TITLE:

Terror attacks in Brussels on March 22nd, 2016: the Belgian experience.

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ABSTRACT:

In 2016, 1,441 attacks were counted for a total of 14,356 fatalities worldwide. In Europe, more specifically, the terror attacks in Nice were the heaviest with 86 dead followed by the ones in Brussels on March 22nd with 32 deceased. In terms of number of injured people on that day, the attacks in Brussels were proportionally not so deadly. In total, there were 324 hospital contacts related to the attacks. Why a so low proportion of fatalities in a country where no trauma system exists yet and knowing that the evacuation of casualties was made difficult by a dysfunctional mobile network as well as by a change of evacuation plan after the second attack in the underground?
At a coordination level, the crisis center first tried quite successfully to turn the mass casualty event into a minor mass casualty event, keeping care containable. Patients were first brought to the nearest hospital, but were then relocated to main hospitals farther away. Furthermore, the military hospital in Brussels was used as a buffer capacity. The first Forward Medical Post (FMP) was moved to the military hospital, which created a new FMP in a safe area.
At an intra-hospital level, not every patient requested a total body computed tomography scanner, which preserved resources. Key-resources like emergency room, intensive care and operating room were built up gradually during the day. Safety measures were also implemented gradually due to the level three terror threat in which the country was at that time.
In sum, as terror attacks by coordinated groups become more sophisticated and as more random attacks as well are made simultaneously on soft targets in western countries, using new terror methods of improvised explosive devices radio commanded or vehicle/drone borne or by making dirty bombs, we need to be prepared as good as possible. At a coordination level, the attacks in Brussels have shown that first, the battlefield experience with tactical casualty care and damage control resuscitation is important; second, a secondary FMP and a buffer capacity are paramount; and third, communication is always the Achilles' tendon in a mass casualty event. Beside this, March 22nd has also revealed that the intra-hospital dynamic needs to be improved by developing access plans, by learning the pathology to be expected and related training, by making cards to describe staff functions, by elaborating a disaster plan and relevant training with e.g. some e-learnings for all staff of main national hospitals.