Work Never Stops: Harsh Lessons Learned in an EMSC Course

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Having just returned back to active duty with the Cycle Response Unit (CRU) after one year away, my first week back was to be a gentle one. The morning of day one was spent preparing my CRU Paramedic kit (always unnerving as you really have to slim your equipment down to the bare minimum after having had the space of an ambulance vehicle to stow all the equipment you could ever need) and the rest of the week I was to be lead instructor on a EMS Cyclist course.

On the morning of the final day of our course, we gathered our students together and proposed that, prior to their assessments later in the day, they decide if they wanted a final practice on the cone course or road riding, whichever was their weaker area. I had one student opt for the road ride, so whilst the rest went to revisit the cones with my co-instructor and an assistant, I took one student out for an observed road ride.

It was overcast with sunny spells, a warm springtime morning during which visibility was good and traffic density was moderate (for the City of London). My student was a Team Leader (my superior at other times) and we had a good ride during which we took a few stops to observe and reflect upon various traffic issues; particularly, filtering through stationary traffic with the intent of making a left turn (UK roads, so think right turn in USA and Europe). We discussed the pros and cons of overtaking or using the cycle lane on the approach, the cycle box at the junction, plus safe lines to use and where hazards may arise. This is a subject I'd highlighted with some concern during a classroom presentation earlier in the course as it is the most common cause of cyclist fatality in London.

As we were returning to base, a pedestrian standing at a bus stop hailed me and informed me that a cyclist was under a lorry further along the road (you seem to get a vibe about jobs and this one was "bad"). I called to my student, informed him of a possible running call, and instructed him to follow me. Blue lights went on (we are currently working on a cyclists blue light protocol and course here in London) and big ring was engaged. I had traffic on my side backing up (a confirmation of "bad") so took to the other side of the road to make progress. It was initially empty but after a short distance I encountered an oncoming van. I made firm eye contact with the driver and by using hand signals, instructed him to stop, allowing me and my student a safe passage past. After a brief sprint we came to a traffic light controlled crossroads where a four wheel steer cement mixing lorry was stationary mid-left turn (UK roads) and at the back wheels, a cyclist's supine torso was protruding out.

The London Fire Brigade (LFB) were already on scene, but since UK Fire & Rescue service are not EMT or Paramedic trained, my student and I found ourselves as first EMS on scene. Our first impression was of an open pelvis fracture and probable thoracic trauma with head injury (no helmet worn). The patient was pulseless, so we got to work on the airway whilst our collegues in the LFB performed chest compressions. Within a minute, a solo LAS Rapid Response Paramedic Unit (car) arrived to back us up and it was manned that day by the familiar face of a Team Leader and CRU member of staff who had just recently finished a one year secondment to the CRU. Our patient was in a workable cardiac rhythm (PEA), so all possible traumatic causes were reversed as far as our skill levels allow; airway protection was initially impossible due to trismus (jaw locked shut), but intubation was achieved after it subsided; we were now backed up by plenty of other LAS staff, drug therapy commenced and we looked at

extrication. The initial LFB report was that the patient's legs were entwined with the axle and that the vehicle would have to be raised. This would mean all our rescusitation efforts would have to cease as the area would not be safe to work in until the vehicle was stabilised with blocks and raised, but after cutting up the cyclist's bicycle and removing it from underneath the vehicle, we were able to extricate and immobilise the patient and remove them to an ambulance for conveying to hospital.

In London we have one Helicopter Emergency Medical Service staffed by a BASICS doctor and a Paramedic. As we gave our report on arrival we were informed it was on another call, so a BASICS doctor was activated from a central London hospital, arriving by car just in time to convey with the patient to the nearest multi-trauma unit.

A police traffic officer who attended the scene of the fatality commented on the hazard of frontal four wheel steer vehicles' ability to "suck cyclists in" under their turning wheels once contact has been made.

Myself and my student then returned to base, debriefed and completed paperwork over a cup of tea and then got back to the course assessments (he passed!).

The job reaffirmed to me how recognisable the CRU are now in London. It also reminded me how much closer you are to members of the public when you are on a bicycle, and that you are far more easy to wave down for aid — I doubt a motorised vehicle would have seen the pedestrian who waved me to a halt. It showed how adaptable and flexible we can be, and how quickly and easily we can respond, offering vital pre-hospital care to those in need to a standard that equals or exceeds that available by a motorised vehicle.

I was glad to have been with a clinical lead (Team Leader) at the time of the incident and happy to see another familiar CRU face arrive (by car this time) so promptly and give so much to our efforts as did all the emergency services who attended. This incident highlighted that as EMSCIs, we should always be prepared to deal with the worst at the most unlikely of times, and the importance of carrying full operational kit at all times.

Unfortunately, it also showed how vulnerable cyclists can be when they don't act or get treated as legitimate road users, so take care, it is a jungle out there. Ride safe, and be prepared.

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