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MEDIA RELEASE

BOURKE STREET MALL INCIDENT: BLOOD SUPPLY RECOMMENDATIONS

EMBARGOED UNTIL 12:01am Monday 25 May 2020

THE Bourke Street Mall mass casualty event highlighted the challenges involved in supplying blood and blood components, leading to a series of recommendations from the Victorian Blood User Group aimed at assisting plans for future incidents, published online today by *Medical Journal of Australia*.

“Haemorrhage is a leading cause of mortality in mass casualty events (MCEs), accounting for almost 50% of deaths in the first 24 hours, and transfusion emergency preparedness is increasingly recognised as a critical element of an integrated approach to MCEs, with timely availability and appropriate delivery of blood components being an essential part of management,” wrote Dr Linda Saravanan, a haematologist with Melbourne Pathology, and Dr Amanda Ormerod, a clinical haematologist with Latrobe Regional Hospital and Dorevitch Pathology.

In February 2017, one month after the Bourke Street Mall incident, in which six people were killed and 30 injured, members of the Victorian Blood User Group highlighted concerns with communication during the incident.

“Poor communication from hospitals to their pathology laboratories was noted during activation of hospital Code Brown alerts [a hospital alert activated internally when notification of an external incident is received, usually by emergency services or health departments, which requires mobilisation of additional capability and capacity within that facility to receive an influx of patients],” Saravanan and Ormerod wrote.

“There was also uncertainty and lack of transparency surrounding supply of blood components from Lifeblood to hospitals in Victoria, not only to those involved in the incident but also those awaiting delivery of routine blood inventory.”

At a forum in August 2017 Blood User Group representatives and invited guests, including National Blood Authority representatives, heard presentations from the Victorian Department of Health and Human Services, Lifeblood and four hospitals that received patients, outlining issues and learnings from the incident, followed by further discussion. Five recommendations came out of the forum:

- pathology staff must form part of hospital critical incident management teams;
- implement safe, non-sequential allocation of unit record numbers for consecutive emergency patients;
- ensure adequate levels of pathology staff familiar with critical event management;
- include pathology staff in practice disaster scenarios; and,
- consider standby phase in Code Brown responses.

“Incorporating the lessons learnt from this incident will allow for more organised responses and streamlined communications between all departments and institutions,” Saravanan and Ormerod concluded.

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