

(France is divided into "departments"). The various texts that have successively established the rules concerning the organization of the Red Plan on a local level and national level have been analyzed, and the differences they reveal have been stressed in the light of the events that have led to its evolution.

The first emergency plan for numerous victims elaborated in the Paris area dates back to 1975. The first Director of Medical Assistance had been named one year earlier. At the time, the regulations were those of the Paris fire brigade, and anticipated three situations: Blue Plan, 10 victims; White Plan, 20 victims; and Red Plan, 50 victims. Later, these three were grouped into a single category: the Red Plan, with three "functional chains" for collecting, selecting/treating and evacuating.

The first actual application of this system occurred in 1978 after a gas explosion in rue Raynouard, and it was obvious that there were many flaws in the functioning of the Plan. These flaws were further exposed after responding to two additional explosions involving the emergency teams, and to spontaneous evacuations done by passersby and policemen. One year later, another gas explosion in rue Saint-Ferdinand provided the opportunity to implement the Red Plan. Since then, the lessons learnt during the major interventions and from the regular training have prompted regular updates in the regulations. The 1986 terrorist attacks in Paris made it clear that it was necessary to integrate the SAMU (urgent medical aid service) into the Red Plan, a decision that proved satisfactory later with the 1987 and 1988 train accidents, primarily that of Gare de Lyon. The new series of terrorist attacks in 1995 was the occasion to improve the way victims are cared for, thanks to the creation of a center for those implicated in the accident, and a specification in the role of the emergency medical-psychological department. In 1999, a new step was made due to the special geographical context of the Paris region, when an "interdepartmental" (interregion) Red Plan was adopted along with a new medical file.

Conclusion: Emergency aid was born from the war experience. The application of the regulations to actual and major accidents with limited effects has generated the conception of a more effective emergency plan, whose regulations should remain flexible in order to encourage regular evolutions.

Key words: casualty collection; chains, emergency aid; evacuation; functional; multiple casualties; plan; planning; preparedness; regulations; SAMU

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Sydney 2000: Olympic Stadium Medical Programme

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The Sydney 2000 Olympic Stadium is the world's largest ever purpose built Olympic facility, with a capacity of 118,000 people. Over the course of the Olympic programme, (8 days of athletics competition as well as the Opening and Closing Ceremonies), more than 1.9 million people passed through the turnstiles of the Olympic Stadium. Meeting the challenge to provide timely, effec-

tive, and efficient emergency care to all people in the stadium is discussed. It begins by looking at the challenges that needed to be overcome; it details the operating plan that ultimately was put in place; it outlines the disaster preparedness programme, the resources committed to implementing the programme, and the results achieved.

Ultimately, the plan involved over 100 medical staff providing medical care for over 100,000 people for each session of competition. How this was carried out is detailed and the activity of the programme is presented: 100–120 people treated per session: 50–60 of these needed basic first aid, and 50–60 needed more formal medical intervention (detailed medical assessment and invasive interventions). Ultimately, 5–7 people per session were transferred by ambulance to a hospital. No one died.

Key words: first aid; interventions; mass gatherings; medical care; Olympics; plan; preparedness; stadium; staffing

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Fifty-month CEP-Experience in an Area of a Half-million People

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Introduction: Following the education as Coordinating Emergency Physicians (CEPs) according to the Bavarian Rescue Laws (BRLs), we formed a voluntarily acting CEP group in our rescue region in Western Bavaria in January 1996. The group was accredited by the authorities in May 2000. To improve the performance of our missions, we analyzed the system capacities according J. de Boer¹ and tried to implement M. Villareal's QC tools.²

Methods: From January 1996 to February 2001, we handled 50 missions that were prospectively registered and analyzed since June 1997. According to de Boer's Criteria for Disaster Preparedness, we calculated the capacities of our rescue chain using the elements: (1) medical rescue capacity, (2) medical transport capacity, and (3) the local hospital treatment capacity according to the number of available hospital beds. We did these calculations to be prepared for the EMS management of the World Exhibition of Fire Brigades, which took place in our city in June 2000. M. Villareal's tools for QC were tested on scene and in postevent meetings to gain best information and feedback for our learning curve as CEPs.

Results: In total, we served 23 missions during daytime (4 in the morning, 19 in the afternoon), and 27 missions were necessary during the night. Regarding the reasons for the calls, there were 24 fire alarms, 14 accidents (cars, railroad, aircraft), 4 poisonings, 5 explosions or bomb alarms, and 3 during mass gatherings. Of these missions, 41 were graded as events of first degree (according to Villareal's staging system) and 9 required additional manpower like SEGs (special acting groups) so that these events were graded as 2nd degree casualties according to Villareal.

From the total number of 3,724 hospital beds, a theo-