After Action Report
SARS Complaint, Mid-Continent Airport
June 12, 2003

The following participated in a debriefing on June 19, 2003 regarding public health response and support as a part of the suspected SARS complaint one week earlier at Mid-Continent Airport.

Present:

NAME_01	Via Christi Regional Medical Center
NAME_02	Via Christi Regional Medical Center
NAME_03	Emergency Medical Services
NAME_04	Public Safety
NAME_05	MMRS – County Health Department
NAME_06	MMRS – County Health Department
NAME_07	County Health Department
NAME_08	County Health Department
NAME_09	County Health Department
NAME_10	Health Director – County Health Department
NAME_11	Communications
NAME_12	County Manager
NAME_13	9-1-1 Director
NAME_14	9-1-1 Supervisor
NAME_15	Public Safety
NAME_16	MMRS – County Health Department
NAME_17	Intern – Manager's Office
NAME_18	Intern – Manager's Office
NAME_19	Intern – Manager's Office
NAME_20	County Health Department
NAME_21	Assistant County Manager
NAME_22	Sedgwick County Emergency Management
NAME_23	Sedgwick County Emergency Management

Sequence of Events

The best way to start an examination of this event is to begin with the sequence of events as much in their entirety as possible, and then analyze what went right, and what can be improved.

The situation began in the skies over Oklahoma when a passenger on a commercial flight noticed a person hacking and wheezing. This person, a resident of Wichita, had spent the last three weeks in Hanoi, Vietnam. Another passenger on the flight became convinced the coughing passenger was infected by Severe Acute Respiratory Syndrome (SARS).

The flight attendant was convinced of the situation by the passenger, and notified the Captain. The Captain of the craft contacted airline headquarters and asked for clarification, which he did not receive.

The control tower then notified Airport Public Safety, who placed a 9-1-1 call at approximately **10:26 a.m.** The 9-1-1 operator took the initial report, and the word SARS was specifically mentioned by the caller.

At approximately **10:31 a.m.**, 9-1-1 assigned the call to EMS field units, and reported 46 passengers on board the aircraft. EMS responded to the airport at **10:39 a.m.** The delay in response was caused by a flurry of consultations with the Emergency Medical Service supervisors over cell phone, in an attempt to keep conversation on the air about the incident at a minimum.

At approximately **11:00 a.m.** 9-1-1 notified **Emergency Management** of the incident in person, and placed a call to **NAME_06 (MMRS).**

NAME_06 then called **Via Christie ED** at approximately **11:15 a.m.** to notify them of what was happening. The alleged patients arrived at the facility at approximately **11:20 a.m.**

At roughly the same time, contact was made between 9-1-1 and MMRS, who was enroute to the airport. MMRS contacted also contacted the **Kansas Department of Health & Environment.** Also, at approximately that same time, Sedgwick County Emergency Management was notifying the duty officer of the Kansas Division of Emergency Management.

The MMRS field team arrived at the airport at approximately **11:20 a.m.** and received a briefing. The team then boarded the aircraft and visited with the passengers and crew, obtaining standard epidemiological information.

At approximately **12:00 p.m.** OFFICIAL_01, Public Information Officer with the Kansas Division of Emergency Management / Adjutant General's Department called and relayed that KDHE did not believe we had an actual SARS situation.

At approximately **2:15 p.m.**, a decision was made to brief the Board of County Commissioners (BoCC) and the press simultaneously. The briefing was scheduled for **3:00 p.m.**, and was well attended by local media.

What went right?

To begin with, a number of things about our response went right. One of the reasons for this, I believe, is our prior planning for bioterrorism events, inspired through the County Health Department and the Metropolitan Medical Response System (MMRS). Once it was determined that something was out of the ordinary, the system was activated. It

responded well, it did the things it was designed to do including gather information, and spread education about the likelihood of the situation and special information about SARS. Calls to passengers were begun at about 4:00 p.m. by OFFICIAL_02 of the Sedgwick County Health Department Epidemiological Team and were finished by approximately 10:00 p.m. that evening. A few messages were returned the following morning from out-of-town passengers. They were informed that there was no risk of SARS.

What could be improved? [Lessons learned]

Our partners in the hospital community are anxious to have more advance notification. Had the situation turned out actually to be SARS, it is possible by transporting the patients to the facility we could have made that facility not available to anyone else – i.e., the heart attack, broken arm, etc., would have had to be diverted or wait because the Emergency Department facilities were shut down by a possible case of SARS.

We have discovered that this situation doesn't fit any of our existing "trigger" mechanisms. For example, we know when there is a bad automobile wreck to place the hospitals of "trauma alert." We don't have the same level of guidance or experience with a Public Health emergency. This points out a potential gap in our system: **at the current time, our 9-1-1 system doesn't have protocols or guidelines to help it determine a public health emergency is in the process of happening.** The reason it doesn't have those guidelines is that, to our knowledge, they don't exist yet. So, we will be doing some research to see if we can help create those guidelines to help us in the future.

Because we were unfamiliar with responding to a basic Pubic Health emergency, we don't feel we opened our Emergency Operations Center in time to do coordination that would have been very valuable. We also failed to get a public health decision-maker resident in the Emergency Operations Center to make sure political leadership and the Public Information Officer were properly informed about the on-going state of affairs on a regular basis.

A new telephone system has just been installed in the Emergency Operations Center. Lack of familiarity with the system caused some folks to not be able to access others, or conversations with others to help solve the problem.

Another area of improvement discussed was the fact we should consider adding medical personnel to our EOC staff – both from the Public Health perspective, and the private enterprise perspective.

Review comments on this report

Special thanks should be extended to NAME_03, NAME_01, NAME_20 and NAME_04 for the following additional remarks / clarifications to this document. The following materials add value to this document in helping make issues and times clearer.

Timeline of Events – provided by NAME_03 from E-9-1-1 Records

Call received:	10:26:59	06/12/2003
Dispatched to EMS:	10:29:08	06/12/2003
First EMS unit & Super en route	10:30:11	06/12/2003
Second EMS unit enroute	10:48:00	06/12/2003
EMS Supervisor on scene	10:47:41	06/12/2003
First EMS Unit on scene	10:55:00	06/12/2003
Second EMS Unit on scene	10:56:00	06/12/2003
Triage on 3 patients	11:12:00	06/12/2003
Patients transported to Via Christi	11:20:44	06/12/2003
Arrival at Via Christa St. Francis	11:34:48	06/12/2003

Comments from NAME_01 / Via Christi Health Systems

I think a weakness in the system in this case is that there was no one for the flight crew to get guidance from when the plane was in the air. [Sic] No one who responded on arrival at the airport was aware that a coughing patient coming from a country that had been off the alert list since May 15 should not have triggered the system. Control of contagious disease is based on the science of epidemiology and it is critical that those in the front lines have the information and be required to act rationally on the basis of that information. Otherwise, we have hysteria. This is a critical issue for appropriate airport response in the future.

Comments from NAME_20 / Sedgwick County Health Department

I couldn't agree more … but how does every airline pilot become versed on the latest decision making information, or will the airline provide whoever the pilot could communicate with and ensure that they can provide that information on a real-time basis?