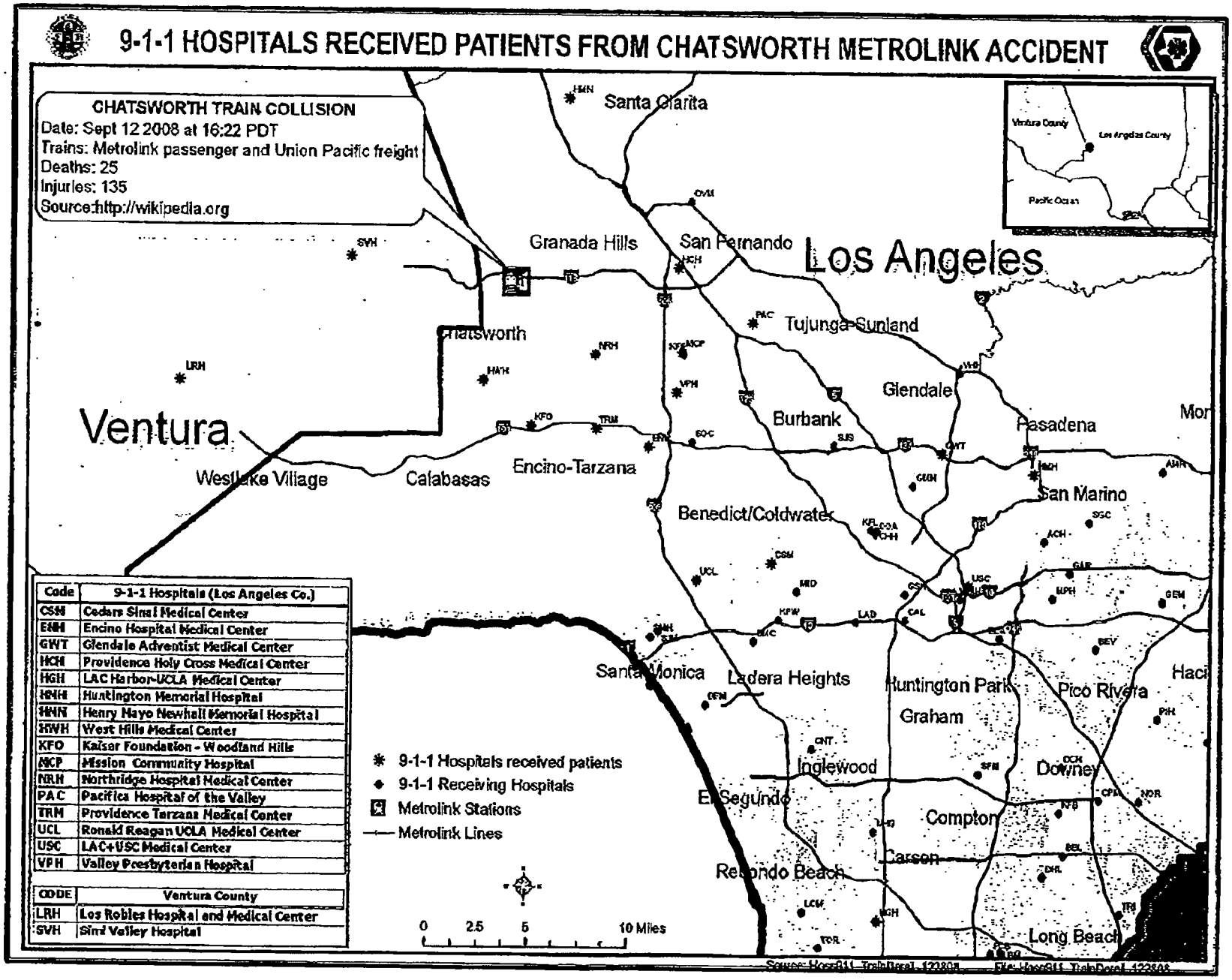
WTF:SRH:JSF
JW:JT:MI:lm/llm

Attachments

c: Executive Officer, Board of Supervisors
County Counsel
Health and Mental Health Services Cluster
Sheriff
Coroner
Fire
Health Services
Internal Services
Mental Health
Public Works
Emergency Preparedness Commission

ATTACHMENT i

9-1-1 HOSPITALS RECEIVED PATIENTS FROM CHATSWORTH METROLINK ACCIDENT



Code	9-1-1 Hospitals (Los Angeles Co.)
CSM	Cedars Sinai Medical Center
ENH	Encino Hospital Medical Center
GWT	Glendale Adventist Medical Center
HCH	Providence Holy Cross Medical Center
HGH	LAC Harbor-UCLA Medical Center
HMH	Huntington Memorial Hospital
HNH	Henry Mayo Newhall Memorial Hospital
HWH	West Hills Medical Center
KFO	Kaiser Foundation - Woodland Hills
MCP	Mission Community Hospital
NRH	Northridge Hospital Medical Center
PAC	Pacifica Hospital of the Valley
TRM	Providence Tarzana Medical Center
UCL	Ronald Reagan UCLA Medical Center
USC	LAC+USC Medical Center
VPH	Valley Presbyterian Hospital

CODE	Ventura County
LRH	Los Robles Hospital and Medical Center
SVH	Simi Valley Hospital

ATTACHMENT II

METROLINK TRAIN DERAILMENT DEBRIEFING
OCTOBER 2, 2008

PARTICIPANT LIST

American Medical Response
Antelope Ambulance
Childrens Hospital Los Angeles
Cedars-Sinai Medical Center
Los Angeles County EMS Agency
EMS Commissioners
Glendale Adventist Medical Center
LAC Harbor-UCLA Medical Center
Henry Mayo Newhall Memorial Medical Center
Hospital Association of Southern California
Huntington Memorial Hospital
LAC+USC Medical Center
Los Angeles County Ambulance Association
Los Angeles County Fire Department
Los Angeles County Sheriff's Department
Los Angeles Fire Department
Los Robles Hospital and Medical Center
Mission Community Hospital
Northridge Hospital Medical Center
Pacifica Hospital of the Valley
Providence Holy Cross Medical Center
Providence Tarzana Medical Center
ReddiNet
Ronald Reagan UCLA Medical Center
Sherman Oaks Hospital
Ventura County EMS Agency
West Hills Medical Center