THE BEACON

OFFICIAL QUARTERLY PUBLICATION OF THE AMBULANCE HISTORICAL SOCIETY OF VICTORIA

Chas Martin O.A.M. Ambulance Victoria Museum

33RD EDITION – SUMMER 2025 **$6.00**

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The Beacon is edited, printed and posted out entirely in-house at Thurgoona, N.S.W

You don't have to be an Ambo! to be an ***Ambulance Victoria Museum*** **Member**.

All interested persons are welcome to join as members at our **subsidised** AHSV rate of **$10.00 PA*** ($30.00-3yrs) * **Includes 4 x quarterly Beacons PA**, * **Free museum admission for family and friends**

Get on board and enjoy reading the true accounts and actual ambulance cases throughout Victoria and join the great teams in Ambulance as they experience Tragedy, Jubilation, Tears, and Laughter all in the mix. Also, this is our Victorian Ambulance history that can be archived to hand on to others in future years. ***Emergency Service counterparts and medical associates most welcome!*Absolutely Great Value!! @ $10***

To join -- simply contact --- *Barb Dent* @ Email: vintambos@bigpond.com or Text **0417 290 946**

Courage

You gain strength, courage, and confidence by every experience in which you stop to look fear in the face. You are able to say to yourself - "I lived through this horror; I can take the next thing that comes along." ***Eleanor Roosevelt.***

Curator's Report

Hello everyone, and welcome to 2025! With the festive season now over I hope that you all enjoyed yourselves and managed to stay safe and healthy.

The year 2025 begins with fresh ideas and new submissions from our AHSV committee focused on taking our museum into the future. Many goals have already been accomplished in this regard. Also, the time will eventually come when we can fully materialise our aspirations in a larger premises and expand our activities even further. Recapping on our past year's operation, and in particular our AHSV 2024 Annual General Meeting, I would like to thank the former committee, and all who supported me to continue as Curator. The entire committee decided to continue in their roles and were re-elected for the next two years. Also, it was pleasing to see more recent members of our team put their hands up to assist our committee. This enthusiasm will allow us to strengthen the management of the museum, and for these willing persons to take on future important roles.

Our volunteer museum team works extremely hard to keep our great organisation ticking and is second to none, and we have a comprehensive complement of ability. This is inclusive of mechanical, electronic, fleet management, general maintenance, presenters, and the catering arm of Anne and Marie, whilst Pete and Barb head up our quarterly member communication, history, and activities with The Beacon. So our team is rightfully the envy of many other establishments. To work beside this special crew of our fine men and women who contribute with so much willingness and dedication for me is a pleasure. The museum team took a break between the Christmas and New Year period to spend this special period with family. Although one museum filming crew member kept a pre-booked filming obligation over this break. So, sincere thanks to Terry (Doc) Brooks, especially as one of the takes went over a two night period during Christmas. We re-opened on Monday the 6th of January 2025 to share and discuss our plans for the ensuing 2025 year, and we always look forward to new blood to join us in camaraderie.

On the last week of December, we were visited by the Community and Engagement group from AV for the purpose of obtaining a deeper insight on what is our objective, and also for the group to learn of the relationship that we share with the public. Our AHSV efforts create a voluntary PR arm of AV and present an informative view of our Victorian Ambulance Service development over the decades. The professional image we portray to the people of Victoria also reaches far beyond our state borders. The C.& E group had an enjoyable visit and an eye-opening session with us. This included having lunch with our team and taking in the vintage ambulance fleet, and time transitioning of vehicles, communications, and pre-hospital care medical equipment. We also presented the video history of Ambulance development in Victoria to enlighten the group, and for their enjoyment.

In 2025, we are looking forward to a visit from our Acting CEO, *Andrew Crisp*. Andrew has shown a keen interest in our endeavours to preserve our rich state ambulance heritage, and being a member of the AV board, Andrew is able to pass on the efforts of our museum, particularly as we are the custodians of our rich Victorian Ambulance Service history and heritage.

Our AHSV Committee, and myself, are elected to work for you, our members, our supporters, and the public. We also gratefully acknowledge our sponsors, together over the years we have achieved many milestones. This progress has been made with gratitude to our late curator, *Chas Martin* and his wife *Marg,* who together gave so much, tirelessly, for so long. The sound foundation and legacy that Chas left will always be the catalyst for our future successes.

The committee and I wish you all a very happy, healthy, and prosperous 2025.

Ralph Casey ASM

Curator.

VCAS AND RMH, WITH VICTORIA, LED THE WORLD

Foreword.

*To Commemorate the 50th Anniversary of the introduction of the lifesaving MICA initiative into the Melbourne based Ambulance Service, VCAS in 1971. And to acknowledge the MICA pioneers. In 2021 Ambulance Victoria (AV) published the book "**MICA in Victoria, The First 50 Years**". The book was a limited print only, and originally intended for serving and former MICA personnel. This informative publication sets out the history of MICA, its beginning, and journey, of trials, tribulation, tears and joy. Many serving and former Victorian MICA and Emergency paramedics have acquired this publication. For those not so fortunate and interested, with AV collaboration, The Beacon will present an adapted series from the book in quarterly parts.*

Part One. (1) *The Background of the MICA Initiative.*

Victoria became a world leader in pre-hospital care with the development of what became known as the Mobile Intensive Care Ambulance (MICA) in 1971. Victoria's new MICA was one of just three mobile intensive care units established around the world and only the second one to be operated exclusively by paramedics rather than a combination of doctors and paramedics.

The concept of mobile intensive care pushed the boundaries of medical practice at that time. It advanced the development of skills and responsibilities for Victoria's 'ambulance drivers', as they were originally known, accelerating their transition to 'ambulance officers' and ultimately to become the 'paramedics' of today.

The development of Victoria's new intensive care ambulance service had its origins in two perhaps unlikely places: Vietnam and Northern Ireland. During the Vietnam War in the late 1950s through to early 1970s, recovery rates for seriously injured servicemen were observed to be significantly higher when they were stabilised in the field by specially trained medics, then rapidly evacuated by helicopter to frontline hospitals. These observations coincided with new thinking from cardiologists in the late 1960s that patients were needlessly dying of cardiac arrest before they could reach treatment in hospital.

RAR Medics in Vietnam.

Coronary care units within hospitals were a relatively new concept in the 1960s, both in Australia and around the world. Previously, patients with heart attacks were admitted to general wards, but during 1961 coronary care units were opened in Kansas, New York and Philadelphia in the United States, in Toronto, Canada and in Melbourne (at the Royal Melbourne Hospital, which would go on to be the birthplace of MICA) and Sydney, Australia. The evolution of new equipment, including electrocardiograph monitors and defibrillators, contributed to the development of coronary care units and the breakthrough of modern resuscitation methods were another turning point for emergency care. The introduction of cardio-pulmonary resuscitation (CPR) for the first time enabled cardiac arrest patients to be kept in a viable state in a pre-hospital setting until they could receive more definitive care.

In Belfast, cardiologist Frank Pantridge MD (1916-2004) was determined to address the appalling mortality rates after myocardial infarction (heart attack). He noted that left untreated, coronary patients usually died in the first 12 hours, with the majority passing in the first three hours, yet most were not admitted to hospital until 12 hours had elapsed. Professor Pantridge also observed cardiac survival rates were much better in the intensive care unit where early defibrillation and advanced life support were available. Prof. Pantridge, sometimes referred to as the 'grandfather' of pre-hospital advanced life support, pioneered the world's first mobile cardiac care service for the community in Belfast in 1966.

Prof. Frank Pantridge

Recognising the need to bring the defibrillator to the patient, rather than bringing the patient to the defibrillator in a hospital, Prof. Pantridge was also responsible for developing the world's first lightweight portable defibrillator using technology developed by the NASA space program. At the request of a general practitioner, a team of doctors and nurses from the cardiac department at Royal Victoria Hospital in Belfast would travel to the cardiac patient and treat them with portable equipment. This breakthrough in treatment at the scene led to Belfast in the late 1960s being described as the safest place to have a heart attack.'

Though lifesaving, this program was less than warmly received in the United Kingdom, where Prof. Pantridge presented his results to the Association of Physicians in 1967.

He later observed:

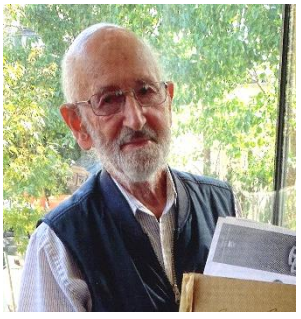
"We were disbelieved and indeed, to some extent ridiculed. The unfavourable comments emphasised lack of *need for pre-hospital coronary care, the prohibitive costs and the danger of moving a patient who had had a recent coronary attack.*"

Official support from UK physicians did not eventuate until the mid-1970s. By that time, Prof. Pantridge and his work had received accolades and honours across the Atlantic Ocean in the United States, leading to a similar mobile coronary care unit being established in Seattle in 1969. While based on Prof. Pantridge's work, the Seattle Medic One Program diverged from the one operating in Belfast, as Medic One was operated by fire department personnel trained to use battery-operated defibrillators. Pioneered by Dr Leonard Cobb, the Medic One Program significantly improved survival rates for out-of-hospital cardiac arrest in Seattle, creating another 'safe place to have a heart attack.' A year later in Melbourne, a feasibility trial started for Australia's first mobile intensive care unit. As early as 1966, cardiologists in Melbourne had made moves with the then Victorian Civil Ambulance Service (a predecessor to Ambulance Victoria) toward the establishment of 'flying squads' or Mobile Intensive Care Units (MICU), as the service was initially known, to provide rapid defibrillation following heart attack or electric shock.

However, it was the shocking toll of road trauma, rather than cardiac arrest, which proved pivotal in securing political backing and funding for the trial in Melbourne. Some 1034 people were killed on Victorian roads in 1969. By comparison, in 2020, with almost double the population in Victoria, there were just 213 road deaths. The year prior in 2019, when COVID-19 pandemic restrictions in Victoria were not a factor reducing road traffic, there were 263 deaths. The 1969 Victorian road toll became the clarion call for a campaign by The Sun News Pictorial - The Ten Thirty Four Campaign - which was later applauded as the most successful newspaper campaign of the 20th century.

Alarmed by the rate of road deaths, in October 1969 a seminar on the Management of Road Traffic Casualties was held by the Royal Australasian College of Surgeons. The seminar was influential in supporting the Australian Medical Association's proposal that led to the compulsory wearing of seatbelts, plus research into the management of road traffic casualties and, importantly for ambulance, support for a greater role for ambulance officers. In May 1971, the Victorian Government approved a three-month trial of an emergency on **site** medical care unit. The initial trial in Melbourne followed the Belfast model with doctors accompanying ambulance officers, but Victoria's intensive care ambulance would later develop into a paramedic-only model.

For brief periods in development the new service was known as the Emergency On Site Medical Care Unit (EOSMCU) and the Mobile Intensive Care Unit (MICU). Ultimately, the Victorian service was officially named the Mobile Intensive Care Ambulance, or MICA, because it was deemed the most appropriate and that it sounded better.



Dr Graeme Sloman - RMH

They say invention has many mothers and fathers: the many who step forward to take their share of credit for a great idea. For MICA, even among those who might themselves rightly claim the title of MICA pioneer in Victoria, either as members of the ambulance service or the medical profession, just one name is offered first and foremost for recognition. That name is *Dr Graeme Sloman*. In the corridors of Ambulance Victoria, right up to the office of the Chief Executive Officer, Dr Sloman is recognised as 'the father of MICA.'

Dr Sloman, AO, D. Med. Sc. (Melb) honoris causa, F.R.C.P, pioneered the introduction of coronary care units in Australia, working with the late *Dr Clive Fitts* to establish Victoria's first Coronary Care Unit at the Royal Melbourne Hospital. Dr Sloman became Director of Cardiology at Royal Melbourne Hospital and later moved across to become Epworth Hospital's first Medical Director, where he established the first Cardiology Unit at Epworth. A world authority in the field of cardiology in the late 20th and early 21st centuries, Dr Sloman pioneered intra-aortic coronary angiography and cardiac pacemakers in Australia, and importantly for ambulance services, he campaigned for the introduction of a free national emergency Triple Zero (000) telephone service and specialised intensive care ambulances in Victoria.

Following the 1969 road trauma seminar by the Royal Australasian College of Surgeons, a sub-committee which was formed to report on the conduct of casualty services, recommended the development of the Mobile Intensive Care Unit (MICU) concept at strategic areas throughout the state. Discussions between the Royal Melbourne Hospital and the Victorian Civil Ambulance Service (VCAS) led to the formation of a sub-

committee of surgeons, cardiologists and VCAS personnel, including Dr Sloman representing Royal Melbourne Hospital. Dr Sloman had long been interested in pre-hospital emergency care and influenced by the work of Prof. Pantridge in Belfast and Seattle's Medic One Program, was concerned that at least one-third of acute myocardial infarction (heart attack) patients died before they reached hospital. He received a Heart Foundation grant to travel to Seattle and learn from the work of Dr Leonard Cobb. After observing the work of Seattle's Medic One Program, Dr Sloman returned to Melbourne determined to establish a similar system to provide earlier treatment to cardiac patients.

MICA paramedic (retired) John Blosfelds, who served ambulance in Victoria for 41 years, including 10 years as the first person in charge of MICA, said, “Dr Sloman had campaigned for years until support and funding were secured for a mobile coronary care unit. Dr Graeme Sloman started the coronary care unit (at the Royal Melbourne Hospital), it was one of the first coronary care units in Australia," Blosfelds said. "The other one was in Sydney, they both started at roughly the same time. They were only small units but the result was they were able to reduce the mortality rate at the hospital by about 30 per cent by constant monitoring, treating arrhythmias and rapid defibrillation. Dr Sloman was also, as a result of that, asked by the Victorian State Electricity Commission to provide some sort of mobile coronary care unit, with a defibrillator to help patients who had been electrocuted."

"He started writing letters to the Hospitals and Charities Commission at that time, to get permission to establish a mobile coronary care unit and it went on for a few years. He kept pushing. 'Then in 1969, the College of Surgeons had its seminar," Blosfelds said.

MICA Flight Paramedic (retired) Philip Hogan ASM, himself a Churchill Fellowship recipient and the architect of Victoria's MICA helicopters, said, “Dr Sloman had earned a place in ambulance history, not just in Australia but globally. “He was the father of MICA” Hogan said. "He was a brilliant and lateral thinker and he wouldn't settle for second rate as a possibility. Dr Sloman faced tremendous backlash from other medical professionals who thought that this was the role of doctors, but he just had the tenacity to push through with this program. Looking back now, I'm glad he did, but I don't know how he did it, being operated by two paramedics only, as was the practice in Seattle.” However, Dr Sloman arranged for two ambulance officers, Wally Byrne and Wally Ross to get the necessary training to prepare them to take a greater frontline role with cardiac patients. Byrne and Ross took part in a one month coronary care course run for nurses in the coronary care unit at Royal Melbourne Hospital and gained practical clinical experience working alongside coronary care staff.

Dr Sloman went out with Byrne and Ross on the first call-out to a patient who suffered a stroke while on the roof of his house. At the 35th anniversary of MICA in 2006 , Wally Byrne (d) remembered those early days with enormous respect for the visionaries behind the MICA trial, especially Dr Sloman. “It was rather fortuitous really, everything happened at the right time” Byrne said. “Graeme Sloman, without him it didn’t go. Sloman was the everything man – he made things happen that a lot of people couldn’t. When it came together it all clicked. It was just a wonderful area we were working (in); there was some magic there”. Dr Sloman continued to be hands-on in the development of the MICA concept, both in Victoria and as a guest lecturer as the idea spread to other parts of Australia and the world. For many years after MICA was established in Melbourne, it became a drawcard for visiting health officials from other countries seeking to learn about Victoria’s world leading model of pre-hospital emergency healthcare. **(End part one**)

The original 1972 MICA vehicle. Car 208

Beyond The Call.

This factual account occurred in the infant years of the Victorian Civil Ambulance Service's inception of the lifesaving MICA initiative, proving it an exceptional success. The following testimony is a worthy and moving account of a life in the balance. It also portrays the challenge for paramedics, and their colleagues, with the patient's wife looking on. It is an illustration of ambulance dedication and diligence reaching far beyond the call of duty. The essence of the context is perseverance rewarded with the ultimate result of a life preserved, and following, the blossoming of a lifelong friendship.

On the evening of December 7, 1975, 2200hrs EST time, at the Alfred Hospital and a residential Balwyn address, some 15 kilometres in separation, the events surrounding this story were unfolding.

Bryan, Lyell, Doug, Alan. - Wives in back row.

At Balwyn, *Douglas Day*, 52 years of age, had suffered a cardiac arrest while speaking with his brother on the telephone. The emergency ambulance crew, *Lyell Hilbrick* and *Tony Austin*, were quickly in attendance. The crew immediately performed C.P.R. and called for MICA backup.
This critical assistance call came to MICA crew, *Alan Watkins.*ASM and *Bryan Cass* ASM, the car was completing a case at the Alfred Hospital. VCAS radio control implored Alan and Bryan to clear their current case as quickly as possible to enable assistance to the crew attending Doug Day. The two MICA paramedics rapidly endeavored to meet this request and received Doug's case, then proceeded on 'Signal 8' to the residential location. Watkins and Cass arrived some 50 minutes after Doug's fatal collapse and took over the resuscitation process. Hilbrick and Austin had maintained the patient, pending MICA arrival. After a further one hour, forty minutes of continuing resuscitation, and several cardiac arrest intravenous procedures, Doug began to show indication of a positive response. Having been defibrillated several times, the patient returned a diastolic blood pressure of 130, he had been clinically dead for this period of approximately 2.5 hours. Doug was immediately transported by the MICA crew under Signal 8 to the I.C.U. unit at the Alfred Hospital. It was here Doug spent the next ten days, followed by more than three months in the general cardiac ward, prior to being discharged and allowed to return to his home and to wife Joy.

Bryan, Doug, Joy and Alan.

This particular cardiac arrest case has left many emergency paramedics and MICA colleagues astounded from the incredible time frame that both attending crews spent maintaining Doug Day's life. The entire process entailing cardiac pulmonary resuscitation and later MICA intervention totaling a period of 2.5 hours may reasonably be considered a state ambulance record, and commendation for diligence. The display of competence and sheer perseverance delivered by these four attending ambulance paramedics will always be championed as an outstanding personal tribute to each colleague so charged with this case. Bryan Cass later explained that the successful outcome of Doug Day's cardiac case was attributed to the equipment and intravenous cardiac drugs, then exclusive to MICA paramedics. Also, that Doug Day's cardiac success supported the fact that this equipment and administration of drugs was ongoing with resuscitation when an indicative patient response presented. The Watkins/Cass/Day cardiac case was a wonderful win and endorsement of the VCAS/ Dr Graeme Sloman MICA initiative. Further to this case was recognition that monitors, and other cardiac equipment, combined with intravenous drugs at that stage, were deemed invaluable in assessing the status of patient response. To this end, a further legacy of the MICA/ Day cardiac case resulted in all emergency ambulances being equipped with this vital cardiac equipment, and cardiac drugs. This eventuation created a further significant step forward in general pre-hospital care for critical medical and accidental cases in Victoria.

Subsequently, on the evening of December 7, at Balwyn, Metropolitan Melbourne, cardiac arrest patient Douglas Day and MICA paramedics Alan Watkins, Bryan Cass, with emergency paramedics, Hilbrick and Austin, were to be written into our Victorian Ambulance Service History.

A short while after the dramatic events of Doug Day's cardiac arrest had settled down, it was not the usual simple letter of gratitude forwarded by the patient or family to Headquarters to be passed on to the relevant crew. Doug and his wife Joy were insistent on taking the attending paramedics and their partners out to dinner, and this dinner was to be the catalyst for a special Cass/Day family friendship that would span the next 37 years. Doug and Joy, Bryan and Dawn virtually became integral to each other's family, sharing the natural unfolding of family progressive events. This bond included Doug and Joy attending the weddings of all three of Bryan and Dawn's daughters, and Bryan and Dawn attending Doug and Joy's Golden Wedding Anniversary. Together both couples attended many other special events and milestones and often visited each other at home.

Doug and Bryan.

Doug passed away on June 15, 2012, aged 89 yrs, having been given these 37 gifted years of life after his escape from his cardiac arrest in 1975. This gift of life enabled Doug to see his four children marry and granted him time to see six grandchildren born and grow to maturity. Before Doug passed Bryan sat beside him taking his friend's hand in a final farewell. At the request of family, Bryan delivered a eulogy at Doug's funeral, a request he considered an extreme honour. Bryan described to me his personal value of this strong family friendship and bond in these words. "I *cannot explain the feeling we had for each other. His family knew there was something special, but there never was a word for it, such was the feeling of this personal time we had."*

'Many people will walk in and out of your life, but only true friends leave footprints in your heart'

Author unknown.

The role of a paramedic follows a difficult path, striking a balance of working under extreme pressure, controlling emotion, showing empathy, and at the same time attempting to protect one's psychological wellness. To be sought out by patient and family in gratitude for a successful job diligently performed, followed by rich friendship, is indeed a satisfying outcome. And also, it is a just and worthy reward for a particular case in our chosen career. Thank you, Bryan for sharing this unique and moving story with us. (inset photographs portray some of the wonderful moments of this special friendship).

A.V. Around The State

Digital Radio Upgrade Program Commences in Rural Victoria (DRUP)

DRUP launches in Barwon South West in December 2024. AV officially launched Stage 2 of the Digital Radio Upgrade Program (DRUP2) with the successful soft launch of the RMR Rural Mobile Radio digital network in Barwon South West (BSW). Various teams in Barwon South West 1, along with those across BalSECC, (Ballarat State Emergency Centre) participated in online training sessions in preparation for the upgrade. This critical program will transition AV from the existing analogue RAV Net radio system to the digital MMRN (Melbourne Mobile Radio Network) Tallyho, enabling direct communication between rural and metro responders. The transition will also provide a consistent and reliable digital network across the entire state. The first teams to receive the new digital vehicles were from Ocean Grove, Point Lonsdale, Bellarine, Belmont, Norlane, and Swan Bay. In total, seven digital vehicles were deployed. Again this digital radio roll out demonstrates AV leading the field in ambulance communications.

And, for interest, let's turn back the clock 81 years to 1944. In this year some VCAS Melbourne ambulances were fitted with one-way radios. These cars could receive calls although were not able to reply to control. However, this was a major step forward in ambulance communications, particularly emergencies. Prior to this, the crew of an ambulance completing a case was required to phone in to HQ for their next job, regardless if there was an emergency waiting. To assist this communication, six ambulance telephones were located within the Melbourne CBD. By 1954 all VCAS ambulances were fitted with 2-way radios. This upgrade was to coincide with Queen Elizabeth 11's visit to Melbourne in 1954. However, these radios were 'valve radio sets.' This meant that depending on the ambient temperature, when they were turned on it could take 3-5 minutes for the valves in the radio to warm up before the radio could be operated. These sets were superceded by transistor 2-way radios in the later 1960s, and following on in 1980/90 came 'critical emergency' and 'technical interface' communications. Although in keeping with communication of the eras of the 1940s, 50s, and 60s in perspective, the communications were "Par for the Course." Telegrams, trunk calls, all fixed line phones, only just TV, and so on.

~ Telegrams, Phone, and Mail ~

It is a rewarding challenge sourcing our ambulance history and personal history requests. Recently *Ralph Casey* passed on an enquiry that came from Canberra. The email sender stated that he was contacting us on behalf of a former Bright NE Victoria medical practitioner *Dr John Wiseman*. The email suggested that Dr Wiseman had played a development role in the first Bright Ambulance Service, potentially during the 1950s. Dr Wiseman is now aged 97 years, and obviously drawing to the end of his life, and he would appreciate seeing a photograph of the Ambulance Station commemoration plaque. It was assumed that the plaque carried his name, so, keen to oblige, the search began. Firstly with my ambo contacts who may shed some light, then an email to the Alpine Shire, Bright's local council. Alpine Shire responded, advising that they were unaware of the original plaque or of its whereabouts, and that a new ambulance station had since been built. The Alpine Shire Community Officer also advised that a book had been published about Bright Ambulance Service History. This publication is titled "*Foot To The Floor*." and the book had been sold at *Crispy's* Hardware Store in Bright, also that a copy was held at the Bright Library.

Next was a phone call to Crispy's Hardware and this call yielded a very helpful contact, although all the books unfortunately had been sold. This person pointed the search in another direction and provided the telephone number of *Dianne Talbot* of the Bright Historical Society. Dianne, in turn, passed on the mobile phone number of the author of the book mentioned, *Ian Stapleton*. Apparently Ian edited the Bright Ambulance History publication solely from information offered by former Bright volunteer ambulance personnel, however most of the volunteers now have passed or are well aged. Shortly after commencing our conversation and outlining my primary enquiry of Dr Wiseman, the topic switched to other Bright Ambulance history encompassed in Ian's book. Emerging from this topic was seemingly our 1957 Ford Mainline vintage ambulance, and this is when our conversation began to take on some real interest. Ian informed me that in the 1970s the Bright community raised funds to begin an ambulance service operated by volunteers and with the sole local G.P. *Dr. Ford.* A second-hand, high mileage Dodge Ambulance was purchased and operated in Bright. Sometime later when further funds were raised, a Ford Mainline Ambulance was purchased to replace the Dodge. It is thought it was purchased within the North East region.

The Ford Mainline was operated in the Bright area by volunteers. Dr Ford would often accompany these crews on a call out. At this point the conversation became a bit confusing. Ian had been informed that, although the Mainline ambulance was purchased with community raised funds, it was stated that the ambulance had later been taken from the Bright community by NEVDAS management, and that this acquisition created an uproar in Bright. Further stated, supposedly when NEVDAS personnel came to a property where the Mainline was garaged, the resident resisted a handover with an unloaded 12 gauge shotgun. Although, I wonder if the ageing volunteers may have become carried away or had one or two when providing this information to Ian. Allegedly there was further anger when the acquired Mainline was put into service as a NEVDAS ambulance and stationed at the Dartmouth Dam project in the 1970s to be operated by volunteers. The conversation was very interesting and went on for over an hour centered on the Mainline, and finally my mind was fragmented, and as 1800hrs was nigh, there was an urgent need for hydration, so the call ended.

We know that the 1957 Ford Mainline in our fleet was donated by NEVDAS in the 1980s, courtesy of then Supt *Gary Pink*. Also, we understood that the Mainline ambulance was originally in service at the Snowy Mountains Hydroelectric Scheme (late 1950s -1960s) and, according to AHSV records held by *Darrel*l *Rintoule*, the Mainline was one of the original five vintage ambulances previously obtained by the first attempt of AHSV in the 1980s. The five ambulances had been stored by MAS around Melbourne and were retrieved in 2005/6 when Chas Martin commenced our Ambulance Victoria Museum at Thomastown. The five vintage ambulances were - 1913 Talbot, - 1942 Chev, -1957 Ford Mainline, - 1963 Ford F100--1973 H.Q. Holden – Just 5 cars to start our Ambulance Victoria Museum at Thomastown. Today, at Bayswater, we proudly showcase 25 immaculate vintage ambulances including our full size Leyland 12-bed "Disaster Bus". I imagine that the Ford Mainline saga will be ongoing for a while. It should be an interesting follow up, and hopefully we can bring you a final outcome in our next issue. Although weighing it up, my gut feeling is that the 1957 Mainline probably originated from NEVDAS on a loan basis, however I well may be incorrect. *(Please see image of our 1957 Ford Mainline ambulance on rear cover page of this Beacon*)

And now, in regard to Dr John Wiseman, where this account began way back, it seems that there is no official historic record or local recall of him being a medical practitioner in Bright. However, this may not be conclusive, as this passage of time could be more than 70 years ago, and one can imagine at 97 years of age his memory may not be comprehensive. It is disappointing on this occasion that we were unable to provide a positive outcome to Dr John, although it would seem that another story has emerged from historic enquiries on his behalf.

Museum volunteer Guru mechanic *Bill Redpath* called me recently. Bill told me that he had attended a friend's father's funeral a couple of weeks earlier. Bill's friend, Gavin is a third generation funeral director, as was his father Robbie who had passed. The subject centered on Gavin's past family residency at Healesville, and in a particular era the 1940/50/60s. Gavin told Bill that his family had operated a Funeral Service since 1937 that covered the Healesville and Yarra Valley areas. Being personally native to the Yarra valley, I was quickly clicked on to the 'Heritage' family that is well known to me. There is nothing unusual about the Heritage family being long term undertakers, and several of my close relatives and friends have been "customers" of Heritage Funerals. However, it seems that Gavin's Grandfather in the 1940-60 period, put funeral vehicles to full use. Apparently the early funeral business vehicle was a 1935 Chevrolet sedan, and this vehicle served the Healesville people and area handsomely. The Chev at the time became the Healesville mourning car, ambulance, and taxi all in the one time frame. In the next quarter we hope that Gavin Heritage's uncle will contact us with details and photographs so Barb and I can publish this unusual account in the next Beacon.

Ambo camaraderie is a treasure. VCAS Pioneer Flight Sister Rona Halliwell lives at a Rowville retirement village with her canine mate. Rona is now 91 years young. We communicate every few weeks checking on each other's wellbeing and a yarn. Each day when the 'sun is over the yard arm', Rona's village friends congregate at her villa with their canine companions, and for a glass or two of the proverbial. When we speak there is normally an Ambo story or two that bobs up and it is mainly humour orientated, although in a recent conversation Rona told me of this experience. - One afternoon some 15 years ago while living at Nunawading, her neighbors had visitors who were leaving. Rona was in her garden and heard a female yelling and thought the couple leaving were having a 'domestic.' The woman screamed to Rona that her husband had collapsed at the wheel. Rona immediately responded. Although she thought this person was an 83, she pulled the male from the car onto the nature strip and began resus., continuing until an ambulance arrived and the crew took over with an AED. Rona retreated back into her house believing the person was deceased. Around a week later a beautiful sheath of red roses was delivered to Rona's home with this message, "*Thank you for saving our father's life".* A short time later, with prior arrangement, the victim visited Rona. She says this was a very emotional meeting, the survivor embraced her and both were in tears. The victim was her neighbor's father aged in his 60s. He made a full recovery and Rona, the survivor, and his wife became good friends. A tremendous effort for a then 76 year old retiree. *Top marks Rona girl!!*

The Spring edition of The Beacon presented an account of the tragic "William Booth Men's Hostel Fire". We wondered how many readers noted within that feature's context, the newspaper clip of Monday, August 15, 1966, "*Police yesterday were forced to ask city and country hospitals not to forward bodies to the City Mortuary. The Mortuary has no more room for them, the facilities have been stretched to the limit by the* ***41*** *deaths from accidents in Victoria over the weekend*." (Only eight deceased from the William Booth fire were taken to the City Mortuary.) This is the era of which I wrote my account of "*The Deadly Decades*" *1950-1980.* This piece appeared in the Spring Beacon edition November 2023.

While glancing through a 1982 Ambulance World publication, I came across the following clip, and I am sure that it will resonate with other "one up" regional colleagues that served in past decades.

"Imagine a wet cold night while you are attempting to maintain an airway of an ejected, unconscious passenger from a freshly wrecked Holden? Then ask the first motorist who stops to fetch the Komesaroff resuscitator or the Thomas splint and see what he comes back with – if he comes back at all! And in the meantime, how do you treat the other seriously injured trapped in the car while panicky bystanders tug at your shoulders telling you "there's another one over there". Well, sooner or later everyone gets to hospital, whether it's to the ward or to the morgue depends on a blend of luck and hasty innovation. *How realistic is this? And the after toll ?*

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AV GoodSam - Reflecting on Rona Halliwell's success with a cardiac arrest demonstrates that our skills never leave us, even well into our retirement. All of us can deploy our knowledge and assist to save a life. **AV's GoodSam** Program always welcomes suitable members for this lifesaving program. Our retained skills can be of invaluable assistance in a cardiac arrest or another life/death situation. More often, on arrival to an **AV GoodSam** case, there are young and fit persons at the scene to assist with CPR. These people can willingly be marshalled and guided to assist. If any reader is interested in assisting **AV GoodSam** simply contact **AV GoodSam** by email: goodsam@ambulance.vic.gov.au

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Words of Wisdom.

When we become disgruntled with our partners, our friends, our job, or most things important in our life, we can easily create many reasons to justify it. But then, do we truly reach deep into our hearts to find if these reasons are really so ? ***P. K. Dent***

Editor's Desk

Happy New year to all! Barb and I hope that 2025 will be a healthy and happy year for everyone. Both of us look forward to continuing our AHSV role of publishing The Beacon in the ensuing year. The Beacon is our personal means of connecting with our AHSV members, supporters, and readers due to our distant location. Also, if you are ever across the mighty Murray don't hesitate to call in for a cuppa or --.

In my last editor summary, "Spring 2024", I made mention of a couple of items in regard to publishing The Beacon. There are others that arise from edition to edition. One is the "*Ambo Humour"* content of The Beacon. With this section I endeavour to strike a balance to satisfy the majority of readers and meet individual viewpoints. From a personal perspective it is considered some banter and amusement is a necessary variation from the often unfortunate and tragic content, given our profession. The segment is primarily for the publishing of actual humorous ambulance experiences, in keeping with the purpose of The Beacon. When publishing humour content I assume that most of our reader base at times have experienced comical and extraordinary life occurrences. The second is one my appeals of old, as we have an extremely proud and rich ambulance history. The majority of our members have been part of this history, therefore deserve to be included in our history records. A wealth of personal experiences and knowledge is hidden away in so many minds out there. These stories belong in our ambulance history for others to learn of and appreciate, so please make 2025 the year to contribute. Another good reason is that I am running out of personal accounts to publish, and also being a focal point is certainly not my preference. However, as Editor, presenting history and personally sourcing the content this is, at times, unavoidable.

We are grateful for the many outstanding and varied individual contributions that have been forthcoming over the duration of eight years. Thank you all! And finally, apart from "*Ambo Humour,"* a subject which can be prone to exaggeration and B.S., I exercise considerable care in establishing the veracity of articles that are submitted for publication in The Beacon. This is a critical issue, as historic and other relevant content of The Beacon is recorded into our Victorian ambulance history. However, I do not consider that it is my role at the time of editing to decide this in either aspect. Furthermore, I believe all contributions are submitted in good faith and are published on that same basis. Although most unlikely, should it be discovered that a particular piece is not in any way factually aligned, then this article will be removed from The Beacon, prior to archiving.

In the Spring edition of The Beacon 2020, Barb and I presented a collective "Emergency Services" feature of the "*West Gate Bridge Disaster 1970"* at Melbourne, marking the 50th anniversary. Sadly this tragic remembrance was overshadowed by Covid on the date. The original feature has now been edited into a "Standalone" Ambulance account. Our first priority was to preserve and record into our history the worthy performance of the *Victorian Civil Ambulance Service* on this tragic day. So, to this end, Barb and I have produced the dedicated 'standalone Ambulance' version of the West Gate Bridge Disaster, which appears in this edition of The Beacon,

In a coming edition Barb and I will publish an edited and comprehensive Beacon feature of the "*Southern Aurora Violet Town Train Crash 1969."* at Violet Town, Victoria. The feature will also commemorate and further record into our history the outstanding performance at this disaster of *Goulburn Valley Ambulance Service, (GVAS)* assisted by *North East Victoria District Ambulance Service. (NEVDAS)*. The two services transported all casualties expediently to hospital with minimal loss of life from the disaster scene. And, finally, Barb and the kids presented me with a new cap for Christmas badged " President of the Grumpy Old Man's Club" I mean really!! Me??

As always, keep smiling.

Pete and Barb.

Congratulations! ***Cassie Parker:*** Cassie recently successfully completed her transition from nursing to paramedic, and where her heart lies. Cassie is no newcomer to front line ambulance work, she has spent around 6 years as a Tallangatta ACO previously running with her Dad, *Grant Parker.* Grant is a 43 yr MICA paramedic (now ret.) who was then stationed at the AV Tallangatta Branch. In the near future Cass will make application to AV to join our front line ranks as a graduate paramedic, and more likely follow on in Dad's impressive footsteps. *All our very best Cassie*! Pete and Barb.

In – Out – About – and – Beyond

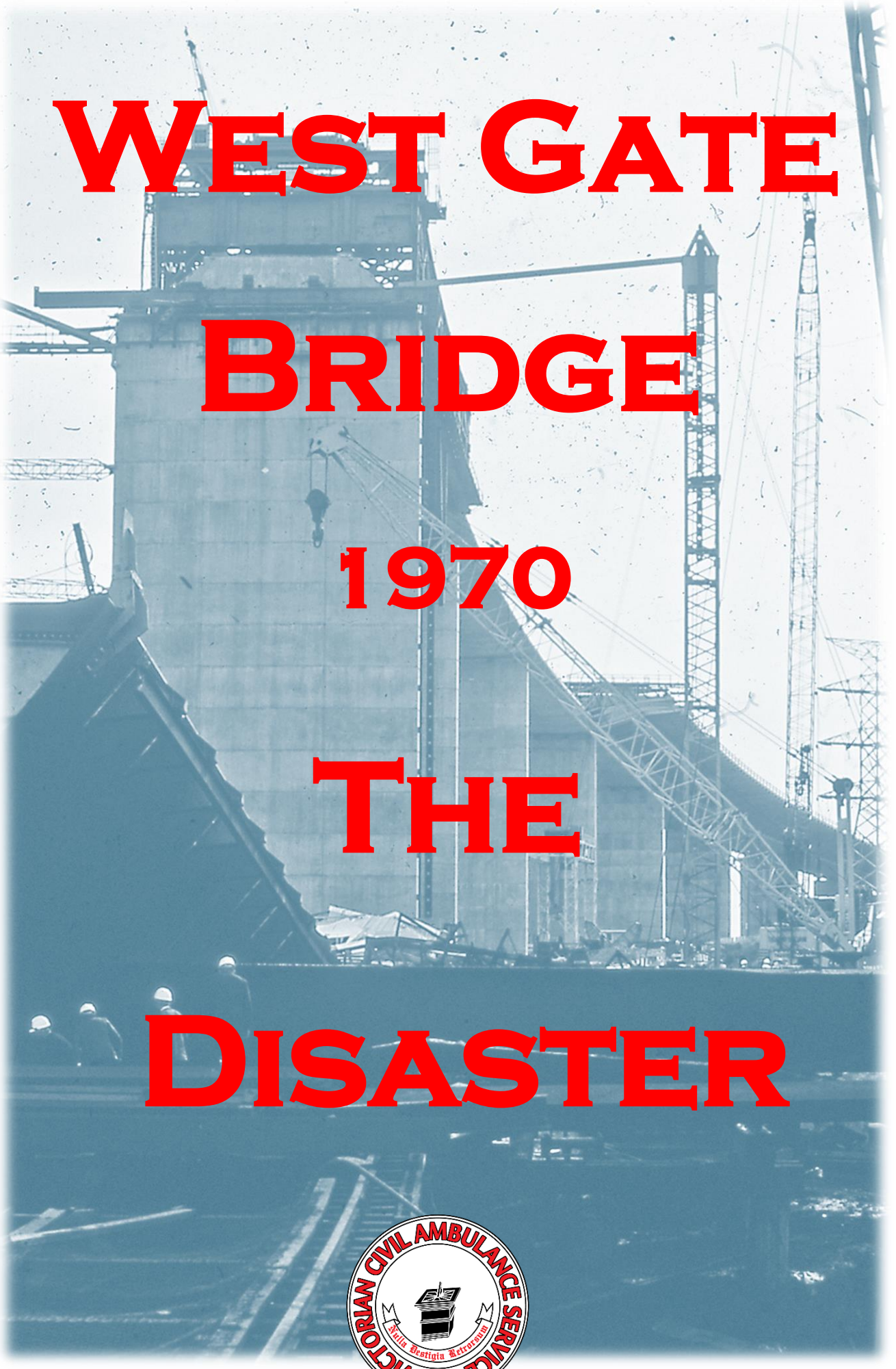
This following escapade on November 22/23, 2024, by Curator *Ralph Casey* and *Doc Brooks,* was certainly a bit 'Beyond.' The two took our Mercedes Sprinter up for filming of a movie at Harrietville. Harrietville is located heading up the road to Mt Hotham N.E Vic. and as crew they both featured in the film being produced. Our two budding movie stars departed suburban Melbourne in the Mercedes Sprinter at 0900 hrs They arrived at filming base camp at Harrietville on the climb to Mt Hotham 6 hours later. Terry said that this revised time was due to a rescheduled ETA by the producer, time rescheduling in the film industry is a fact of life. The filming company had arranged motel accommodation for Ralph and Terry at Bright close by. The film crew checked our men's uniforms and deemed they looked authentic, then it was explained to them the connection to AV through AHSV and our museum. Prior to this they also thought that the Merc. Ambulance was only a prop.

The filming was running behind schedule. However this is not unusual, as this is the case with filming booking for most movies due to many unforseen's that occur. Eventually Doc and Ralph got to take their part. Their role involved carrying out a 'body' on the stretcher and loading the deceased into the ambulance over two different aspects, with other actors involved. However, after eleven takes of carrying and unloading the "body', which meant negotiating an incline carry/load process, our two stars were getting very weary. The only consolation was that the corpse was the lightest extra in the filming crew and he had a great sense of humour. Although Doc said he was so skinny that when shrouded with a light blanket, if this bloke laughed his protruding 'belly button' quivered and telegraphed though the blanket. Finally, at 0130 hrs Saturday, when filming was complete our pair were given a round of applause from the director and crew. From there it was back to Bright to their motel and both our stars crashed into bed.

Doc later explained that real life does not apply when filming, it must be what works on screen. The museum film crew's part may entail sitting around for hours ready to do countless rehearsals and takes. However, our illustrious Doc Brooks puts this downtime to good use, demonstrating a few first aid tips to film crew members, and various aspects of ambulance work. Our Mercedes Sprinter has some twelve movies to her credit. Other ambulances of our vintage fleet have also appeared in movies. Our oldest, the 1913 Talbot military ambulance featured in 'Gallipoli' and also our Ford F350 and GMC ambulances in 'La Brea' TV series, as well as several other movies and TV productions.

Ralph Casey at 0130 hours.

Terry (Doc) Brooks at 0130 hours.



West Gate Bridge

1970

The Disaster

West Gate Bridge 1970 – The Disaster

Preamble

On the morning of **October 15, 1970**, approximately 80 men left for work on the construction of the massive West Gate Bridge. This was a major state project to link Geelong, the Western suburbs, City ports, and Western industrial areas with the Melbourne C.B.D. The West Gate Bridge would provide modern freeway access to these locations.

This cable-stayed type construction was designed to span 2,583 metres (2.58 kilometres) over, and 53 metres (170ft) above the mouth of the Yarra River and Port Phillip Bay.

Tragically, thirty five of these unfortunate men; husbands, fathers, sons and friends, would never return home at day's end to their loved ones, leaving a dreadful legacy of loss, sadness and grief. A further eighteen others sustained horrific life-time injuries, and many of the survivors lived out their remainder of life with severe phsychological scarring and post traumatic stress disorders. This resulting legacy was not isolated to survivors. Many responders, career personnel and volunteers were also affected long term having experienced the horrific sights and unbridled carnage that this tragic disaster presented.
On this fateful day, totally unaware, many names of the workers involved in the West Gate Bridge construction would be written into history as a fatality statistic of 'Australia's worst industrial disaster.'

The Collapse

At 1150 hours on the 15th October 1970, just prior to the daily scheduled lunch break, the span under construction, known as span 10-11, comprising of some 130 metres in length and weighing approximately 2000 tonnes, suddenly collapsed and plummeted 50 metres into the Yarra River below. Many workers were still on, and within, the bridge span. These men rode the span down into the river and onto the ground. In the huts below, administration personnel and workers that had just entered for their lunch break, totally unaware of the iminent fall, were all crushed to death. Their bodies could not be recovered until appropriate machinery and skilled personnel were in place. That which could be done, was done.

This horrific event triggered a history-making scaled response and an astringent test for Melbourne's Emergency Services to carry out rescue operations at the catastrophic scene. The Emergency Services represented that day were: Victoria Police, Victorian Civil Ambulance Service, Metropolitan Fire Brigade, St John Ambulance, Civil Defence (now SES), The Salvation Army, Ports and Harbours, doctors, nurses, padres. Many volunteer organisations and individual persons attended to assist where possible. This massive operation also illustrated man's compassion for man, and brought out the very finest in the many and varied rescuers contributing. The West Gate Bridge collapse is still recorded as Australia's most catastrophic and deadliest industrial disaster. To this day, there are still many people who cannot understand how this tragedy could have.happened.

Sadly, the passage of time has taken its toll on many of the Emergency Services personnel who attended West Gate Bridge in the height of the disaster in 1970, and others that attended later in the duration of its aftermath. Those passed include many of the fine men of our Melbourne and Metropolitan ambulance service, VCAS. However, the families of these attendees today share in the proud and selfless contribution by their loved ones at this national disaster. To recognise VCAS ambulance officers and VCAS ambulance personnel that attended the West Gate Bridge Disaster, an "Attendance Honour Roll" has been created. The 'Attendance Honour Roll' records individual VCAS attendees, and is displayed at our AHSV, Ambulance Victoria Museum. Persons, or next of kin of members named as VCAS attendees within the Attendance Honour Roll are invited to acquire a 'Certificate of Attendance'. The certificates are complimentary, courtesy of the Ambulance Historical Society Victoria Inc.
To obtain the certificate please contact the A.V. Museum Curator. Email: ambulance.historical@outlook.com or phone 0419 619 430.

The following account of the day's activities at the West Gate Bridge disaster has been recalled and written in the interests of preserving our proud Victorian Ambulance history. It has also been written to acknowledge the outstanding performance, co-operation, and camaraderie of our Emergency Services counterparts. And, in paramount importance, to recognise my attending colleagues, together with each and every person that attended the tragedy at its peak, and gave their very best. PKD 11/24

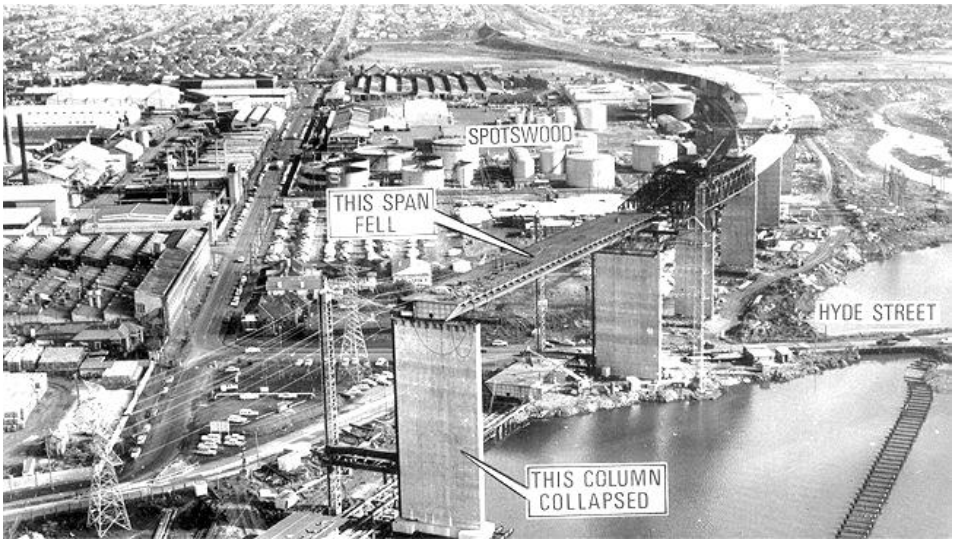
How The West Gate Bridge Collapsed.

On the 15th of October 1970, at 1150 hrs, Australia witnessed a tragedy that is still recorded as our most catastrophic and deadliest industrial disaster to date. The collapse of the West Gate Bridge took 35 lives and critically injured eighteen others.

According to reports, as two spans known as 10 and 11 were brought into close proximity, it was revealed that a gap of approximately 10cm (4 inches) remained between the two. The answer seemed simple enough, use "kentledge" (concrete ballast cubes that each weighed about 8 tons) to realign the girders. It was planned to place these concrete cubes on the northern half of the bridge span in an attempt to push it down to the same height as the south span. However, it would seem that more weight was used than was approved by the engineer and this caused a buckle in the bridge. On Wednesday 14th October, instructions were given to straighten the buckle "without further delay".

Starting at around 8.30 am on the 15th of October, the task of straightening the buckle began. The removal of a large amount of bolts commenced which caused a significant degree of slippage. It was then suggested that the bolts be re-tightened with an air gun. The pressure of this compressed air process caused the bolts to break, the shock reaction being that the bolts failed in tension and created further stress. Subsequently, this bolt failure created a sliding movement which placed many of the span's bolt holes off line with each other. The consequence of this sliding action meant that they could not re-bolt the span as before. The development of the bolts and sliding process then created more buckling to several other panels of the bridge.

Around 11.00 am that morning the Section Engineer contacted Jack Hindshaw, the Resident Engineer, and advised that things were not going well. Hindshaw arrived on site and was instantly aware that a potentially dangerous situation was imminent and decided to get further advice, making a phone call to Gerit Hardenbergh. Hardenbergh was a Senior Representative of WSC (World Services & Construction Pty Ltd) Melbourne. The last words that Hindshaw was heard saying were "Shall I get the bods off?" referring to all the workers on and in the bridge. It was then, at 11.50 am, that span 10 -11 collapsed, taking the lives of 35 men, Jack Hindshaw among them.



Note the administration and workers' huts below the span that collapsed.

A spectacular photo of the actual collapse taken by a student near West Gate Bridge as the concrete column and bridge span collapsed simultaneously.

VICTORIAN CIVIL AMBULANCE SERVICE ATTENDANCE

West Gate Bridge Collapse
October 15, 1970

Foreword

In writing this memoir, I have done so with the best of my knowledge and recall, and also with the belief that this is a true and accurate personal account of the above disaster. The West Gate Bridge collapse occurred at approximately 1150 hrs, October 15, 1970. This account is based on my attendance and experiences that day in the course of duty with the Victorian Civil Ambulance Service. (VCAS) The Victorian Civil Ambulance Service was the controlling authority of ambulance and medical activities at the West Gate Bridge. VCAS provided the entire ambulance cover that was required at the disaster scene from the VCAS fleet. I have edited my original account of 2019, only for the grammatic content and information. Also, I have written in other colleagues that attended, whose names have since been established, to give due recognition. Included are reliable facts and matters of historic relevance. This, with further information, has emerged from other colleagues involved that day. Other than this, all else remains in the original context of 2019, and the Regional Newspaper version of 1995.

Peter Dent. VCAS S/No 149
November 2024.

Aerial shot of the bridge collapse

On Thursday, October 15, 1970, my day's duty began normally travelling from Montrose to Melbourne for an 0700hrs Melbourne HQ shift. Having some eight months earlier attained my Station Officer *(S/O 2)* qualification, I had been tasked with training new personnel with Ambulance Officer duties at V.C.A.S. Headquarters at Latrobe Street Melbourne. My colleague, Cadet Officer *Robert Adams*, then 18 yrs of age, had completed the morning part of our 0700–1500 hrs shift. HQ control directed our crew to return to HQ for our lunch break of 20 minutes. On arrival, we were the only road-crew at Headquarters and we began our meal break in the mess room. Unbeknownst to us, at this particular time, Headquarters control had received an emergency call reporting "A bridge collapse" at Yarraville. It seems that the incoming caller to Ambulance HQ reporting the bridge collapse may not have been fully informative in detail regarding the extent of the disaster. This was understandable given the actual situation of chaos and enormity of this national disaster at hand, which we were soon to learn of.

As a result, and potential significance of this emergency phone call to control, North Control Radio Channel (2) called a V.C.A.S. ambulance that had just cleared from a case in the vicinity of the area. The ambulance was manned by Station Officer (S/O) *Ross Eastwood* and his colleague, Cadet Officer *Peter Harvey*. The crew were requested to attend the reported scene, and to assess the situation of the bridge collapse, then immediately relay this information to HQ control. The following text is the basis of this situation reported to VCAS Headquarters control. S/O Ross Eastwood recounts: *"Arriving at the West Gate scene, we were directed to a section of the fallen span and entered the interior of this section. Four men lay dead, another two critically injured and dying. In the near vicinity, men screamed for help in agony with horrific injuries".* S/O Eastwood's evaluation of the scene, and the magnitude of what lay before him, was immediately relayed to Headquarters control. And so unfolding was the West Gate Bridge Disaster of approximately 1150hrs October 15, 1970, and the response process by Melbourne and Metropolitan Emergency Services, and many volunteers.

While this was occurring in the control room , my counterpart and I were eating lunch when an intercom call came across to the mess room from the control room opposite. District Officer (D/O) *Bill Rutherford* stated he "*had a bridge down with approximately 80 men on it*". Then the disaster bell began to ring throughout Headquarters. My first reaction was that this was only an emergency 'drill', although unlikely, as we were the only ambulance crew at H.Q. that could respond. Sensing his urgency, I immediately went to the control room window slide access. Here, I was urgently briefed by D/O Rutherford on the reality of the situation and instructed that we were to immediately proceed and attend. VCAS Headquarters maintained a "Major Incident Container" for this purpose, locked in a wire cage in the ambulance vehicle parking garage area. In the VCAS control room, North radio channel two (2), (Northern Melbourne) had been isolated, and dedicated to the West Gate disaster communications. This would give a priority airway between S/O Gary Pink on his arrival at the scene, and also the participating ambulance crews, together with ambulance and hospital liaison, although my

communications at the scene were restricted to face-to-face contact only. However, the VCAS radio control decision also required that the normal week day case load of Channel 2 had to be absorbed solely by the operators of South Channel one (1), a monumental task! Subsequently, other than cars involved in the disaster, the remaining on duty Channel 2 ambulance fleet were instructed to operate under Channel 1. This adaption, and the ability to cope under pressure, was an indication of the outstanding performances that were forthcoming from VCAS personnel and associate Emergency Services and volunteers on this day.

Victim recovered from the river mud.

S/O *Jack Smith*, the Ambulance Headquarters' duty Station Officer that day, and I, quickly loaded the medical equipment and disaster gear containers into the back of our Ambulance. With this vital equipment and medical gear on board, we made a rapid departure for the disaster scene. Our departure was precisely at the same time that S/O *Gary Pink* (*Later Superintendent of North East Victoria and District Ambulance Service)* left HQ. Gary was 'one up' manning a Chrysler Valiant ambulance. He was to be the on-site communication officer reporting back to VCAS HQ from the disaster scene. Although Gary Pink and I took different routes to the West Gate scene, at Footscray both our ambulances entered an intersection, again at the same time. The intersection was rigidly controlled by police due to the unfolding disaster and the influx of other emergency vehicles heading to the disaster scene. The situation with both ambulances seeking right of way in full emergency mode created confusion as to which ambulance would receive "clear passage." I do not recall which car won out, although I do recall that for the police controlling the traffic, this coincidence caused a little mirth. However, the laughs and smiles there were the last we would see for many hours to come.

VicPol diver, Daryl Smithwick

We arrived at the West Gate Bridge disaster; a scene that, from first sight, and with my participation in the hours to follow, would remain with me for the entire duration of my life, even given my prior years and varied cases in the Ambulance Service since 1965 had seasoned me well to trauma and death. Although I had personally experienced unbridled bush fire devastation in the region where I had lived, I could only describe the scene before us as something I had seen in a war movie: twisted wreckage, fire, smoke, cries for help, death, dying and despair. The span section of the bridge, near 130 metres in length, was reduced to a maze of 2000 tonnes of massive, twisted steel girders and concrete entanglement, partially submerged in river mud. It was reported that this mud had splashed approximately 500 metres in all directions when this section of the bridge structure hit the ground and the murky river, and the sound of the crash heard kilometres away. Men were crying out with appalling injuries, in confusion, disbelief, shock from smoke, fumes and debris of the overall scene. Police divers, whom I will always hold commended, worked feverishly, feeling for workers that had been flung on impact into, and submerged in, this filthy mud. Later it unfolded that *Ports and Harbours* divers took part in this operation after the police divers had spent some time in the muddy rescue. On our arrival at the disaster, Cadet Officer Adams and I immediately split up. This was to free me for the following roles. I learned after that Rob responded to the requests to assist workers who were located and injured, but many were dead. Rob remained in this role until such time that he left the scene with another ambulance. As any ambulance, North or South operation, within reasonable distance, became available from a completed case or was cancelled from attending a case of lesser priority, they were sent and arrived at the scene. When each victim was retrieved from the wreckage or mud they were carried by emergency service personnel and/or volunteers to waiting ambulances, to be conveyed to hospitals. Some critically injured died in the ambulances. This meant at times injured and deceased were transported side by side two up. At the peak of the rescue operation, colleague Officer *William (Bill) Mc Nally* VCAS, (*pictured above (R) second front white cap),* was involved extricating one of the many victims from the entangled wreckage of concrete and steel of the fallen span. Bill told me later that he and his counterpart had cleared at Footscray and District Hospital when their car was instructed to attend.

Rescuers retrieve a victim from wreckage. VCAS S/O Bill McNally – white cap.

I recall vividly one victim, who had been recovered from the river mud, being placed into one of our waiting ambulances. He was unconscious and obviously choking from the foul mud. I instructed the young crew ambulance officer to aspirate the patient immediately, then the ambulance moved quickly off. To this day, I

wonder if this person survived, and whether personally I could have done more for him as the experienced officer, even though I was charged with other duties as I was instructed previously to remain at the scene and take charge of the casualty clearing process. In hindsight, triage was out of the question, as a continuous stream of rescuers were bringing out injured and dead together as soon as they could be extricated from the wreckage or mud. Nearly all were critically injured due to the impact velocity of the bridge collapse of mass and height. To this end these persons were placed directly into ambulances which immediately left on 'Signal 8' for waiting hospitals and the dead were placed aside and covered. At the height of this tragic disaster unfolding, Officer *Peter McMurtrie* arrived at the Royal Melbourne Hospital (RMH) in a Dodge Clinic Bus with ambulatory day hospital outpatients for RMH appointments. Officer McMurtrie was instructed by VCAS control to immediately assist RMH to mobilise their emergency medical team consisting of doctors and nurses. When completed, he then transported the team under a 'Signal 8' to the West Gate Bridge Disaster scene. This team initially arrived at my casualty clearing location, however I only recall one doctor working with us (*indicated below in inset image, in overalls and rubber boots bending over a casualty*) I assume that the remaining doctors and nurses despatched themselves to other areas of the disaster chaos by request to assist with trapped casualties.

Two colleagues, A/O's *Bill Sharp* and *Darrell Rintoule***,** attended the bridge collapse in emergency response. Darrell recounts his experience of that attendance: *"When we arrived at the scene of the disaster, all surviving casualties had been conveyed to hospital. Only deceased remained and, like other colleagues, I was appalled by the extent of the horrific and fatal injuries these men had sustained in the collapse. Some workers, after "riding the bridge down", were mercilessly catapulted into the putrid mud. This was due to the final impact velocity of the fallen structure hitting water, mud, and land below. Ambulance Officer Sharp and I placed four of these deceased men into our ambulance and transported them to the Coroner's Court. The odour of this putrid mud/sludge remained for an incredibly long period in the ambulances that had attended, regardless of cleaning processes over a long period of time."* When it became obvious that the immediate injured, dying, and the accessible deceased, had been recovered, including those who could be located by the police divers from the river and transported from the scene, our next operation was to recover, identify, log and remove the residual of the deceased from entrapment in the bridge wreckage located above ground. The police divers would continue their search for bodies in the mud and water and submerged bridge section over a period of 3-4 days. One body to be recovered later was one of our own officers, (*Joseph Ozelis*) who had left our Service some 3 weeks earlier to take an industrial first-aid position on the bridge construction above**.** The formal process for removal of the deceased was initiated by senior Victoria Police and V.C.A.S.

V.C.A.S. Deputy Superintendent *Bob Donald* had arrived at the scene at the request of our relatively new Superintendent *Gordon Ortmann*. Bob Donald was a former military officer and a good bloke; he also possessed a notable ambulance background within VCAS. I personally believe this was why he was requested to attend in the place of the new Superintendent. Deputy Superintendent Donald, and a high-ranking police officer, respectively summoned a detective I believe was from Victoria Police Homicide Squad, and myself. Both of us were instructed by our superiors to work together as a team to carry out the morbid function of supervising the removal of the deceased, and when possible record identification and details. This task we set about immediately. I have always wondered so many years on whether this police officer is still alive and recalls our association. I have long forgotten his name, although, I believe I remember a comment from him as: "This is ------ lovely. Tonight is our police ball (or event of this nature) I won't feel like going after this episode". This police member and I worked together, encountering some very grotesque and hideous sights. One victim was hanging entangled in concrete and reinforcing steelwork and other materials above us. His body had been badly burnt. This occurred when the bridge structure collapsed, due to inflammable fuel stored on deck as well as gas, acetylene etc. which exploded and burnt on impact. This victim was not the only burns case, we called a team to cut free his body. When finally he was extricated, we then searched the victim's remaining clothes for identification, as we did with others. Then, if the victim was successfully identified, I would log the deceased's name and any available details on the fatality list that I carried.

RMH Medical Team Doctor tending victim at casualty clearing area.

At the time of watching the macabre release of the burned man by rescue workers using steel cutting equipment to free his body, we had a tomato sandwich and mug of tea thrust into our hands. Looking around, our provider was a Salvation Army Officer. God bless him! I had eaten little lunch and missed breakfast and, as such, I

consumed the welcome sandwich and drank the tea. Then I looked at my hands, the true state of which I will not describe. Suffice to say, no gloves were provided in those days, and the residual of the lurid tasks my hands had been undertaking was evident. Still, the food offering was soon consumed without any prior conscious consideration. In my mind and with this particular gesture on that day, and the wonderful provision of food, care, and comfort to the dying, the Salvos will always live with me in great endearment and respect.

During the course of the task to which my police associate and I were charged, we came across volunteers attempting to dig and release a body from between a main steel bridge girder and the ground. The girder I imagine was some 4 metres in dimension and vertical. The body was protruding from between the massive steel girder's bulk and the ground, with only his pelvis and torso outwardly visible. Caught by the moment with disbelief of what I was witnessing, I enquired of the volunteers rather harshly as to their actions. Then I promptly bent down, placed my hands under the poor soul's armpits, and pulled the upper body clear. This was all that remained of the victim from the impact contact point of ground and the girder, and I walked away in disgust. Considering the circumstances of this particular victim's body, over the years,I have wondered if he may have been trying to run to safety as the bridge was collapsing down on him. Strangely, given the numerous fatalities, the vision of this partial body, and the burnt victim, these really were the only two that remained with me all of these years on.

Towards the day's end body retrieval slows. L-R: Check shirt?, (In suit) VicPol Det. Sgt. Bob Micken, Peter Dent VCAS, VicPol Const. Peter Gibbons, and Ross Smith.

When my police colleague and I had completed our body reconnaissance and listing, we returned to the area that was originally designated for casualty clearing. This area was now forming a temporary mortuary for bodies recovered and awaiting removal to appropriate destinations. Recovering the remaining workers' bodies was now a slower process, this being due to very difficult extrication. The police had cordoned off the area with barricade tape preventing bystanders from entering the area. Those gathering included some loved ones of the bridge collapse victims. A number of these people, desperate for information, approached me as I was holding the fatality list. A covert quick cross reference to the list would often confirm the tragic truth, however, I had to remain non-committal in conveying the worst in the best interests of these enquirers, and also as ministers of various religions were present in the enclosed area administering prayers over the dead. The pastors also offered spiritual comfort to those bereaving or fearing the worst outcome. However, some names would not be revealed on this day as the retrieval of the deceased workers from the murk of the Yarra River, and under wreckage and huge girders, would go on for days. After all the known workers and bridge construction personnel bodies had finally been recovered, Victoria Police secured the disaster site. A police caravan was stationed at the verge of Hyde Street and manned 24 hours a day, for approximately two weeks. Newport police were allocated the task of finding and sorting personal property found on the scene and returning it to family members.

At approximately 1700 hrs, Station Officer Gary Pink and I were relieved of our duties at West Gate Bridge by a fresh shift. Also, later that evening, Station Officer *Charles Martin* attended the West Gate scene. His role was to supervise the recovery of four workers unaccounted for. It was assumed that their bodies were submerged in the heavily contaminated muddy sludge. After many hours into the night, under flood lights, two of the victims were eventually recovered by police divers. The two deceased were transported to the Flinders Street Mortuary, their ambulance was escorted by S/O Martin in his VCAS administration vehicle. The entire operation had now been scaled-downed to a final recovery process, and an investigation scene. Many emergency services and other personnel still remained at the scene, together with representatives of all sections of the media. The West Gate Bridge Disaster was being broadcast, reported, and telecast both nationally and internationally. The final phase of the operation had begun. The massive task of shifting the masses of steel, concrete wreckage, equipment and huts lay ahead.

Station Officer Gary Pink and I were returned to Ambulance Headquarters where we cleaned up. From there a couple of well-earned beers at the International Pub adjacent to H.Q. Then we went home to our eagerly awaiting families. All family members of our attending ambulance personnel were most grateful that we, unlike so many that day, were returning safely home.

Other than those who had been on duty all the previous night, and those still in attendance, most personnel who had played a specific role, or attended in capacity in the previous day's disaster, were summonsed to attend a debriefing at Ambulance Headquarters. The West Gate Bridge Disaster debriefing commenced at approximately 0930 hrs the next day. Included in attendance were Superintendent *Gordon Ortmann* as Chair, Deputy Superintendent *R (Bob) Donald*, District Officer *Norm W Mills*, Station Officers *G Pink*, *J Smith*, myself, and others unfortunately I cannot recall. All aspects of the West Gate Bridge disaster and performance of emergency services and ancillary services were discussed. It was a general consensus that all services attending had performed well, given the magnitude of the disaster, and, considering the ability to respond, the emergency facilities and resources available at that time. It was abundantly clear however that disaster plans, disaster equipment, and fast response plans were urgently needed to be implemented and developed for the future. Thankfully, now this appears the case. It would seem, and indeed I hope, that these plans are continually upgraded and monitored.

A total of 35 men tragically lost their lives at the collapse of West Gate Bridge, many others sustained lifetime injuries and psychological scars, family loss and grief. I have been asked many times over the years if the events that I participated in on this fateful day had personally impacted. However, I can truly state that the West Gate Bridge disaster from my own experience was taken as normal course in my chosen profession. Although the memories of this day will remain with me for the term of my life, and as the years pass, I drift back to that day in recall. Amidst these memories from my attendance at this disaster over the hours, the standout memory that I took away from this carnage is the dedication in which man commits himself to assist fellow man in peril, regardless of personal danger.

And from my observation, I gratefully acknowledge my VCAS colleagues, and my counterpart Emergency Services colleagues, and I am proud to have worked alongside them. Other organisations, and countless volunteers made an outstanding contribution to the rescue process that day. Every attending individual gave their very best under devastating and dangerous circumstances. The West Gate Bridge tragedy has been written into history as our nation's worst industrial disaster. The State Premier at the time, *Sir Henry Bolte*, immediately announced a Royal Commission into this catastrophic construction failure, chaired by *Mr Justice Barber*.

"So Be It"

Peter Dent (JP NSW)
Former: Ambulance Service Victoria

'A PARAMEDIC'S ACCOUNT.'
Ambulance Victoria Museum
Peter Dent – 2017/2024

Peter Dent - Circa 1970

FROM THE WRECKAGE OF DISASTER, DEATH, AND DESPAIR .....

..... TO THE SPLENDOUR OF AN ENGINEERING MASTERPIECE

VICTORIAN CIVIL AMBULANCE SERVICE
WEST GATE BRIDGE DISASTER, 1970
ATTENDANCE ROLL

This attendance roll is dedicated to the *Victorian Civil Ambulance Service* personnel who, together with their Emergency Service counterparts, responded to the West Gate Bridge Disaster at 1150 hours, October 15, 1970.
The first responding V.C.A.S. ambulance to attend the West Gate Bridge Disaster scene was crewed by: *S/O Ross Eastwood, S/No.148* and *Cadet A/O Peter Harvey, S/No. 80.*

We also pay tribute to our medical profession associates, the Salvation Army, and all volunteers.

Adams,	*R. Robert*	*A/O*	*S/N 16*	*Mills, N. Norman*	*D/O*	*S/N 76*
Burnette,	*G.H. Jock*	*A/O*	*S/N 160*	*Moroney, P. Peter*	*A/O*	*S/N 193*
Dent,	*P. Peter*	*S/O*	*S/N 149*	*Moxom, P. Peter*	*A/O*	*S/N 126*
Doenson,	*A, Tony*	*A.O*	*S/N 49*	*O'Gorman, F. Fred*	*A/O*	*S/N 232*
Donald,	*R. Bob*	*Dep. Sup.*		*Pink, G. Garry*	*S/O*	*S/N 83*
Downie,	*A. Alan*	*A/O*	*S/N 23*	*Reeves, R. Robert*	*A/O*	*S/N 173*
Eastwood,	*R. Ross*	*S/O*	*S/N 148*	*Rintoule, D.Darrell*	*C.A/O*	*S/N 221*
Harvey,	*P. Peter*	*C.A/O*	*S/N 80*	*Sharp, W. Bill*	*A/O*	*S/N 13*
King,	*R. Russell*	*C.A/O*	*S/N 176*	*Shott, B. Brian*	*A/O*	*S/N 138*
Martin,	*C.M. Chas*	*S/O*	*S/N 136*	*Vasil, S. Steven*	*A/O*	*S/N 238*
McMurtrie,	*P. Peter*	*S/O*	*S/N 246*	*Walsh, P. Peter*	*D/O*	*H.Q*
McNally,	*W. Bill.*	*S/O*	*S/N 153*			

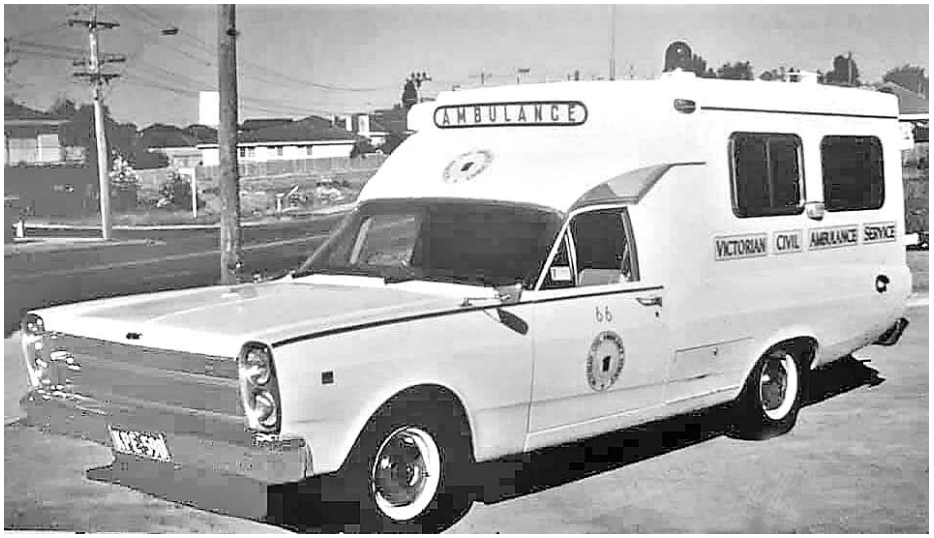
In the absence of formal historical records and the passage of time, all reasonable endeavour has been undertaken to establish all names of V.C.A.S. attendees at the West Gate Bridge Disaster. Any omission is sincerely regretted and unintentional. Also, those names provided, together with details, are deemed to be accurate in all aspects.

Legend: S/N – V.C.A.S. Service Number D/0 – District Officer Dep. Sup. – Deputy Superintendent C.A/O Cadet Ambulance Officer A/O – Ambulance Officer S/O – Station Officer H/Q – Headquarters.

General aerial shot of the scene.

The Magnificent Ford Galaxy and Ford Fairlane

The 'Highback' Ford Galaxy and Fairlane's 308 V.8. Auto were the primary make of ambulance that attended the West Gate Bridge Disaster. Although the Chrysler Royal V8 'Highback' was still in the VCAS fleet, it was in the process of being phased out. Both vehicle models excelled in both performance, patient ride and comfort.

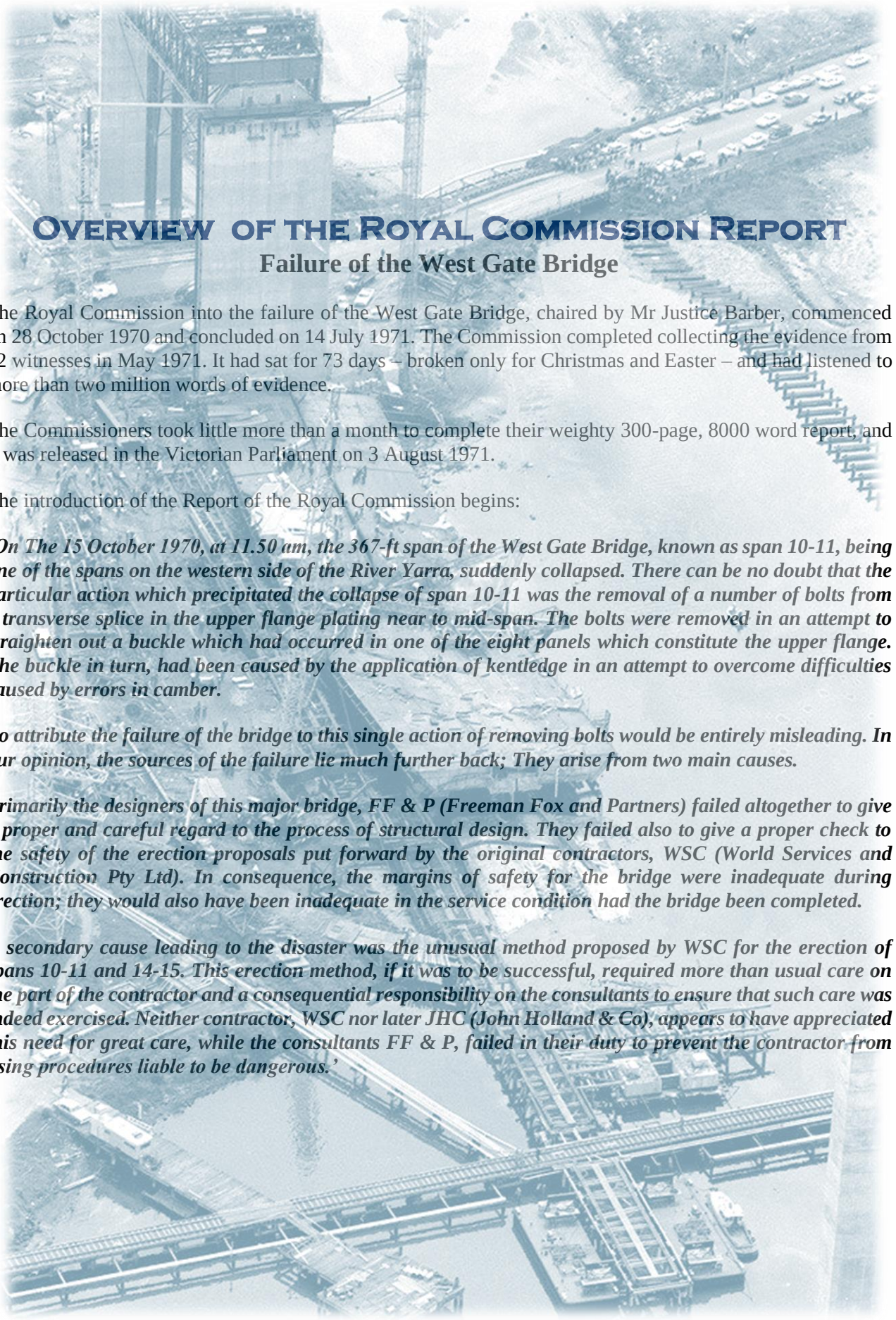


The workers who lost their lives:

Royvin Barbuto – Boilermaker
Amadeo Boscolo – Carpenter
Cyril Carmichael – Ironworker
Peter Dawson – Rigger
Anthony Falzon – Carpenter
Bernard Fitzsimmonds – Ironworker
John Grist – Boilermaker
Jack Hindshaw – Engineer
John Little – Rigger
Peter McGuire – Rigger
Jeremiah Murphy – Rigger
Joseph Ozelis - First Aid (Ex V.C.A.S.)
George Pram – Rigger
Christopher Stewart – Boilermaker
William Tracy – Engineer
Edgar Upsdell – Ironworker
Robert Whelan – Boilermaker
Barry Wright – Boilermaker

Ross Bigmore - Carpenter
Bernard Butters - Boilermaker
Peter Crossley - Engineer
Abraham Eden – Rigger
Esequiel Fernandez -Ironworker
Victor Gerada - Ironworker
William Harburn - Boilermaker
Trevor Hunsdale - Fitter
Charles Lund - Rigger
Ian Miller - Engineer
Dennis O'Brien - Rigger
Frank Piermarini - Rigger
Lesley Scarlett - Ironworker
Alfonso Suarez - Boilermaker
George Tsihilidis - Boilermaker
Robert West - Boilermaker
Patrick Woods – Rigger

Deo Fidemus



Overview of the Royal Commission Report

Failure of the West Gate Bridge

The Royal Commission into the failure of the West Gate Bridge, chaired by Mr Justice Barber, commenced on 28 October 1970 and concluded on 14 July 1971. The Commission completed collecting the evidence from 52 witnesses in May 1971. It had sat for 73 days – broken only for Christmas and Easter – and had listened to more than two million words of evidence.

The Commissioners took little more than a month to complete their weighty 300-page, 8000 word report, and it was released in the Victorian Parliament on 3 August 1971.

The introduction of the Report of the Royal Commission begins:

'On The 15 October 1970, at 11.50 am, the 367-ft span of the West Gate Bridge, known as span 10-11, being one of the spans on the western side of the River Yarra, suddenly collapsed. There can be no doubt that the particular action which precipitated the collapse of span 10-11 was the removal of a number of bolts from a transverse splice in the upper flange plating near to mid-span. The bolts were removed in an attempt to straighten out a buckle which had occurred in one of the eight panels which constitute the upper flange. The buckle in turn, had been caused by the application of kentledge in an attempt to overcome difficulties caused by errors in camber.

To attribute the failure of the bridge to this single action of removing bolts would be entirely misleading. In our opinion, the sources of the failure lie much further back; They arise from two main causes.

Primarily the designers of this major bridge, FF & P (Freeman Fox and Partners) failed altogether to give a proper and careful regard to the process of structural design. They failed also to give a proper check to the safety of the erection proposals put forward by the original contractors, WSC (World Services and Construction Pty Ltd). In consequence, the margins of safety for the bridge were inadequate during erection; they would also have been inadequate in the service condition had the bridge been completed.

A secondary cause leading to the disaster was the unusual method proposed by WSC for the erection of spans 10-11 and 14-15. This erection method, if it was to be successful, required more than usual care on the part of the contractor and a consequential responsibility on the consultants to ensure that such care was indeed exercised. Neither contractor, WSC nor later JHC (John Holland & Co), appears to have appreciated this need for great care, while the consultants FF & P, failed in their duty to prevent the contractor from using procedures liable to be dangerous.'

MEDICAL HISTORY HIGHLIGHTS

The Underground Hospital Mt Isa Queensland. – On December 7, 1942, the Japanese Imperial Navy, without any declaration of war, attacked the USA Naval Base at Pearl Harbour. The bombing attack with 200 aircraft, launched from Japanese aircraft carriers, sank many unsuspecting US war ships laying peacefully at anchor. The attack killed 3,400 servicemen, and some civilians. This covert aggression bought Japan into WW 2, allied to Germany and Italy, and was also the catalyst for America's entry into WW 2 alongside England and her Allies. The Pearl Harbour attack also signalled the Japanese push south to Australia through the islands. Japan's objective was to invade and occupy Australia, our nation then a population of a mere 7 million people. The entry of the United States into WW 2 in 1941 was to be Australia's saviour in the treacherous and uncertain years that lay ahead.

With the Japanese push towards Australia underway through the islands to the south and Sunda Straight, Singapore fell to the Japanese forces. On February 19, 1942, 242 Japanese bombers, launched from aircraft carriers in the Arafura Sea, bombed Darwin, the first of a further 63 bombing attacks on our northern outpost. North-western towns also bombed were Broome, Derby and Wyndham. With the risk of invasion, our country was in a very perilous position. Our armed forces were fighting in the Europe theatre and the Middle East. The Queensland town of Mt. Isa, with its valuable copper mining and in reach of Japanese aircraft carriers, was considered a likely and imminent target also for a Japanese bomber attack.

A ward of the hospital

With commendable foresight, to protect hospital in-patients and staff, the Mt. Isa Hospital Superintendent, *Dr Edward Ryan*, enlisted the assistance of *Vic Mann***,** the Mt Isa Mine Superintendent. Dr Ryan and Mr Mann, supported by a complement of willing locals, mainly mining volunteers, decided to build an underground hospital. This undertaking would be at the existing hospital site and envisaged mainly for maternity purposes. Once this project was approved, work began immediately; blasting, excavating, drilling to create (3) three east/west tunnels forming the underground hospital, serviced by a ventilation tunnel. The tunnels are of various widths, ranging between 2.6m – 3.5m wide. The mining work was completed in approximately two weeks and the fitting out took a few more weeks. The underground shelter took on an "E" shape with the mined wards an all-up area of approximately 20m x 20m. A ladder was located in the ventilation shaft to serve as an emergency exit in the case of a bombing attack causing damage.

New born baby ward

The excavation was timbered using contemporary mining methods; the floor natural rock, then the tunnels were equipped with furnishings and fittings to perform all the functions of a hospital. There were small male, female, and maternity/children's wards, a surgical theatre and a delivery room. Services included electric lighting and telephone. Dr Ryan kept the shelter fully equipped and ready for use with linen, medical equipment, dressings, and pharmaceutical stocks. This emergency project to shelter innocent patients from potential death and injury from aggressive forces demonstrates the great Australian spirit. Protecting our most vulnerable members of our community in times of threat. Rudimentary? Yes, but a haven from Japanese bombers and survival. Re-discovered by kids playing in the ventilation tunnel, the underground hospital was restored to its original status from 1997 – 2001 based on old photographs with authentic furnishings and equipment. This is an absolute must see for medicos visiting Queensland outback towns.

Footnote: On August 15, 1945, after almost 4 years of bitter warfare and millions of military and civilian deaths, in the islands north of Australia, including New Guinea, Japanese Imperial Forces were depleted and defeated. However, despite repeated US and Allied requests, Japan refused to surrender. Subsequently, the atrocities and many deaths continued in N.G. jungle warfare and Japanese occupied territories. In order to end WW11, US President Harry Trueman approved the atomic bombing of Hiroshima. However, Japan still refused to surrender until the second atomic bombing of Nagasaki one week later. It was only then that *Japanese Emperor Hirohito* announced the unconditional surrender of all Japanese land, sea, and air forces. The surrender was formally signed on board USS Missouri 2 September 1945. After the Tokyo war criminal trials, many Japanese military officers and subordinates were hanged for war crime atrocities and mass killings of civilians committed during Japan's occupation of countries and territories. -- LEST WE FORGET. --

As it was Then

Ambulance response times have become an intensely debated topic nowadays, the following flashback is from decades ago and personal experience. Officers joining VCAS in the 1960s were issued, as part of the standard Ambulance officer's kit, a 'Melbourne and Metropolitan' street directory. And from recall, mine was a 'Melway'street directory, the attendant of the two man crew was also the 'navigator', and I assume is still largely the case today. This role was part and parcel to the ambulance crew duties when an ambulance received a call for any case including an emergency case (Signal 8). The attendant would refer to the Melway and find the location and/or street or road for the car to rapidly respond . In the main, this practice worked reasonably well as the driver hearing the call would immediately travel in the case direction. Then the attendant would further guide him, unless of course the location of the case was known. However, the downside of this procedure was when an officer was operating 'one up.' In the event of receiving a Signal 8 case, if the location was unknown, this would require him to stop and establish his destination point in the street directory prior to proceeding to the emergency.

To overcome this single response situation and also to assist with 2-man crew emergencies, the following emergency call procedure was introduced by VCAS. In the first instance when control received an incoming emergency Signal 8 case, a control room A/O assisted the S/O or D/O controller. This role was to refer to the Melway street directory and establish the precise location of the case. Subsequently, when the controller gave out a Signal 8 case to a car, he would also advise the Melway reference, (ie.) Essendon 'Melway page 26, F16.' This information was well thought out assistance for both one and two man crews, and saved precious time and possibly in some cases a life. This initiative was well received by crews and the benefit noted by management. Subsequently, a short time later, all VCAS cases given out by radio and telephone included these street directory references. This system could also assist to eliminate fatal mistakes. In very early days of my career on one afternoon shift running with a senior man, we received a Signal 8 cardiac arrest, with a doctor in attendance. I referred to the Melway, found the location, and we proceeded post haste, however, arriving at this address there was no emergency unfolding. We immediately radioed control to check the location. On verification, there were two Acacia's - one a street, the other a court. We were at the wrong one. This may have been a communication fault of the caller, or control, or with our in-car interpretation. Whichever the case, when we did attend, the patient had expired. Although the attending doctor stated that this outcome had already occurred prior to the call, the case indicates the value of the afore-mentioned VCAS Melway strategy.

Fast forward to our present and the constant emerging statistics and hysteria pertaining to ambulance response times. I am fascinated by these never ending revised ambulance response times, and the excultation of shaving "nine tenths of a minute off from the last average response time period." Possibly the passage of time has left me behind with all of this, however, I ponder just how much influence this miniscule time would really have on a paramedic? and what true significance does it reflect on patient outcomes? This is particularly so when an ambulance crew can spend their entire shift ramped at a hospital. Maybe the ambulance response time analysis, expense and human resources could be far better appropriated.

Flash back.

A recent phone call to former Ambo extreme long termer, *John Blosfelds,* held the same interest and intrigue as all others. He is a history source in his own right, and can go way back to his commencement date with VCAS. in 1952. Among the many remarkable accounts of Victorian ambulance history that John has recalled in conversation direct from the grey matter, comes the following, and this account is synonymous with the time of the year. John told me in the late 1940/1950s that VCAS Supt/Sec *Fred Raven* had the following arrangement to assist families to come together on Chistmas Day. If the loved ones of any person confined to a nursing home or hospital in the Melbourne area wished to have these patients home to share Christmas luncheon with family, then VCAS would provide ambulance transport for these persons from their place of care, home to loved ones for Christmas lunch, then return the patient to care afterwards that day. This was for the VCAS minimal charge, regardless of the return distance. The minimal VCAS charge for an ambulance service based on a return trip totalling eight miles (4 miles each way) was one pound, five shillings. £1.50/- ($2.50c). The special Christmas fee was on a cash only basis, as a subscriber scheme, or any pensioner free travel did not exist. If the family did not have the full amount on hand then they undertook a promissory payment afterwards. John recalls one Christmas at the end of shift, when the crews returned and handed in these funds with the receipt book, there were 75 persons that had taken advantage of this special Christmas day transport. In summary, I think that most of us look back on this era of ambulance management as very regimented and austere. Although I am sure that we all would look on this gesture and agree that this is a commendable example of caring and of good will to our fellow man.

Thalidomide – The Dubious Tragedy

Of the many diverse ambulance cases that presented in the 1960 and 1970 decades, there was a regular and particular case that most ambulance crews found a degree confronting and sad. This was a case from Yooralla. Yooralla was a hospital school for crippled children, located at Balwyn and at Box Hill, outer Melbourne. Est. 1918, the facility accommodated a complete scope of child disabilities. The children included the residual of the Poliomyelitis epidemic of the 1940s and 1950s, and sadly, the child victims of the infamous drug Thalidomide. The latter is the main reference to my opening statement and following context. A transport case to, or from, Yooralla would often pull at one's heart strings and instil both sadness and anger that this could have occurred. The children catered for at this centre varied in age from infants to adulthood, with the Thalidomide victims generally ranging from toddlers onwards. To observe the young male and female victims' dreadful structural deformities presented a depressive atmosphere. These otherwise healthy, beautiful little, and developing boys and girls were structurally malformed with tiny hands attached to shoulders. Others had little feet attached to their pelvic structure, and some with huge heads, or another body malformation, or either blind or deaf, and sometimes both. This treacherous betrayal of man by fellow man for financial greed had inflicted a future life of misery and disablement on these precious innocent babes, kids, and eventually adults.

Observing these near hideous human structural deformities and defects installed in my mind at the time a sense of deep gratitude that our three children were born normally, and I assume my colleagues shared the same thought. However, despite their terrible afflictions, the children at Yooralla were not deprived of a good education. I recall one case being to transport a Yooralla resident from Fairfield Infectious Disease Hospital (FIDH) back to the Yooralla Centre. In this case the patient was a male aged in possibly his very late teens, or early twenties, he was wheelchair bound in a 'High Fowlers' position. This young man had a very large, deformed head, and small immobile deformed legs. Our patient was a bright and pleasant young bloke, he spoke well and held an interesting conversation, he also held a Ph D.! From a personal face value observation the care given at Yooralla to these unfortunate kids was kind, caring, and affectionate, although with another case we transported this was not so. Our patient was a little girl around 10 years of age, born blind, being transferred from hospital back to Yooralla. On our arrival back at Yooralla this poor little girl became upset and disorientated, accompanied with panic, and this concerned me. The child's escorting nurse sought a doctor from within who was obviously annoyed at the inconvenience, and he came into the back of the ambulance with her. This doctor began yelling at the child and shaking her shoulder, further upsetting her into uncontrolled sobbing. I called on him to stop this immediately. With my request he alighted from the ambulance angered and airing his authority to me, a mere A/O, then he and I engaged in a very heated exchange. I informed him that I considered his professional behaviour severely wanting, and of an unnecessary and appalling standard. Accompanying this, I had a compulsive, however 'well restrained' desire to impart on him some true country justice. Following is an interesting account of the dark researched history surrounding this medication. Included are the potential statistics of Thalidomide's horrific consequence for unsuspecting women.

Overview of Thalidomide**;** In the late 1950s and early 1960s, the use of thalidomide for pregnant women or women that were to fall pregnant in the ingestion period took place in over 40 countries. Pregnant women, or women becoming pregnant taking Thalidomide resulted in the "biggest anthropogenic medical disaster ever. It is estimated that more than 10,000 children were born with a range of severe deformities, such as *phocomelia*, including thousands of miscarriages. Thalidomide was introduced in 1953 as a tranquilizer, and was later marketed by the German pharmaceutical company *Chemi Grünenthal* under the trade name *Contergan* . The drug was sold as a medication for anxiety, trouble sleeping, tension, and morning sickness. Although initially it was introduced as a sedative and medication for morning sickness without having been tested on pregnant women. While in early stages of women taking this medication was deemed to be safe in pregnancy, concerns arose regarding birth defects were only suspected in 1961, and Thalidomide was removed from the market in Europe that year.

Although Thalidomide was first developed as a tranquilizer by Swiss pharmaceutical company Ciba in 1953, in 1954 Ciba abandoned the product. Subsequently, the product was taken up by German pharmaceutical company *Chemie Grünenthal*. The company had been established by *Hermann Wirtz Snr*, a Nazi Party member, after World War II as a subsidiary of the family's *Mäurer & Wirtz* company. The objective of the company initially had been to develop antibiotics for which there was an urgent market need. Hermann Wirtz appointed chemist *Heinrich Mückter*, who had escaped prosecution for war crimes for his experiments on prisoners of Nazi concentration camps. Muckter's role was to head the development programme due to his experience researching and producing an anti-typhus vaccine for Nazi Germany. He hired *Martin Staemmler*, a medical doctor and leading proponent of the Nazi eugenics programme*(1), as head of pathology, as well as *Heinz Baumkötter*, the chief medical officer at the Sachsenhausen concentration camp, and *Otto Ambros*, a

chemist and Nazi war criminal. Ambros was the chairman of Grünenthal's advisory committee during the development of Thalidomide and was a board member when *Contergan* was being sold.

The total number of embryos affected by the use of Thalidomide during pregnancy is estimated at more than 20,000, and potentially of these, approximately 40 percent died at, or shortly after, the time of birth. Those who survived had limb, eye, urinary tract, and heart defects. Contergan's initial entry into the U.S. market was prevented by *Frances Oldham Kelsey at* the U.S. Food and Drug Administration (FDA). The birth defects of Thalidomide led to the development of greater drug regulation and monitoring in many countries. The severity and location of the deformities depended on how many days into the pregnancy the mother was before beginning treatment; Thalidomide taken on the 20th day of pregnancy caused central brain damage, day 21 would damage the eyes, day 22 the ears and face, day 24 the arms, and leg damage would occur if taken up to day 28. It is claimed that Thalidomide did not damage the foetus if taken after 42 days' gestation.

Thalidomide in Australia and New Zealand. Although the Australian obstetrician *William McBride* took credit for raising concern about Thalidomide, it was discovered that it was a midwife Sister named *Pat Sparrow* who first suspected the drug was causing birth defects in the babies. These victims were patients under McBride's care at Crown Street Women's Hospital in Sydney. German paediatrician *Widukind Lenz*, who also suspected the link, is credited with conducting the scientific research that proved Thalidomide was causing birth defects in 1961. William McBride was later awarded a number of honours, including a medal and prize money by L'Institut de la Vie in Paris. Mc Bride's involvement was later disputed, and in events that followed he was struck off the Australian medical register in 1993 for scientific fraud related to work on Debendox. Further animal tests were conducted by *George Somers,* Chief Pharmacologist of Distillers Company in Britain, which showed foetal abnormalities in rabbits. Similar results were also published showing these effects in rats and other species.

Lynette Rowe, who was born without limbs, led an Australian class action lawsuit against the drug's manufacturer, Grünenthal, which fought to have the case heard in Germany. The Supreme Court of Victoria dismissed Grünenthal's application in 2012, and the case was heard in Australia. On 17 July 2012, M/s Rowe was awarded an out-of-court settlement. The settlement is believed to be in the millions of dollars and the verdict and settlement provided a precedence for class action victims to receive further compensation. In February 2014, the Supreme Court of Victoria endorsed the settlement of $89 million AUD to 107 victims of the drug in Australia and New Zealand.

The Beacon gratefully acknowledges Wikipedia for the historic background of Thalidomide.

*(1) The Eugenics program; WW2 Nazi Germany Fuhrer Adolf Hitler considered the German people superior to any other human race. In Nazi German occupied countries and in Nazi prison camps he ordered the development of his " Ayrian Race". This fanaticism was to breed a new generation of Germans, and a superior Nazi German race of people. Namely all of fair complexion, blonde hair, and blue eyes, this new race would rule his new fanatical Nazi world. Hitler's perverted campaign began with forced sex of blonde, fair skinned, and blue eyed women prisoners, and also women in Nazi occupied countries. The eugenics program commenced with selected German soldiers of the same skin, hair and eyes ordered to engage with these women. Also on Hitler's command accompanying this insanity were the depraved obstetric eugenics experiments. These unprecedented and manic atrocities were carried out on imprisoned concentration camp females. The eugenic experiments were inhumane and hideous, they occasioned nothing short of depravity and unparalleled torture and suffering of these unfortunate females. PKD 11/24

Adolf Hitler 1899 - 1945 (suicided in Nazi Fuhrer bunker Berlin Germany 30 April 1945 aged 56 yrs.)

"Never forget that evil is evil. You cannot lead it to the light. But if you let it, evil can lead you into the darkness."

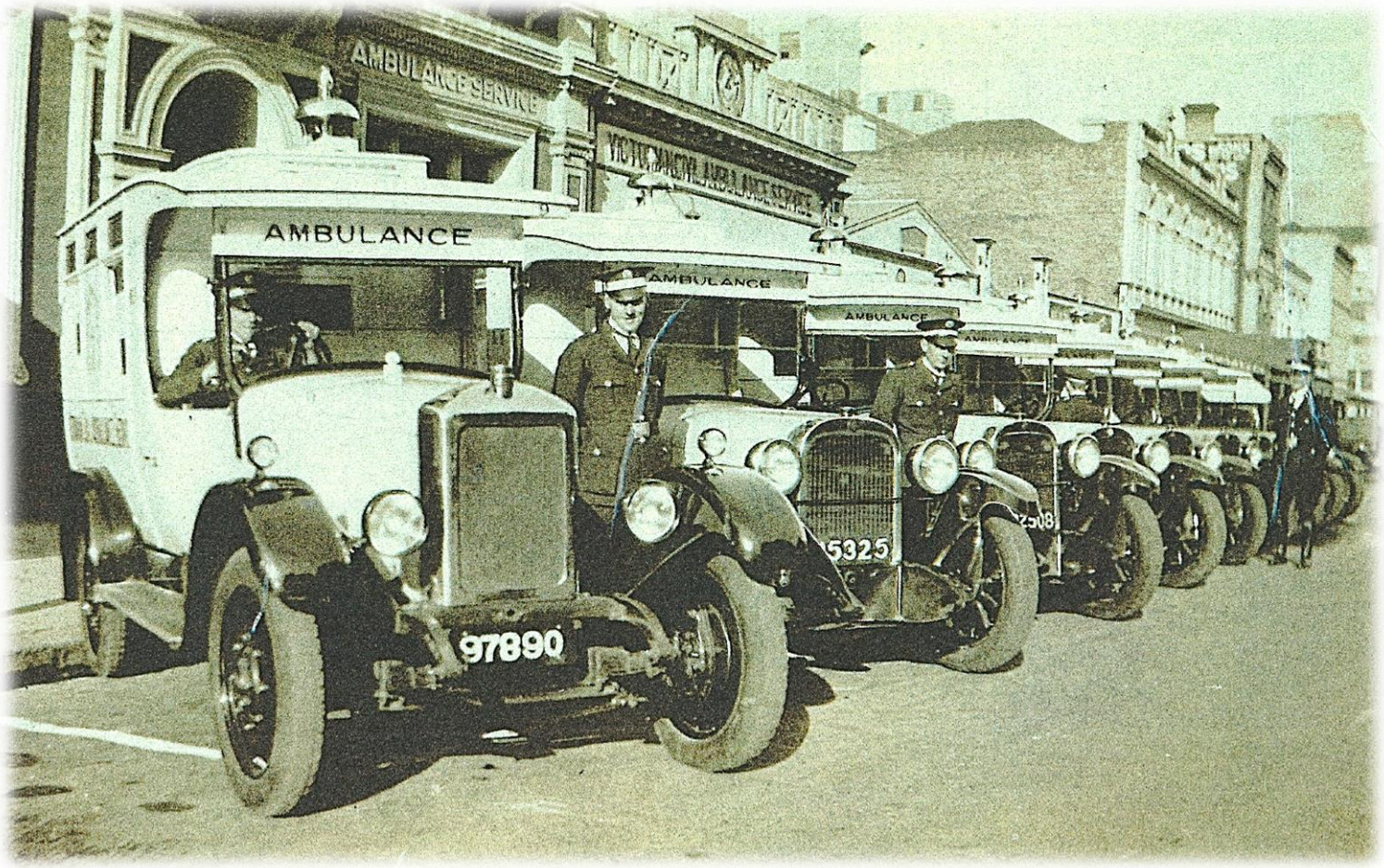
Gena Showalter

ARE YOU EX-OPERATIONAL ASV OR AV?

Our AHSV, as a tribute to your former service in ambulance to the people of Victoria, are providing complimentary (free) certificates of *"Recognition of Service."* These certificates are of the finest quality, design and print, A4 laminated showing your name and service history. The certificates are posted out, cut to size for A4 framing, for others to see and respect. If you have worn our uniform with pride and gave your best, you have earned this recognition (Posthumous certificates are also available). This may be a limited opportunity, so don't miss it! For a simple application form email Pete or Barb: vintambos@bigpond.com

Not on computer ? Phone Barb for a postal form: **0417 290 946** or Pete **0427 508 888**

Hi Peter, the certificates arrived promptly and undamaged, thank you for your efforts, we are very proud to display them. This was even better than awards and medals handed over in the Superintendent/Managers office in the past, so impersonal. So thank you again for this service recognition. Dave Gawne 19/11/24



I suggest that this sepia photograph is from the mid-1920 era, although the makes and models of the various ambulances are an unknown. I do know however, that the engines are started with a 'crank handle'. The handle is inserted into the small hole seen at the base of the vehicle's radiator. The handle engages with the fan belt pulley. The person then turns the handle clockwise until the petrol engine starts, often the compression of the engine can create a 'kickback' and break the wrist of the person turning the handle. The vehicle would have a manual gear box with 3 forward and 1 reverse gear. Driving signals are indicated by hand and arm gestures. If there are any vintage car buffs out there who can give further info on these vehicles please contact me: email vintambos@bigpond.com or phone 0427 508 888. Pete.

Our 1957 V8 Ford Mainline Ambulance N.E.V.D.A.S.