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DB0052024

Southport Major Incident

Structured Debrief Report

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0.1	30/04/2025	Draft	NEW	Document Creation – the content is the same material as the previous draft debrief reports, a request was made to amend the format.
0.2	06/05/2025			Addition of themes and lessons Timeline updated
0.3	09/05/2025			Overarching themes, lessons and recommendations added
0.4	14/05/2025			Observations to compare organisational expectation (plans and policies) with actions taken as shown in the debrief outputs.

Contents

Executive Summary

Background

On July 29, 2024, a devastating multiple stabbing incident occurred at The Hart Space Community Centre in Southport, resulting in the deaths of three children and injuries to numerous others. The North West Ambulance Service (NWAS) declared a Major Incident, deploying significant resources and coordinating with multi-agency partners to respond. This incident preceded broader episodes of civil unrest.

Scope

This report focuses exclusively on the events of July 29, 2024, related to the Southport stabbing. It does not address subsequent civil disorder or NWAS's involvement in the broader investigation following the incident.

Purpose of the Incident Report

The primary aim of this report is to review NWAS's response to the incident, identify areas for improvement and notable practice, and identify lessons and recommendations.

Methodology

Staff involved in the incident response were invited to complete an MS Forms to establish some basic information, and then in-person debriefs. They were split into Integrated Contact Centres (ICC), Paramedic Emergency Service (PES), and Command/Command Support cohorts to keep the group sizes manageable and ensure no voices were lost.

The method combines the College of Policing (initiator, sponsor, facilitator, scribe, groups, basic questions) and After-Action Review (expectation and differences) models, and lesson identification and description.

The debriefs involved capturing information through MS Forms (denoted as **F**) and in-person sessions (**IP**) held in September 2024, which was then themed and compared across the cohorts. These findings informed the identification of lessons and notable practices, which will be validated by staff directly involved in the areas of work and assigned for future action.

This report is a foundational step in enhancing the effectiveness of NWAS's response processes and ensuring preparedness for similar critical incidents.

Lessons identified

12 lessons and recommendations were identified which include:

- Training and exercises for staff preparedness
- Review of notification procedures
- Discipline around information flow and methods of communication
- Incident response methodology review to improve flexibility and application of operational discretion
- Review of incident management equipment both in ICC and on the ground
- Review of debriefing processes

A separate action tracker will be produced through collaboration with internal stakeholders to support the recommendations. Tracking of progress will take place through internal governance structure (EPRR Group, Trust Management Committee, and Board).

Areas of notable practice include the support staff felt from those around them, the quick application of clinical procedures and decision making on scene, and the team working between multiagency partners on scene.

1. Background

1.1 On July 29th 2024 a multiple stabbing incident occurred at The Hart Space Community Centre, Southport, that resulted in the deaths of three children, and several other casualties.

1.2 NWAS declared a Major Incident, and responded with a large number of resources, working closely with multi-agency partners.

1.3 This tragic incident was then followed by national and regional episodes of civil disorder, which fall outside of the remit of this document.

2. Scope

2.1 This report covers a major incident (stabbing) on July 29, 2024. It does not cover the following periods of civil unrest.

2.2 This report does not cover the support provided by NWAS to the wider investigation of the incident itself, where, for example, NWAS provided daily support to the multi-agency search of the suspect's home address.

3. Purpose of this report

3.1 The purpose of this report is to outline the response phase to the Southport stabbing incident on July 29th, 2024, and identify lessons and areas of notable practice from the debriefs that followed.

3.2 The report provides an overview of the incident for context, and then a summary of what staff expected, what happened and why there was a difference (After Action Review format). Each theme shows if it relates to a lesson, and if so, which lesson. The table of lessons is located at the end of the body of the report (section 5).

3.3 The raw data has been transferred into the College of Policing-suggested tables shown in Appendix 1. The responses taken from the MS Forms are verbatim unless they affect anonymity or provide detail which is too specific for the requirement here. The MS Forms respondents are allocated a code as individuals, the staff at the in-person debriefs are taken as a cohort. IP denotes the in-person debriefs and a collective view.

3.4 Appendix 2 shows the quantitative data from the MS Forms.

3.5 The lessons from this report will be validated with practitioners from the workstream and assigned to an owner. The lessons may require multiple actions to address them. These will be identified, validated, owned and tracked in the same way as the lessons

themselves. Updates will be reported into the EPRR Group, chaired by Executive Director of Operations.

3.6 Appendix 3 provide a glossary for some of the acronyms and abbreviations used.

Methodology

3.7 The decision was taken by the debrief team, in collaboration with the Strategic sponsor, to split the debriefs into Integrated Contact Centre (ICC), Paramedic Emergency Service (PES), and Command/Command Support cohorts. This was to ensure the groups were small enough that everyone could have an opportunity to contribute (as per College of Policing suggested structure) and limited the risk of people not wanting to express their views due to the hierarchy present.

3.8 A list of staff who were involved in the response was provided to the Resilience Team. Each identified member of staff was sent an MS Form to complete for initial information collection, and asked if they would like to attend an in-person debrief. The cohorts were:

- ICC – 43
- Managers/commanders/command support – 14
- PES/ on scene response - 33

3.9 Returns on the MS Forms were:

- ICC – 21 (49%)
- Managers/commanders/command support – 11 (79%)
- PES/ on scene response – 24 (73%)

3.10 The in-person debriefs were held at an external, non-NWAS venue in a non-hierarchical situation. This was designed to put staff at ease as they were not in a work environment. The following numbers attended in each cohort:

- ICC – 22 (51%)
- Managers/commanders/command support – 16 (2 were not included in the provided list) (114%)
- PES/ on scene response – 14 (42%)

3.11 The debriefs were conducted using the After-Action Review model (AAR) which asked

- what did the participants expected to happen,
- what did happen from their perspective,
- what was different and what impact did this have.

3.12 The questions noted what the participants thought went well, and what could have gone better as per the College of Policing debriefing model.

3.13 In Appendix 1, participants who provided MS Forms feedback are shown by the group they were allocated (ICC, PES, Command), the anonymous ID number allocated by the form, finishing with F to indicate the source. Information gather from the in-person debriefs will be shown by the letters IP. Views recorded from the in-person meetings are majority consensus, the comments and views were not attributed to individuals.

3.14 The information has been coded to allow grouping of topics, and themed for each debrief and overarching themes.

3.15 Each theme informed the lessons that were identified.

4. Incident Description and timeline

4.1 Scene setting

On the morning of the July 29th, 2024, NWAS was at REAP[1] 2, and at the time of the first call being taken was at CSP[2] level 1.

The 09:30 system call showed the trust as having had a steady night and being described as having average activity for a Monday morning after a busy weekend.

The following timeline is formed of information taken from the CAD Sequence of Events, and logs submitted by staff.

First Call Received at	11:47:58
Total of Resources attending Scene	37
Total of Resources Allocated to Incident (Inc Tx and Sx)	49
Total Individuals Attending Scene	63
Major Incident Standby Declared at	12:05:56
Major Incident Declared at	12:26:30
First Resource Allocated within	2 Minutes 13 Seconds
First Resource on Scene within	9 Minutes
First Senior Paramedic Team Leader on Scene within	9 Minutes
First EMA On Scene within	10 Minutes
First Senior Clinician on Scene in within	25 Minutes
First Priority 1 Patient Left Scene in	46 Minutes
Last Priority 1 Patient Left Scene in	1 Hour 40 Minutes
Last Patient Left Scene in	3hrs 55 Minutes
Number of Patients Transported	13

[1] REAP – Resource Escalation Action Plan
[2] CSP – Clinical Safety Plan

5. Themes and recommendations

5.1. What did the participants expect to happen?

By asking the participants in the debrief what they expected to happen, it allows the organisation to understand any differences between the organisation's plans, the participants expectation/knowledge, and the activity that transpired. Differences between the plan and the expectation may reflect training, education, ambulance service or life experience, and should be explored to assist in future planning and training.

ICC

The question in the MS Form reads *'When you were assigned to this call, what did you expect to happen?'*. This seems to have been interpreted by most of the respondents as the expectation place on them rather than their own expectations, and 'assigned to the call' was a distraction for those who participated in the response but not specifically assigned. The wording of this question will need to be reviewed.

Of those who expressed their expectations, a manager expected to be informed as soon as possible (ICC3F), crew to be allocated (ICC2F), to be able to follow and complete action cards (ICC4F), to be able to complete the role they were given (ICC7F), to not be briefed as they knew what to do in the role (ICC12F), someone to take charge and advise the best steps to take (ICC19F), early declaration of major incident (ICC20F), leadership (ICC20F).

PES

When you arrived at scene on the 29th, what did you expect to happen?

The expectations of the PES staff seem to vary depending on how long into the incident the staff perceived they arrived. Those with longer travel times expected a more mature command structure and managed scene, although this was also anticipated by staff who said they were in the first few vehicles that arrived at scene. Counter views were that they expected an element of 'chaos' due to the nature of the incident.

<u>Scene management</u>

A chaotic scene if one of the first vehicles but with police on scene and fire on the way (PES11F). 'A control over MOP's trying to rubber neck' (PES2F), cordons in place with scene management by police (PES19F)

'Being one of the first on scene, I wasn't expecting it to be declared a major incident. Attending, I thought it was only for one patient, this clearly changed whilst I was already on scene' (PES24F).

A command structure with people in tabards, a clear CCP, CCS, Parking area, etc (PES2F, PES3F PES4F, PES6F, PES7F, PES8F, PES13F, PES16F, PES17F, PES18F, PES19F, PES21F, PES22F) including where to leave the vehicle. A briefing from a commander/acting commander (PES5F) and sharing of the JDM (PES6F) and risk assessment (PES10F). HART to be tasked by HART team leader (PES14F).

Resources such as HART and APPs to be on scene (PES10F).

Patient triage, treatment and transport

Patient allocation and distribution (PES3F, PES4F, PES5F, PES10F, PES19F) and to see a lot of dead and critically injured children (PES5F). Triage to have been completed or in progress (PES7F, PES19F, PES21F).

Commanders and command support

'When you arrived at your command location on the 29th, what was planned or what did you expect to happen?'

Many of the responses detailed what happened rather than the exception of what would or should have happened from the staff perspective. The comments below answer the question.

Receipt of information

Listen to updates en route to the incident over the open airwaves channel (C11F). To have been passed the location of an RVP and or the FCP, and a briefing from the operational commander to cover all the elements of IIMARCH (C2F). Be told the timing of the next JESIP meeting (C2F). Briefing regarding the Tactical plan (C2F). Notification from ICC or other members of the command structure within those on call (C3F). Notification from ICC (METHANE), if PDA was activated, and to start to make arrangements for getting additional information from partner agencies (C3F).

Command structure

Liaise with the NWAS operational commander and receive a tasking as a senior clinician (C11F). Colocation with an operational medical advisor (C2F). Receive the names of commanders from fellow blue light services (C2F) and allocation of a Safety Officer (C2F). Colocation of NILOs from all agencies at scene (C2F). For a NILO to take a coordination role supporting NWAS commanders, and another working externally (C3F). The tactical commander and NILO to meet for situational awareness (C5F). MERIT to be in contact with the command structure and NILO (C6F).

Equipment

Tabards being utilised, normal operational staff wearing appropriate PPE. Band 7 staff (& above) and commanders to be utilising body worn video cameras. I would have expected communication at the incident ground to be taking place via airwave radio (C2F). Action card to be used (C3F).

Patients

Receive casualty distribution information inclusive of triage categories (C2F).

Summary

There was a general expectation that all the people who needed to be made aware would be notified quickly, and resources identified and allocated. This expectation can from ICC and PES. There was a balance of those on scene between expecting 'chaos' and a management structure to tell them what to do. This seemed to be broadly based on how long it took the crew to get to scene, but some envisaged it happening sooner. The expectation around command and control extended to triage having taken place and clinical processes being started.

The command cohort expected to be notified and passed information to enable them to make decisions. This included locations of key positions (forward command and rendezvous points). The use of equipment including airwave radios, body worn video cameras, and tabards was covered. A strong command structure with support and advisory roles allocated was also anticipated.

Across all cohorts, the expectation of leadership was prominent although different language was used to describe it.

Is there anything that you would do differently next time you go to a major Incident?

As part of the questionnaire, the respondents were asked if they would do anything differently. This was to encourage personal reflection and could indicate if there are things that could be included in planning and training. Some reflected on the use of action cards, body worn video cameras, taking in mega mover stretchers, having louder voices in JESIP meetings, be more proactive with communication, make sure vehicles stay unlocked and keys in, utilise patient extrication bag from RRV quicker.

There were some other comments that should be noted:

'I don't want to go to another major incident.'

'I am hoping never to have to go to one again'

'Having now lived one, I know what to expect and feel this has been the best education I could have received in this.'

When taken in context with the other statements the respondents made, these are not throwaway comments. This should be considered when working with staff in training and exercise scenarios as there could be a variety of mental and emotional resilience in the room.

5.2. Themes

The following table show what themes were found in each debrief cohort and identifies areas where the themes are common.

	ICC	PES	Command and command support
Areas for improvement	Information flow: Initial calls Declaration Notification	BLANK	Information flow: Notification
	Command and control: Team roles Staffing	Command and control: Scene management Access and egress Resourcing and allocation Role conflict Team roles	Command and control: Scene management Multiagency coordination Roles
	Communication	Communication	Communication
	Equipment: ICR Airwaves IT systems	Equipment	Equipment
	Processes: SORT	Triage and treatment	Triage and treatment
	Preparedness	Preparedness	
	Post incident welfare	Post incident welfare	Post incident welfare
Notable practice	Teamwork and leadership	Teamwork	Information flow
	Working under pressure	Communication	Scene management
	Information flow	Scene management	Coordination
	Preparedness	Triage and treatment	Resourcing
	Welfare	BLANK	Post incident welfare

This section details areas for improvement and notable practice drawn from a combination of the MS Forms and in-person debriefs. The raw data is provided in appendix 1 and 2. Where lessons are identified, the code is provided and explained in the next section in more detail with associated recommendations.

5.2.1. Cohort – ICC

Information flow

Areas for improvement:

ICC found it difficult to gain situational awareness from the calls from the public due to the number of calls and different type of information contained in them.

There was a perception of nervousness and/or lack of urgency in all parts of the response structure to declare a major incident. The incident declaration did not happen quickly, and this left the teams trying to work together with limited leadership or understanding of the situation. There were staff in different control rooms who could see the stack and felt the Primary ICC were not reacting to the information. During the in-person debrief, it was noted that the staffing of the major incident roles would also impact BAU and was a consideration in the declaration.

ROCC were not notified by ICC, and they were the ones to inform the Strategic Commander. This is not in line with the Incident Response Plan v8.5 action cards.

Notable practice:

Regular meetings and teams chat in management groups were felt to be beneficial, and the communication between control rooms helped consolidate information from various calls. The declaration of major incident standby helped organise and mobilise resources, and the clear METHANE from scene gave additional assistance.

Observation

The Duty Manager action card asks the user if what they are dealing with is a major incident, based on what they know. It does not tell them how to make that decision, this is assumed to be knowledge the post holder has. They are also to inform the ROCC so they can activate their own action cards.

Lessons identified – SPTMI02, SPTMI03, SPTMI09

Command and control

Areas for improvement:

Team roles were confused in the ICC with some staff not knowing how to balance their duties in BAU and the incident. There were staff who did know want to disturb managers who were dealing with the incident, even when they were unsure of what actions they should be taking. This caused them to negatively reflect on their actions. Other staff delegated tasks around updating their management structure that they felt they would do themselves next time.

There was a lack of coordination around the CIH, CHUB and ROCC where actions were missed or duplicated. This included a PES vehicle being sent to hospital to meet a helicopter when there were 2 PTS crews standing by. Action cards were felt to not reflect the work CIH would or should be doing. They were trying to manage pre-alerts from the incident as well as other trauma calls and there were no other clinicians available to assist as they were working on the incident. ICC made the decision that pre-alerts would go via CIH with limited communication, however it was thought to work well. Counter comments show the staff found this difficult to deal with. This was reflected in comments regarding a dispatcher trying to also manage BAU.

There were comments around the staffing levels, particularly in the Primary ICC, in terms of inexperience in roles and acting up into management positions. This made the action cards difficult to follow due to the reduced number of staff available. Staff are also not dual trained in call-taking and dispatch, comments show the team feel this reduces flexibility and resilience. Some staff felt that, as they were one of the more experienced, they were unable to express their uncertainty in the role.

Observation

The staffing levels have been checked and confirmed as 97% in dispatch.

The action cards for Clinical Hub (31 and 31a) set out the expectation of their roles which includes direct communication between then and the Critical Incident Manager who may or may not request support. The card instructs CIH to allocated resources are moved onto the correct talk group. Regional Health Control Desk (card 24) inform hospitals and health partners with a given notification wording and inform ROCC of any capacity issues. This can be quite onerous if there are many receiving hospitals and is intended as one-way messaging. ROCC Manager (card 25) show them identifying specialist capabilities and liaise with the Strategic Commander, RHCD, PTS and Clinical Support Hub.

Lessons identified – SPTMI02, SPTMI03, SPTMI09

Teamwork and leadership

Notable practice:

There were many comments around Duty Managers working well across control rooms, based in part on their ongoing good working relationship. The clinical hub was working within the system to try and take pressure off hospitals. Managers helped talk staff through action cards which was appreciated, and supervisors were supporting staff on calls. The pride in what the teams had achieved was expressed by the managers.

Working under pressure

Notable practice:

Staff were able to achieve even while working under the pressure this type of incident brings. One person was able to talk a member of the public through CPR for one of the victims, others worked their way through their action cards, allocated vehicles while maintaining situational awareness of both the incident and BAU. A member of staff took a description of the assailant, it was quickly made apparent to the Team Leader and the information passed to the police.

Communication

Areas for improvement:

Police had not made any type of declaration (according to a point in time referenced in the debrief) and NWAS did not receive a METHANE report on ESICTRL. Police at scene were telling staff it was safe to go forwards but not communicated it to ICC.

Hospitals were calling NWAS to check that the notification they received was real, and managers were calling for more information. This put additional stress on the small cohort of staff who were trying to notify and pass situation reports.

Internally, there were calls going into ICC from people wanting information who were not directly involved in the response, and some from staff in the command structure who had a knock-on effect on ICC by asking the ROCC for information which was available through other elements of the command chain.

Updates from scene were noted to be sporadic and unstructured. They were instructed to stand off but attended the scene. Messages were not sent in a METHANE format or with recognised terminology.

The ROCC were trying to gain situational awareness but found it difficult to get updated from scene or ICC. They knew a lot of resources had been sent but were not clear if the PDA had been achieved or who was in the command structure.

Observation

Teams messaging, chats and channels are part of daily business so an understandable means of communication in a major incident. There is limited governance in terms of who in a group has access to the information being included, and it is not possible to download chats for submission as evidence. It also circumnavigates the information cascade process leading to staff being made aware from unofficial sources which may be inaccurate. WhatsApp groups are also used with the same positives and negatives, but is not currently sanctioned by NWAS.

The Incident Response Plan recognises staff not involved in the response may contact those who are for information or to offer assistance, but it adds to the workload. Those staff not directly involved could be used later to take over from those in the initial response phase.

Action cards for those on scene state regular updates should be provided into ICC in the METHANE format, and the cards for ICC instruct the user to ask for one. Commander action cards and the Incident Response Plan make it clear how communication should work within

the command structure. ICC can become very busy, and on scene there is a large amount of information and sensory stimulation; to be effective staff might need to be coached for information.

Lessons identified – SPTMI05, SPTMI06

Equipment

Areas for improvement:

10 of the 21 MS Forms respondents looked at their action cards. There were no comments about their efficacy beyond the CIH. 0 out of 21 had a Body Worn Video Camera.

No major incident suites/Incident Coordination Rooms were used during the incident. The ROCC state they do not have radios or live C3 terminals which they want for managing and monitoring incidents, staff at the Primary ICC state they don't have a room, and another ICC said their room is not set up as the equipment doesn't work and they need to be available to support staff in the dispatch suite.

First on scene was asked several times to change channel, and LifeX does not give ICC the option to 'push' channels to change. This relies on staff noting they need to change and knowing how.

Several of the systems in daily use were criticised for being unsuitable in a major incident. C3live can only be updated by ICC, and the date/time stamp makes reading the information difficult. It was suggested that recording METHANE information on the C3 major incident module would assist in talking crews through the situation report. Pathways is not considered useful as it slows down when sub-questions/stem selections are asked from the main question (system provides them to gain more detailed information) and it is designed for single patients. Finding telephone numbers on LifeX was noted as time consuming and complex.

Hardware was mentioned as some staff felt iPads would offer them more flexibility to move around while maintaining situational awareness. Others state the single screens in place means C3 has to be minimised to reach applications like SharePoint to access guidance.

Observation

The Incident Response Plan advocates the use of the Major Incident Suites, available in each ICC, for management of major incidents. This is to enable staff to focus on complex management. The suites were not used during the incident.

All action cards for those attending scene and in the command structure instruct staff to check the talk group they need to be on. This assumes they are aware of how to change channels, and does not assume ICC will do it for them.

Lessons identified – SPTMI05, SPTMI06, SPTMI08, SPTMI12

Processes

Areas for improvement:

There was confusion around who allocates staff for SORT, some SOPs say CHUB and others for dispatch.

3 SORT trained ambulances were sent to a site for deployment of the PSU but had expired driver training and would be unable to drive the vehicles.

Lessons identified – SPTMI02, SPTMI03

Preparedness

Areas for improvement:

There was a lot of discussions in the in-person debrief around how prepared the staff felt. They believe training is very PES command focused and does not cover ICC action cards or decision making. Releasing staff from ICC for training is considered challenging, and there is a lack of confidence in some of the staff which could affect their willingness to declare major incidents. Loggist were noted as having limited opportunities to practice their skills, there are not many places available on exercises and limited spaces at events.

Notable practice:

Staff who had been involved in training and exercises felt more prepared and had run through scenarios with their dispatch team. They considered this preparedness to help them provide support to the Primary ICC. This practice also led to staff noting which vehicles held SORT-trained staff as a matter of normal procedure, both inside and outside their normal geographical footprint.

A member of staff who had completed Loggist training on SORT undertook the role of Loggist as there were no other staff trained.

Lessons identified – SPTMI02

Post incident processes and welfare

Areas for improvement:

When the hot debrief took place, some ICC staff were still undertaking tasks that were associated with the incident and as they had not had a clear stand down message, they did not feel comfortable stepping away. EMAs were missed off the decompression session and cold debrief invitations, the names for both came from a collated list provided to the organisers. They expected to be included in an ICC hot debrief but were not.

Staff who were responding to the incident had connections to the area and may have felt more emotional about what happened.

There was felt to be a disconnect between NWAS Senior Leadership and the staff in ICC. The letter sent to those involved was impersonal, generic, and only received by email. When senior managers went to thank staff, it was a different shift in the room.

Notable practice:

SPTLs were deployed to hospitals for crew welfare, this was considered successful.

Observation

The Incident Response Plan states that ICC should be involved in the hot debrief after an incident, this does not appear to have been followed.

Lessons identified – SPTMI10, SPTMI11

5.2.2. Cohort – PES

Command and control

Areas for improvement:

Scene management was considered difficult due to the speed and how dynamic it was. Staff, other emergency service, and members of the public went to ask for assistance. There was a recognition that there was no one there to tell staff what to do until commanders arrived but it was also noted that everyone on scene was trying to do their best. Staff defaulted to normal clinical procedures.

Clarification who was undertaking what role on scene was lacking.

The first vehicle on scene was not aware it was a major incident and was met with a very challenging scene. It was observed that senior clinicians are more used to trauma and multiple casualties so might be better at managing this type of incident. There were comments which showed the scene become more stable when the clinicians arrived, and more so when the commanders arrived.

There was an element of role conflict where clinicians were managing the scene, 'higher ranking staff' were treating patients.

Access and egress were challenging due to both the environment and those attending. It was a long residential road, and no instruction had been given regarding the direction in which to approach, or where to park. The Parking Officer role had not been allocated. It was evident there was little coordination between the responding services for parking, access, or egress. Some staff had to walk a considerable distance with their equipment due to parking location.

Observation

The first, second, and subsequent resource on scene action cards set out specific roles that are to be allocated to manage the scene, access and egress, triage, and casualty care locations. These are to provide coordination, reduce the impact of vehicles blocking roads or crews having a distance to transport equipment and patients, and to make sure crews get to priority 1 patients first. Operational discretion adds a level of flexibility but the plan is prescriptive. There is nothing in the Incident Response Plan or action cards stating ICC must tell staff what route to take to access the scene and, for the first few vehicles, they might not have had time.

Lessons identified – SPTMI01, SPTMI06, SPTMI07

Scene management

Notable practice:

Staff commented that the AP and SPTL appeared to have control of an evolving scene and received enough of a briefing to be able to carry out what they were tasked with. This included 'a really good first report'. A clinical lead made themselves available and clearly voiced decision and rationale which gave situational awareness to those around them.

The HART team leader briefed staff on the way to the incident and, after meeting with the AP on scene, tasked them with setting up CCP which others considered to work well.

Multiagency partners were on scene and JESIP meetings were occurring.

The scene was considered to be well resourced with appreciation being noted for ICC getting them to scene in a timely manner including HEMS/BASICS.

Lessons identified – SPTMI01, SPTMI06, SPTMI07

Teamwork and leadership

Notable practice:

It was acknowledged that it was a very difficult scene to attend, and that people pulled together and did their best. Crews worked together to problem solve, everyone found a role. This was further enhanced by formalisation of structures. The professionalism and capability of clinicians at scene was described as 'a credit' with care, compassion and safety evident.

The teamworking extended to the police being referred to as part of the team.

Lessons identified – SPTMI01, SPTMI06, SPTMI07

Communication

Areas for improvement:

It was recognised that there was limited communication from scene to the control room but also limited questions coming from ICC. It was suggested that a METHANE being provided via the MDT would benefit incoming crews.

Staff attending were anticipating 1 patient but were met and allocated to multiple.

Some staff were passing standbys to hospitals, others were going via CIH.

Notable practice:

Using a major incident channel enabled those away from scene to stay aware of what was happening through good METHANE reports. This included that the attacker had been arrested, and the scene was safe to approach. This enabled earlier access to the scene.

Observation

The action cards provide instruction for information to and from scene and between roles as described in the ICC section.

Lessons identified – SPTMI01, SPTMI06, SPTMI07, SPTMI09

Triage and Treatment

Areas for improvement:

TST was used in part, but the bands were not. This was attributed to the speed of the incident. The nature of the injuries led most patients to be in the P1 category which then needed additional triage to establish who was more critically injured within that group. They were assessed for injuries and most suitable receiving hospital based on surgical need.

Notable practice:

TST was used to recognise severity of injury and assist in command decision making. Staff would with police who were complemented on how 'fantastic' they were with the patient, the parents and crews. Police had applied chest seals to one of the patients. Another patient rapidly deteriorated and the decision and action between NWAS and HEMS to take them to definitive care was 'seamless'.

The CCP was in a good position to bring casualties in and out within minimal delay to their care. A sheet on the floor set up by Fire and Rescue was seen to work well. There were casualties at different addresses, when NWAS were made aware, staff were tasked to assess. HART worked with FRS to search and clear the gardens.

Observation

Triage has been covered on mandatory training in 2024 and 2025 since it was rolled out by NHS England. The equipment is on the vehicles. It is not clear if staff chose to not employ the methodology including the bands, or if triage was quickly negated due to the number of clinical resources on scene. Best practice is to move from TST to normal clinical triage as soon as resources allow.

Lessons identified – SPTMI01, SPTMI07

Equipment

Areas for improvement:

A solo responder could not look at the action cards on the way to the incident. Of 24 staff who replied to the MS Forms request for information, only 4 looked at action cards.

There was equipment being taken off different vehicles which were having to travel without it. Mersey have not had training on the Shiller machines (carried by NWAA) so were unable to work with them.

Supernumerary staff did not have radios available to them. Of the 24 staff who responded to the MS Form, 8 had an earpiece and none wore them. The reason for this was not noted from the debrief, nor the impact. 16 staff change their talkgroup on scene. 2 staff had body worn video cameras, 1 used and docked it.

Observation

The Body Worn Video Camera SOP provides all operational staff with the option to collect a camera from station at the start of their shift with a view to reducing violence and aggression against staff. This includes HART staff. Section 2 of the SOP refers to commanders, command support roles, and clinical and operational leaders for whom wearing a camera when on shift is mandated. ICC Duty Manager and ROCC Tactical Commander are included in this list. The SOP does not cover staff outside of the command/leadership cohort using their camera in an incident.

By not wearing an earpiece on scene, it could allow members of the public or other non-NWAS responders to hear messages not appropriate to be shared causing an information breach. It could also increase the noise on scene making it more difficult to manage, or staff may miss messages.

Lessons identified – SPTMI01, SPTMI08, SPTMI12

Preparedness

Areas for improvement:

Comments in the debriefs included lack of training for all the roles that are listed and required, and that it is too complex. Some of the equipment was relatively new to staff who didn't feel they had enough exposure to the right training.

The focus of training was seen to be at leaders and commanders with the expectation they will be there quickly. The scenarios are remembered as arriving when the command structure is there, not while the scene is unfolding, and minimal resources are available.

Lessons identified – SPTMI01

Post incident welfare

Areas for improvement:

There was a lack of understanding about what to expect from a hot debrief and would have preferred something more local with just the debriefer and responders. The staff did not like the inclusion of cameras or Teams as they did not know who the people were and felt they were being watched.

There were differences in what people thought they needed or wanted in the time after the incident. Some wanted to go home, others to stay in work, to take time for decompression. Some wanted to be able to go to the funerals, to pay their respects and gain closure for themselves and the families but felt managers were reluctant to support this.

Observation

Hot and Cold Debriefs are explained in the Incident Response Plan and the Debrief Policy, covering the intention for identification of safety and time critical learning, and checking on the welfare of staff. Location type is also included.

Lessons identified – SPTMI10, SPTMI11

5.2.3. Cohort - Command and Command Support roles

Information flow

Areas for improvement:

It was felt that the notification process is complex, and the complexity exacerbated by lack of clarity around which team contacts which role. In addition, people who were aware of the incident were contacting each other which led to misunderstandings, inconsistent messaging, and the perception that staff were being left out.

One of the Duty NILOs was contacted by ICC, the other was made aware of the incident as a colleague saw it on C3. This caused that NILO to perceive ICC had not completed the notification cascade correctly.

Where there was a gap in information, people endeavoured to fill it. This included casualty numbers, distribution plan, and who was in the command structure. When the scene was contacted, the information was available but hadn't been passed into the command structure. Staff within the command structure were also bypassing the hierarchy as they were not getting what they needed. This had a negative cascade effect on the workload of other parts of the response.

Staff who weren't directly involved in the response but had an interest in the incident due to staff management wanted to be made aware so they could support their team. Setting up the command structure and response staff was the priority.

Different methods of communication were used including airwaves, mobile phones, Teams chats, and WhatsApp. People were contacting others that they thought had the information they wanted. When collating evidence of communication after an incident, this would need to be considered along with storage options. There was also a concern raised that those communication groups could lead to self-deployment with ICC unaware of who was attending scene. This creates a safety issue as the staff might not have the most up to date risk information, they might go to the wrong RVP or via the wrong route which causes access and egress issues, and they can't be followed up for welfare if they are not logged as attending. It was noted that staff should log on to the Green Room managers on duty page to show their availability and for ICC to allocate them to the job.

Notable practice:

Briefings were given on scene and to those away from scene. They were not always structured in the recommended templates but those who were given information felt they had enough understanding of the situation to perform their role.

Observation

The use of Teams channels and WhatsApp groups has been covered in the ICC section but, as it was also raised in this debrief, it suggests it is a pan-NWAS issue. The want for information may have exceeded the need, and discipline to keep to the process and wait for notification was lacking. This may have been with good intentions but had a negative impact elsewhere, including on workloads.

Lessons identified – SPTMI04, SPTMI09

Command and control

Areas for improvement

RVP and FCP locations were not passed so staff were attending different locations, some having to walk a distance. The disruption in communication and partial lack of situational awareness between the staff assuming a NILO role is indicative of the effect of lack of coordination.

Observations around role conflict were made, where clinicians became commanders and commanders took clinical roles. It is not clear from this debrief if this was considered a positive or negative. It was noted that this was not as per the Incident Response Plan but felt that it was clinically led which was positive for the patients. The intensity of the scene was perceived to encourage staff to focus on their clinical role, which was embedded behaviour, rather than a command role that was not. The group recommended a review of the expectations of those who will be attending scene in the first instance, and what training they would require.

Functional role allocation was not evident, particularly the Parking Officer as there were several comments about the location of all blue light service vehicles in a residential area. The absence of this role potentially caused difficulty with access and egress. The group felt the Incident Response Plan was quite prescriptive and does not have the flexibility to in implementation required for a relatively small, fast-moving, well-resourced incident and it should be reviewed.

The Command team expressed concern that some of those on scene who were not additionally trained were potentially waiting to be told what to do. They suggested this could be associated with the reduction in autonomy in their normal roles where they are encouraged to ask for support and advice around decision making. The view was the staff need to be empowered to make their own informed decisions while understanding context and implications.

JESIP huddles took place on scene but were not scheduled so there was a lack of understanding as to when the next meeting would take place which affected planning. It was observed that, when they did take place, they were effective and deconflicted issues, clarifying information and leading to better situational awareness. There was confusion over the identification of a casualty who had been triaged but the identity/location was described by different services using different terminology. No triage bands had been applied to show they had been triaged. This was not detrimental to the patient's condition but did cause concern between the agencies.

There was a comment that the Police took a while to establish if a Tactical Coordination Group (TCG) would stand. This does not need to be a Police decision and NWAS could have instigated one.

Away from scene, casualty numbers were discussed, the definitive needed to be from scene to the Tactical Commander and into the TCG. The Communications team were also privy to this as it was requested for the media statements.

The Strategic Commander requested internal meetings via Teams, managed by ROCC, to keep situational awareness. One of the attendees at scene said they found this helpful as it gave them awareness of what was happening away from scene but reflected that it was not necessarily helpful in terms of communication within a hierarchy. A record of these meetings would also need to be submitted for the evidence folders.

Observations

The functional roles are available in the Incident Response Plan, Action cards, and vehicle handbooks. Training records have not been explored for this report, so it is unclear what has been provided around how staff do the roles when allocated.

There was a mixture of staff being proactive and taking on roles themselves, and others waiting to be instructed. This reaches into waiting for the Police to dictate meeting times and location. The plans anticipate staff knowing their content and the rationale for actions provided, and the confidence to employ them.

Lessons identified – SPTMI01, SPTMI06, SPTMI07, SPTMI09

Coordination

Notable practice:

A message was put into a Teams chat for all available NILOs and loggists to book on to the Green Room, so they were seen as available, but that they were not required at that point in time. The Loggist who was deployed to the TCG was briefed by one of the NILOs to ensure they were comfortable with what they were going to be involved with. This was due to the recognition that the member of staff had connections to the area. One NILO noted they were nearest to scene, booked on, and made the Duty NILO aware so their presence and information could be coordinated. The NILO who was furthest away remained remote and worked as a coordinator. Another NILO who had been liaising with the Police, made their way to the TCG to support the Tactical Commander.

The Tactical and Operational Medical Advisors worked together to coordinate their work, recognising that one was too far away to attend scene but could complete their role remotely.

A respondent talked about a coordination room referred to as an Area Operations Coordination Centre (AOCC) being set up and considered to have good effect as it took some work away from commanders. An internal meeting was set up on Teams by ROCC and chaired by the NWAS Strategic Commander with a view to gaining and providing situational awareness. They felt that there was good cooperation from the attendees.

Good partnership working with police and fire service colleagues was noted, as was the receiving of patients at the hospitals who had been put on standby.

Observations

Utilisation of various methods of communication are shown here to be positive, noting that they may have unforeseen effects.

An AOCC is not recognised as a function or location in the plans, Major Incident Suites are.

Lessons identified – SPTMI01, SPTMI06, SPTMI07, SPTMI09

Communication

Areas for improvement

Crews reported they were told they were going for 1 patient and when they arrived on scene found multiple casualties. The expectation on arrival made them need to reframe their thought processes and expectations. Commanders commented that having a loading point and dispatching staff to it would make the process more manageable for all.

MERIT said they received limited information and were not told about the stand down. They were proactive in contacting the command structure and felt this was the reason they were included.

Communication between the NILOs was not prescribed through action cards or SOPs but worked well where there was awareness of each other's roles and responsibilities on the day. Where they got drawn into business it disrupted the communication but did not have a noted negative effect.

The commanders felt that using C3 to log all of the information was not practical or effective as it was difficult to find what information they wanted.

Lessons identified – SPTMI01, SPTMI06, SPTMI07, SPTMI08, SPTMI09

Scene management

Notable practice:

One of the responses observed that the information they received through the command team showed the scene had been cleared quickly with the benefit of on scene NWAS clinicians and air ambulance staff. Staff took responsibility for scene management with a view to saving live.

Lessons identified – SPTMI01, SPTMI07

Triage and treatment

Notable practice:

The in-person group felt that, although the TST bands were not used, there were enough resources in place to allow clinical triage (business as usual). TST is the preferred and planned method of triage in the first instance with a move to Major Incident Triage Tool or Business as Usual as soon as possible which is what took place.

Observation

TST was discussed in the ICC debrief with the same result, namely it was used in part by some staff but replaced with clinical decision making.

Lessons identified – SPTMI01, SPTMI07

Resourcing

Notable practice:

Resourcing on scene was noted as being sufficient and the respondent felt learning had taken place from previous incidents. They also observed that, even without functional roles being assigned, tasks were completed, and patients were treated.

Lessons identified – SPTMI07

Equipment

Areas for improvement:

Of the 11 commanders the responded to the MS Forms, 3 had a Body Worn Video Camera, 1 used and docked it. Comments included the observations that there was limited use of cameras on scene, and a reflection that as their role was more aligned to welfare, they would consider using it in other incidents to capture decision making.

10 members of the command team had an earpiece, 4 wore one. One reflected that getting staff to use earpieces is unlikely as getting them fitted and to work when you are arriving at that type of scene is challenging. They also felt that commanders would be reluctant to pass information over the radio if all were able to hear, and a separate channel should be used for everything apart from situational awareness updates.

5 of the 11 respondents looked at their action cards, only the NILO on scene provided comment regarding efficacy, reporting that they did not find it useful. A member of staff attending scene noted they did not see action cards being used.

3 of the 11 wore a tabard. The NILO and Tactical Commander at the TCG, Strategic Commander, and remote NILO and MERIT doctor/Medical Advisor would not be required to wear one. The Operational Commander, MERIT Doctor on scene and one scene NILO did wear tabards. Fire and Rescue NILOs did not wear one, Police NILO did. This meant the Police NILO role was clear and the on scene NILO could colocate easily.

It was observed that it was a hot day and the uniform including tabard and high visibility equipment left staff prone to overheating. Some staff wore helmets which made them identifiable, but the lack of high visibility jackets meant they blurred into the background with the number of people on scene.

Observations

The action cards for all commanders instruct that the cards must be used, talk groups checked and utilised, and all commanders and functional roles with the exception of Tactical and Strategic Commanders and the NILO should wear a tabard.

Action cards for all on scene state the donning of PPE is required.

The Body Worn Video Camera SOP stats all clinical leaders and commander should access cameras when on shift and use them in major incidents.

Lessons identified – SPTMI01, SPTMI08, SPTMI12

Post incident welfare

Areas for improvement:

Comments were made as to the lack of guidance available in plans to staff required to run hot debriefs. Bringing all responders together was challenged in the in-person responses, suggesting smaller, local debriefs supporting welfare would be more appropriate. This would require local managers to have suitable training as they have more rapport with their staff, and it would not have been perceived as 'a wider NWAS thing'. The in-person group felt the debrief should be more welfare based and could be completed at hospitals.

Recovery was explored by one of the respondents, replicating the response structure with a recovery one, allowing the response to be handed over. They felt this should be taken on by corporate support teams rather than 'an over reliance on Service Delivery Commanders'. They referenced collation of evidence and data as part of the recovery.

Good practice:

Staff allocated to the care of staff at the debrief felt they had received a good brief which helped them understand what the responders had been involved in and how to amend their behaviour accordingly. Confusion about who was taking what role in the debrief was quickly rectified and that the location had been arranged well. Food and drink were provided, and the site was private which allowed staff to show their emotions.

Observation:

As covered in the PES debrief observation, the rationale for hot and cold debriefs are set out in the Incident Response Plan and Debrief Policy. This includes cognisance around staff welfare.

Lessons identified – SPTMI10, SPTMI11

5.3. Lessons identified

Lessons were identified from the themes shown in the previous section. They are articulated to show an evidence-based conclusion, based on analysis of observations and insights from experience, documenting an issue and cause where known[3] .

The recommendations are based on the lessons and written to

- be easily understood,
- provide guidance on a practical course of action and initial steps to resolve gaps,
- be specific, measurable, achievable, relevant and timebound

More specific actions to achieve this, also written as SMART, are provided and may be supported by separate action plans reporting into Trust learning governance structures.

[3] UK Resilience Academy (2024) *Lessons Manage Best Practice Guidance*

ID	Lesson	Recommendation	Owner
SPTMI 01	Induction, mandatory and exercise training scenarios did not prepare operational staff for a mass casualty incident of this type. They expected a command structure to be in place, to be allocated tasks, for the patients to be adults. They did not feel prepared for an evolving scene as previous exercises and training had everyone in the required posts.	Ensure that all EPRR exercises that the Trust undertakes follow a structured process for development, objective setting, realistic scenario design, and are inclusive of specialist responders, commanders, and non-specialist staff. End of Q3	Assistant Director of Resilience
SPTMI 02	Induction, mandatory and exercise training is not sufficiently targeted at ICC staff, leading to them feeling unprepared for an incident of this type. It was also felt the training was infrequent, and not available to staff outside the management structure. This may have led to lack of confidence in declaring a major incident.	Review ICC EPRR training and exercising, specifically the allocation of functional roles, the separation of mainstream versus incident tasks and the use of bespoke separate major incident facilities. End of Q3	Assistant Director of Resilience Director of ICC
SPTMI 03	The amount of inbound information into the C&M ICC exceeded the capacity and skill set of key individuals. Some of those individuals were in an acting position.	Ensure that all staff, including those in an 'acting up position', with a likely key role in a major incident have been fully trained before undertaking that role. Timeframe	Deputy Director of ICC
SPTMI 04	Commander notification cascade was disjointed. NWAS Strategic Commander was not notified of the incident through formal channels.	Review and revise the notification process to the command structure and include it in training and exercises to reduce the likelihood of staff circumnavigating the process. End of Q1 26	Deputy Director of ICC

SPTMI 05	The hospital's process of calling the ROCC back after receiving an alert, and staff calling ICC for additional information increased the workload on the already busy teams.	Ensure that only those who are directly involved in the incident communicate with each other, and that the process for doing so is clear, straightforward, trained, and exercised. End of Q3	Assistant Director of Resilience
SPTMI 06	There was an information gap between the C&M ICC and the operational scene leading to both delayed information flow and decision making. Due to rapid changes at scene and possible cognitive overload, those first on scene may need to be talked through situation reports.	Review the content, and train and exercise the use of staff action cards and SOPs to ensure that they offer advice about how to identify required information, and achieve 2-way information flows including coaching of responders. End of Q4	Assistant Director of Resilience Deputy Director of ICC
SPTMI 07	The rapidly evolving scene and multiple critical patients made functional role establishment ad-hoc, leading to uncertainty of CCP, parking and operational command functions while effectively treating patients with a good level of clinical resources. This led to issues with access and egress. The Incident Response Plan was felt to be too rigid and created a complexity of response that hampered commanders	The IRP and associated SOPs should be reviewed to include incident management principles as well as absolute required actions. Training and exercising around these plans should ensure that the key roles are covered and allocated using operational discretion to afford flexibility to the incident response. The training should be for all staff not just managers/ commanders. End of Q4	Assistant Director of Resilience Training aspect links to MR20 and raised nationally.
SPTMI 08	Bodyworn video cameras were available to all response staff from their base station yet there was limited use and did not meet the expected learning from the MAI. Tabard use on scene from all partners was limited which led to difficulty identifying roles, and some ambulance staff did not wear high visibility jackets	Review the use of equipment associated with incident management to ensure it is fit for purpose, that staff understand why it is required, that it is available, and to promote use through exercising to embed behaviour. End of Q3	Director of ICC Area Director CAM

	which made them get lost in the crowd. The cause for these points is not known. Earpieces are provided to all staff yet few were used. One respondent said it was because they were difficult to attach to the radio, particularly in this type of environment. C3 and LifeX were found to be cumbersome in a rapidly moving environment and not helpful for logging information.		
SPTMI 09	Communication methods were varied across the Trust between those who were responding and those not involved. This included Teams chats, mobile phone conversations, Teams meetings, Whatsapp groups. It proved not only challenging as it allowed circumnavigating of the formal information flow but also makes evidence gathering difficult.	A formalisation of what methods can be used for communication should be in place and ensure this is monitored and complied with. T End of Q2	Assistant Director of Resilience
SPTMI 10	The current IRP does not properly set out post-incident processes. This includes welfare arrangements, plan reviews, DCIQ reporting and evidence gathering.	Create and implement a Post Incident Procedure that is measured but effective and that takes in to account the geographical challenges and demographics of NWAS staff. End of Q3	Assistant Director of Resilience .
SPTMI 11	The hot debrief carried out was poorly received and did not deliver its intended outputs and benefits which were to identify any immediate safety critical issues that need to be addressed, areas	Create and implement a post incident procedure which clearly supports welfare as well as learning and is flexible enough to be managed by local teams in response to a variety of incidents. Associated Commander training and	Assistant Director of Resilience

	of notable practice to be recognised and repeated, and ensure staff have access to welfare support. It was felt to not properly focus on immediate staff welfare needs at an individual or local group level, it was managed with area or NWAS wide lens.	wider training for first line management includes elements of Hot Debriefing and a structure for undertaking them. End of Q4	
SPTMI 12	The questions asked within the MS Forms gave some surface level data in terms of the use of equipment but no branched questions to explore rationale, challenges or opportunities. During the initial design, there were concerns about too many questions being off putting to staff who may be less likely to complete it. There was around 50% return from the ICC cohort in both MS Forms and in-person sessions, 75% MS Forms for PES and Commanders, and 50% in-person for PES which means the data may not be indicative of all the responders.	Review the debriefing and data collection process for incidents and exercises to improve levels of attendance/completion and gain stronger data. End of Q2	Assistant Director of Resilience

APPENDIX 1 - Debrief output

NHS North West Ambulance Service NHS Trust	**Structured Debrief Report Matrix**
Debrief commissioned by:	Ian Moses (sponsor)
Date of debrief:	16th Sept 1 and 2 - PES 23rd Sept - ICC 25th Sept - Commanders
Debrief location:	Formby Hall, Formby
Debrief team:	Dave Williams (facilitator) Scribe: 16th Sept Hayley Mason 23rd Sept Paul Goddard 25th Sept Hayley Mason
Debrief participants:	Available separately.
Debrief Subject:	On 29th July, a series of stabbings were carried out by an individual at a location in Southport holding an event for children. NWAS and partners declared a major incident and sent resources to scene. A hot debrief was held the same afternoon and involved a variety of staff from the response.

	3 cold/structured debriefs were held in September. Due to the numbers of staff involved, this was split into 3 homogenous cohorts – ICC, PES and Command/Command Support 12 lessons have been identified which include: • Training and exercises for staff preparedness • Review of notification procedures • Discipline around information flow and methods of communication • Incident response methodology review to improve flexibility and application of operational discretion • Review of incident management equipment both in ICC and on the ground • Review of debriefing processes Areas of notable practice include the support staff felt from those around them, the quick application of clinical procedures and decision making on scene, and the team working between multiagency partners on scene.

Integrated Contact Centre (ICC) session

Feedback

Areas for Improvement			
Item	**Identified by**	**Rec. no.**	**Comments**
Information flow			
Initial calls			
I was aware of 2 calls from members of the public for the same location, however there was originally conflicting information being given e.g. number of patients	**ICC10F, IP**	**SPTMI02** **SPTMI03**	
We had a number of calls in for the incident with varying information on all of them, trying to gather the information was very difficult due to the number of calls and all the different information presented on them.	**ICC16F, IP**	**SPTMI02** **SPTMI03**	
Declaration			
A major incident was not declared for some time so we were all trying to work together without fully understanding who was supposed to deal with what	**ICC20F**	**SPTMI02** **SPTMI03**	
Perception that there was nervousness from staff in all parts of the response structure to declare a major incident	**ICC1F**	**SPTMI02** **SPTMI03**	
I saw multiple calls coming in, all saying the same thing. CAM were not reacting to them. With the calls that were coming, we all thought someone would call the incident sooner. It just didn't happen. There seemed to be no urgency.	**ICC14F**	**SPTMI02** **SPTMI03**	

I was alerted to the incident by the CIH, the location of the incident (bordered CAL) I brought CAM's stack up and immediately saw a flurry of flags appearing on the map down one street with various problem texts which caused me to assume there was an ongoing MTA. I called the CAM DM and expressed my concerns and questioned them on what channel they were going to put the incident on. I requested he looked into the incidents and acted accordingly. I felt his concern did not meet mine therefore I decided to immediately escalate it to ICC on call. I then proceeded to contact GM DM as I was very aware this should be a major incident declaration given the information we already had. It is like the incident was not taken with the seriousness it needed and therefore the actions and processes that needed to take place took their time to evolve. Major incident declaration in my opinion should have been made at call time by ICC.	**ICC17F**	**SPTMI02** **SPTMI03**	
There seemed to be a lack of leadership at the start of the incident. This may be due to the incident being run over 2 ICCs with the incident being in Mersey, but the CIH being based in Lancs. After Major Incident was declared there seemed to be more control and order to the running of the incident.	**ICC20F**	**SPTMI02** **SPTMI03**	
When trying to decide if it should be declared a major incident by ICC a big consideration was the impact on staffing and the difficulty in staffing the major incident roles as well as maintaining BAU service	**IP**	**SPTMI02** **SPTMI03**	
Notification			
ROCC were not told about the incident by any of the ICC managers from that area	**ICC1F**	**SPTMI04** **SPTMI05**	(ROCC required to tell external stakeholders)
Strategic Commander not informed by ICC, this was done by ROCC.	**ICC1F**	**SPTMI04** **SPTMI05**	

The only negative thing that I experienced was taking a radio message from one of the crews en route to Alder Hey who expressed to me that they had been told to try and not contact the CIH so I passed a courtesy call on their behalf to the hospital.	**ICC7F**		
Command and control			
Team roles			
I wasn't sure at what point I should have tried to continue with normal business, rather than focus on the major incident, but wanted to help regarding allocation and time saving as well as dealing with other separate category 1 and 2 calls.	**ICC6F**	**SPTMI02** **SPTMI03** **SPTMI07**	
I didn't want to seem to be harassing the duty manager or performance manager regarding things they may have felt were insignificant while trying to evoke action plans etc. I felt out of my depth. I failed in my duty to try to allocate the pre-determined attendance for a major incident. I hadn't even thought about it until the Duty manager mentioned it, and I then suddenly realised.	**ICC6F**	**SPTMI02** **SPTMI03** **SPTMI07**	
In future I would link in with the Duty Manager and On call myself. This was done by my Team Leader (on my instruction) however in hindsight I should have done it.	**ICC10F**	**SPTMI02** **SPTMI03** **SPTMI07**	
The major incident cards are out of date and need changing to include CIH more. The team were acting above and beyond that morning, which started others passing on things to us that we should not have been doing.	**ICC14F**	**SPTMI02** **SPTMI03** **SPTMI07**	

CIH AP took it upon themselves to ring hospitals despite this being the responsibility of the ROCC/RHCD. This had the unintended consequence of the ROCC passing hospital enquiries through to CIH which is not their responsibility.	**IP**	**SPTMI02** **SPTMI03** **SPTMI07**	
A PES resource got diverted to Southport Hospital to meet the HEMS crews and bring them to scene – however PTS had two crews stood by waiting at Southport Hospital, but nobody had told ICC.	**IP**	**SPTMI02** **SPTMI03** **SPTMI07**	
There was no coordination of activities between the three control rooms, CIH, CHUB and ROCC/RHCD. This meant lots of actions were being done by different people/places and it was very confusing.	**IP**	**SPTMI02** **SPTMI03** **SPTMI07**	
Staffing			
Mersey control room had multiple staff positions uncovered (e.g. minus two managers and had to take a dispatcher out to act up). Broughton had core staffing numbers, but it still was not enough.	**IP**	**SPTMI02** **SPTMI03** **SPTMI07**	
Being short staffed (managers) we couldn't get into all the jobs to get all the information. We couldn't set up properly for a major incident due to staffing levels. Action cards was difficult to follow due to the staffing. We didn't have a communications officer. I think 4 members of the dispatch team had only been signed off 1 week prior	**ICC16F, IP**	**SPTMI02** **SPTMI03** **SPTMI07**	
I also felt that the control room was short staffed,	**ICC6F**	**SPTMI02** **SPTMI03** **SPTMI07**	

Management in the ICC was short staffed so I was asked to act up to Performance Manager to assist.	**ICC7F**	**SPTMI02** **SPTMI03** **SPTMI07**	
Dispatchers was shouting out information about calls they was in, I was trying to go in and out of as many as I could to try and make an informed decision on our response. The phone was going with roc on call asking about information, other Duty managers pointing out certain jobs regarding the incident.	**ICC16F**	**SPTMI02** **SPTMI03** **SPTMI07**	
I was also trying to note info and pass pre-alerts with the patients involved, whilst also trying to take information for other trauma incidents that were happening elsewhere. When I tried to get the paramedics in control to look over other jobs happening, they were unable to as they were too tied up with trying to organise this incident. It was hard to deal with this incident plus other jobs that were coming in through CIH	**ICC19F**	**SPTMI02** **SPTMI03** **SPTMI07**	
The domestic dispatcher was also deploying his own RRVs which was difficult – Manchester control has a dedicated RRV dispatch desk which would have taken some of the pressure off The dispatcher struggled to allocate resources to the incident as well as keep up with BAU incidents for their patch.	**IP**	**SPTMI02** **SPTMI03** **SPTMI07**	

Now that the ability to dual-train staff in both call taking and dispatch has been stopped it has removed a lot of resilience within ICC as staff cannot be re-deployed when needed.	**IP**	**SPTMI02** **SPTMI03** **SPTMI07**	
Communication			
Multiagency communication			
Police at scene told crews it was safe to move forward but the police had not passed that to control.	**IP**	**SPTMI05**	
No M/ETHANE report was passed from police via the ESICTRL talkgroup. Mersey control duty manager rang police for an update, but they had none and the FIM had not made any declaration (major incident or PLATO).	**IP**	**SPTMI05**	
Hospitals			
Mersey control made decision for pre-alerts to acutes to go via CIH without consultation with them – however it worked well.		**SPTMI03** **SPTMI07**	
There was a high number of 'enquiry' calls from acutes wanting more information after they had been notified of the incident – this put added pressure on staff who were already inundated with tasks		**SPTMI05**	

The biggest issues that occurred on the day was hospitals not understanding that a major incident had occurred. [Redacted] hospital was informed due to being a nearby hospital to the incident. Their switchboard advised their process is to ring back for more information- this is different to every hospital and slows the process of passing the METHANE down. Their managers then proceeded to call for more information and at one point thought this was a divert, I had to explain this was not a divert but a major incident. There needs to be learning from this as hospitals need to understand this is a major incident and they need to be prepared to receive patients and ensure NWAS are released to respond to the incident in a timely manner. [Redacted] hospital rang asking for more information/understanding of the situation- METHANE passed and reiterated its a major incident. Sites need to understand that all information will be cascaded via the major incident line and not to contact asking for more information, this ties staff up who are trying to carry out their actions.	**ICC18F**	**SPTMI05**	
Internal communication			
Strategic commander was asking for updates/information from the ROCC who in turn were having to pester ICC – strategic commander should have gone through the chain of command i.e. to Tactical.	**IP**	**SPTMI03** **SPTMI04** **SPTMI05**	
Lots of calls into ICC from people wanting information who were not directly involved with the job added to the already immense pressure on ICC due to number of tasks and lack of staffing.	**IP**		

Updates back to ICC from resources at scene were lacking (e.g. the fact that they were moving forward with the police). First resource on scene advised that it was an "emergency incident" which caused confusion in ICC who took that to mean it is not a Major Incident.	**IP**	**SPTMI03** **SPTMI04** **SPTMI05** **SPTMI06**	
First resource that was due to arrive at scene was told to stand-off due to reports of multiple attackers, however the first resource went directly to scene	**IP**		
Update from first on scene was "send me everything" which was not clear to ICC as to what that meant.	**IP**	**SPTMI06**	
ROCC found it hard to get updates from ICC or scene as it was very busy during the incident, they were unclear who was operationally running the scene and if the PDA had been allocated (recognised a lot of resources had been sent). Tactical Commander sent to different places, made it unclear to the ROCC what the command structure looked like	**ICC1F**	**SPTMI03** **SPTMI04** **SPTMI05**	
All responding managers need to be signed on to the Green Room so we know they are on duty as it was difficult to tell	**ICC1F**	**SPTMI03** **SPTMI04** **SPTMI05**	
There was little communication from Mersey and I felt like it was very chaotic, there were lots of crews shouting up, passing info etc but no-one really seemed to understand what was happening, who was dealing with what etc.	**ICC19F**	**SPTMI03** **SPTMI04** **SPTMI05**	

EMAs put into jobs “police on scene” but it is not clear if police are actually on scene or at an RV point.	**IP**		
Equipment			
Incident coordination room			
The ROCC is not set up as a major incident suite, just a meeting room, There are no radios or C3 live terminals withing the room which are needed to monitor or manage a major incident	**ICC1F**	**SPTMI08**	
The major incident suite was not used as we don't have one set up in Estuary point	**ICC16F**	**SPTMI08**	
The major incident suite was not set up as the equipment does not work and I needed to have a real time situational awareness of the incident as well supporting the staff in the dispatch suite.	**ICC8F**	**SPTMI08**	
Airwaves			
First on scene was asked multiple times to change on to the incident talkgroup but didn’t for an unknown reason.	**IP**	**SPTMI08**	
We didn't have the option to push radios over to the major incident channel since the introduction of the new LifeX system.	**ICC16F, IP**	**SPTMI08**	
IT systems			

It was difficult to see updates on C3 live due to all to the information being time stamped. C3 live can only be updated by ICC, this and the time stamping make it inappropriate for logging information. The Trust needs to look at a logging tool where more than one person can enter information which is easy accessible and can be used for handover to other commanders taking over	**ICC1F**	**SPTMI08**	
Pathways is not a speedy system to use in an emergency. For example, to get hands on chest or to control bleeding or to get a person cut down during a hanging. The system can be slow to respond once answer stem selections are chosen.	**ICC13F**	**SPTMI08**	
ICC would have benefited from the Major Incident module within C3 to help record the M/ETHANE report as well as be able to talk the crew through it to get better information.	**IP**	**SPTMI08**	
Finding the telephone numbers for doctors within LifeX is too time consuming/complex when it is time critical.	**IP**	**SPTMI08**	
Mersey control room are operating on a single screen which resulted in difficulty accessing other programmes such as SharePoint to access guidance etc. it also meant that C3 had to be minimised to get to these other programmes. Acting managers and dispatchers do not have iPads.	**IP**	**SPTMI08**	
Processes			
SORT			
Respondent was confused over the SORT element as it wasn't mentioned on the action card as one of their actions, but manager told them other points were dispatch actions not for CHUB (shows unfamiliarity with own and other actions in a major incident)	**ICC4F**	**SPTMI02** **SPTMI07**	

There is no procedure for the SORT staff deployment. The action cards for CHUB PM does not include this however dispatch thought this was a CHUB role according to their SOP.	**ICC9F**	**SPTMI02** **SPTMI07**	
The only thing that did not go well was I had x3 SORT trained ambulances sent to Ashburton in readiness for deploying the ISU PSU but I was informed that personnel or x2 of the vehicles had expired driver training and were not able to drive any or 1 of the vehicles.	**ICC8F**		
Preparedness			
Command training is very PES Ops focused, and ICC would expect bespoke ICC training. Training does not cover decision making within ICC or the ICC action cards. ICC very rarely involved in exercising and when they are it is quite scripted.	**IP**	**SPTMI02** **SPTMI07**	
Release for training/exercising is always dependent on ICC staffing and the staffing never seems to be of an adequate level to facilitate the release.	**IP**	**SPTMI02** **SPTMI07**	

ICC major incident training is only for managers and dispatchers do not receive any which disadvantages them when using the action cards or acting up. A lot of training for dispatchers is online/eLearning and they are expected to complete it whilst also at their desk on shift. Dispatchers don't have an understanding of the major incident roles within ICC – if they had that understanding they would know what to expect and what the ICC managers are going to ask of them (including information requirements). EMAs/Dispatchers need more training to give them the confidence to declare a major incident and the empowerment of staff is missing.	**IP**	**SPTMI02** **SPTMI07**	
ICC staff no longer get the opportunity to do observation shifts with PES Operations shifts with the primary reason given being staffing deficiencies and ICC being unwilling to fund it. This has caused a decline in awareness of job roles/pressures/processes.	**IP**	**SPTMI02** **SPTMI07**	
ICC Loggists get extremely limited opportunity to practice Loggist skills – event Loggist shifts are often covered by a select few staff (e.g. football clubs are covered by the same single person for the whole season) and loggists are not often used in exercises.	**IP**	**SPTMI02** **SPTMI07**	
Post incident Welfare			
Staff had personal connection to area/incident and that was not accounted for in the plan.	**IP**	**SPTMI10** **SPTMI11**	

Because I am relatively experienced, I felt I couldn't state that I wasn't sure what to do for the best. I feel that things like this should be practised more. I felt like everything was a blur and feel that I didn't really do anything useful whereas I should have been more confident in dealing with the major incident as well as the normal business operations.	**ICC6F**	**SPTMI02** **SPTMI10** **SPTMI11**	
Expected an ICC hot debrief but didn't get one. There was lots of confusion about when the hot debrief was to take place and when it did the ICC staff were still dealing with tasks related to the incident and had not had any kind of stand down message so did not feel comfortable stepping away.	**IP**	**SPTMI10** **SPTMI11**	
Issue with how staff were identified as being involved to enable them to be invited to debriefs. No EMAs attended the cold debrief. EMAs were missed off the debrief/decompression sessions. The joint hot debrief went straight to the ICC duty manager and missed the EMAs out.	**IP**	**SPTMI10** **SPTMI11**	possible that EMAs are not in a position to check emails so may have missed the invite
Felt there was a lack of thanks/recognition – an unpersonal generic letter was received by email but that was all. Senior management came to ICCs to thank staff, but it was on a day when the team on duty was a different to the team who actually dealt with the incident.	**IP**	**SPTMI10** **SPTMI11**	
Staff did not get to fully 'switch off' from the incident due to the aftermath – public disorder, VIP visits, police operations etc.	**IP**	**SPTMI10** **SPTMI11**	
The hot debrief was not facilitated effectively which allowed it to degenerate into a "blame game".	**IP**	**SPTMI10** **SPTMI11**	

Notable Practice			
Item	**Identified by**	**Rec. no.**	**Comments**
Teamwork and leadership			
Three duty managers across three control rooms worked well together as they routinely work together so there was a strong working relationship already in situ. Broughton control room allocated resources and advised Mersey control room afterwards which worked well and was appreciated. Support and resources from CAL and GM was freely offered and gratefully received.	**IP**	**SPTMI02** **SPTMI07**	
In the clinical hub, clinicians were focusing in and around the area to deflect from hospital, this worked really well as a team and I'm very proud of everyone on duty that day.	**ICC3F**	**SPTMI02** **SPTMI07**	
GM DM was really helpful talking me through the action cards when I got confused	**ICC4F**	**SPTMI02** **SPTMI07**	
I found the whole incident very organised	**ICC4F**	**SPTMI02** **SPTMI07**	

Informed the team leader (of the type of calls being received) who came straight to the desk who stood and supported me through the call in case I needed help. I felt like if I needed them they were there.	**ICC5F**	**SPTMI02** **SPTMI07**	
I noticed how the Duty Manager and Performance Manager were focused and working extremely well together. They were calm, direct and that gave me the confidence to carry on with my roll.	**ICC7F**	**SPTMI02** **SPTMI07**	
Supervisors were supporting other staff on calls. I did not see any problems. The ICC was calm.	**ICC13F**	**SPTMI02** **SPTMI07**	
The team leader on duty during this incident is a trusted and competent person so this definitely helps.	**ICC13F**	**SPTMI02** **SPTMI07**	
I wasn't assigned to assist but I chose to assist due to the nature of a major incident occurring and the volume of phone traffic into the ROCC. It would have been impossible to not assist due to the volume of traffic coming into the ROCC alone, I chose to assist the coordinator by contacting the GM hospitals/ICB to help in completing action card 24 in a timely manner.	**ICC18F**	**SPTMI02** **SPTMI07**	
There was a lot of pride from the first line/immediate supervisors/managers in what their teams achieved	**IP**	**SPTMI02** **SPTMI07**	
Working under pressure			
Calltaker answered a call giving details of children being attacked and was able to talk a caller through CPR.	**ICC5F**		
I was fully supported and checked in on regularly, but I feel from a personal point of view staff struggling should have the option to leave if they feel they are struggling.	**ICC5F**	**SPTMI02** **SPTMI07**	

I actioned as many instructions as possible from Action Card 21c including calling the support centre in relation to ensuring there was enough radio capacity for the incident and that the support centre were aware that a Major Incident had been declared	**ICC8F**	**SPTMI02** **SPTMI07**	
I allocated 4 vehicles for the incident and held back any further allocation in GM West Sector until I was satisfied there were enough resources to deal with the incident. I noted CAL had allocated 4 vehicles also. I monitored the incident via the dedicated radio channel and the 1st sitrep advised that they had enough resources allocated or at scene.	**ICC8F**	**SPTMI02** **SPTMI07**	Shows good situational awareness and balancing of BAU and incident response requirements
One of the Performance Managers in GM took the initial METHANE and noted this into the incident notepad.	**ICC8F**	**SPTMI02** **SPTMI07** **SPTMI08**	
Most of the other instructions on Card 21C were actioned via the CIH such as notifying HEMS and Trauma Cell	**ICC8F**	**SPTMI02** **SPTMI07**	
The CHUB performance manager and Advanced practitioners took roles and followed the action cards	**ICC9F**	**SPTMI02** **SPTMI07**	
From a Call Handling perspective the calls were managed well. One EMA was given a description of the attacker and my Team Leader quickly located an EMA that was on a call to the police and passed this information on	**ICC10F**		

A large amount of calls came into our desk, all with different information. I approached the situation with a "clinical" mindset - of we pass over the information we have and shut the job and move on to the next one. This was a good approach, it did not give us time to think about or dwell upon the information given.	**ICC11F**	**SPTMI02** **SPTMI03** **SPTMI05** **SPTMI07**	
Everyone in the ROCC carried out their action card and answered phone calls as they came into the ROCC. The telephone traffic increased considerably with other agencies requesting more information on the incident or returning calls as per the action cards.	**ICC18F**	**SPTMI02** **SPTMI03** **SPTMI05** **SPTMI07**	
Information flow			
Regular meeting with CCD and the ROCC with a Microsoft Teams Group set up.	**ICC9F**	**SPTMI07**	
All the Management team have a teams chat and we made others aware of the first calls to come in	**ICC11F**	**SPTMI07**	
A colleague informed me that there had been multiple stabbings in the Southport area which involved children, and the situation was ongoing. This information allowed me code the call correctly Using the pathways ATTEND process for incidents with the public allows the call to be coded quicker as Pathways is not a speedy system to use in an emergency.	**ICC13F**	**SPTMI08**	

There was effective communication between NWAS control rooms to help highlight information from the various calls and consolidate it.	**IP**	**SPTMI02** **SPTMI06**	
Mersey control duty manager called major incident standby which helped organise and mobilise resources.	**IP**	**SPTMI02** **SPTMI06**	
Comprehensive and clear METHANE finally received from AP really helped the response.	**IP**	**SPTMI02** **SPTMI06**	
Preparedness			
I think things went well due to being prepared, running through possible scenarios with our dispatch team who have been prepared for this type of incident, Major Incident Training, Tabletop exercises, Commander Training. All this contributed to the outcome of providing support and assistance to the primary ICC and the incident itself.	**ICC8F**	**SPTMI02**	
Dispatchers knowing to note down their SORT trained staff through discussing scenarios and advising them what we as a management team expect off them. In the future I will Look for SORT call signs across NWAS instead of just in my geographical footprint and note these call signs into the notepad.	**ICC8F**	**SPTMI02**	
I undertook a role of a Loggist as there were no Loggist trained staff in the department and I had done a brief training session on SORT.	**ICC9F**	**SPTMI02**	
Welfare			
ICC deployed SPTLs to all acutes for crew welfare which worked well	**IP**		

PES session

Feedback

Areas for Improvement			
Item	**Identified by**	**Rec. no.**	**Comments**
Command and control			
Scene management			
Because of the scene was so dynamic and very rapidly changing it was hard to maintain control of both clinical and operational aspects of the incident as I was seen as the one in charge. Every member of staff, public and police colleagues came to me for information and instruction and help	**PES1F**	**SPTMI01** **SPTMI07**	
I had no one to tell me what to do, until my Incident commander arrived at scene some 26 minutes later. My experience was that my job was twofold initial triage and then allocation of clinical staff and trying to get an incident overview to handover to clinical and operational leadership when they arrived on scene.	**PES1F**	**SPTMI01** **SPTMI07**	
The use of SORT should have eliminated a lot of the issues that were found on scene (lack of organisation, lack of clear command structure); however, this incident has demonstrated that SORT is unfit for purpose. This incident was resolved by frontline crews doing what they always do, and that's cracking on regardless of what's thrown at them.	**PES2F**	**SPTMI01** **SPTMI07**	

I was met on arrival by the scene manager who at the time seemed to be a local SPTL and AP and I was passed a task which I undertook. Overall the scene was chaotic due to police, fire, patients, parents, homeowners, bystanders and other ambulance staff hart team etc etc everywhere all trying their best to do a job under very difficult circumstances	**PES8F**	**SPTMI01** **SPTMI07**	
On nearing scene several ambulances were leaving under police escort. Once we arrived on scene it appeared chaotic (to me this would be expected).	**PES9F**	**SPTMI01** **SPTMI07**	
We were greeted by another crew just telling us to grab our stuff and go down. We went to the nearest group of people with patients, tried to get the attention of the highest ranking staff member who seemed to be attempting to control the small situation but as he was in the middle of it all and otherwise engaged this was difficult. We were called over by a Helimed crew instead whilst taking handover from this clinician as she was elsewhere, we were told to go to a different patient by the higher ranking staff member as they were more time critical and needed transport immediately and in effect left one patient without any clinicians.	**PES3F**	**SPTMI01** **SPTMI07**	

There was still some disorganisation to the scene despite its maturity, it was originally unclear who formed the ambulance command structure on scene and took admittedly a short period of time to locate this. The incident command role was still being fulfilled by the initial advanced Paramedic on scene. I would have expected this role to have been taken over by a duty operational commander by the point at which we arrived. MERIT and NILO I believe weren't on scene on my arrival. It was originally still unclear whether all patients had been accounted for. An initial brief came from the attending BASICS team as to location of patients and priorities left on scene. We allocated ourselves a role after discussion with the acting operational commander to liaise with police to ensure a complete sweep of the scene had or was about to happen and to attend a remaining P3 casualty.	**PES19F**	**SPTMI01** **SPTMI07**	
Initially no one knew the extent of what was unfolding. First car to arrive did not know that it was a major incident and was met with multiple casualties and a devastating scene. I think what should have happened eventually did happen when further senior clinicians arrived. I feel that perhaps APs are more practiced and experienced somewhat in trauma and or multiple casualties and therefore the scene was managed more effectively once these arrived. And without a doubt more controlled when commanders arrived, including a casualty clearance point.	**PES12F**	**SPTMI01** **SPTMI07**	
Paraphrased I was immediately met with a parent and child as soon as I got out of the vehicle, my colleague went into scene. I did not know if the attacker was still at large. I liaised with trauma cell for advice and asked for a colleague via senior colleagues as my patient needed to travel. From my perspective I felt alone and not managed or guided through the process, and also not knowing if the scene was safe.	**PES12F**	**SPTMI01** **SPTMI07**	

I went in with a preconceived idea that the incident was more established than it was. We actually arrived earlier into this incident than I had anticipated. It did appear extremely chaotic at first, but then I would anticipate that most major incident of this nature would be initially be chaotic. There was no clear command at the start of this incident, but despite this I think other roles were quickly established and we started the process of doing what needed to be done very quickly, and as more and more NWAS arrived to the incident the more control we got over it. ***Paraphrased*** On our arrival, there wasn't really a command position established; however, I thought it had been established by an SP, It was extremely chaotic, and I don't think there had been a grasp on the situation we were presented with, we weren't given any direction at this time. So my colleague and I took it upon ourselves to take on differing roles in an attempt to gain some oversight of the situation. He started to establish a CCS, and then made my way through the scene to try and establish casualty numbers. As I made my way down the road, again it was extremely chaotic and difficult to establish the gravity of the incident. I passed an AP treating a cardiac arrest, who requested assistance from myself but I knew at this time I would be able to do good for greater numbers if I carried on into the scene.	**PES23F**	**SPTMI01** **SPTMI07**	
I was directed into a house by members of the public and police, where they were quite a few casualties. I began a triage process on these casualties, and then once priorities were established, I then began the process of getting them to the CCS. Other casualties had begun to be taken here and more NWAS personnel began to arrive and the incident began to feel like we had more control of it. Another AP had arrived at this time that seem to take command.	**PES23F**	**SPTMI01** **SPTMI07**	

I think the timing of HART arriving and the operational commander arriving was approximately the same time, I did not identify the operational commander initially and therefore carried on with what I thought best at the time, I had an initial brief from an AP but it was not until late into the incident that I fully understood what had happened and the location of the attack.	**PES6F**	**SPTMI01** **SPTMI07**	
Access and egress			
I arrived on scene and was no one advising where the ambulances needed to be, so I just parked the ambulance anywhere in the street. I then walked to scene and went and found someone who could tell me who I needed to treat. I was then advised this patient needed treating and this hospital is where they need to go No parking officer maybe due to the chaotic scene and with it all happening in the middle of the street and us all arriving from different sides of the street. In future, maybe voice up on route to ask if there is someone specific you would like us all to meet or a certain road to approach on.	**PES4F**	**SPTMI01** **SPTMI07**	
Arrived at scene and parked anywhere.	**PES3F**	**SPTMI01** **SPTMI07**	
Arrived on east end hart street. Only resource to arrive that end of street. Could see other resources other end of street. Unsure what command structure was set up. Wide spread out dynamic scene. Every resource bar one arrived at one end. Took a while to reach other end of street where critical casualties also were.	**PES11F**	**SPTMI01** **SPTMI07**	

On arrival no one met us, it appeared that those who were already in attendance and ourselves had arrived via different routes. Auto arrival had not registered due to police cars being in front of us and no further access to scene.	**PES12F**	**SPTMI01** **SPTMI07**	
When we arrived, we could not get close to the scene so parked up about 200 meters away, grabbed the kit we had been tasked to carry and walked into the scene.	**PES14F**	**SPTMI01** **SPTMI07**	
We were directed by fireman who told us where to go. We couldn't get close with our vehicle because of the parking of other vehicles from all agencies. We gathered our kit, put it on the stretcher and walked down to the gathered personnel. It was a residential road so access was unusual. Agencies just parked where they could it was a narrow residential street, when initial teams arrived there was still an active threat. The scene was a mess, with parking. The person first on scene was overwhelmed I imagine. No parking officer. Fire were in the way with their vehicles.	**PES15F**	**SPTMI01** **SPTMI07**	
The incident happened on a long residential road. Because of the type of incident, there was a large amount of police vehicles that had arrived from both ends of the road. The ambulances also arrived from both ends but many were behind the police vehicles. I requested that some police vehicles be moved so that I could move some of the ambulances closer to the CCP. In an ideal world we would have had an ambulance circuit in place, but the ambulance had already arrived.	**PES20F**	**SPTMI01** **SPTMI07**	
The scene was very chaotic due to the amount of Emergency service presence. Hart street is a very narrow Road making access and Egress very difficult, but this was dealt with well and patients taken to the appropriate Hospitals.	**PES22F**	**SPTMI01** **SPTMI07**	

There were police cars in the way and, as it hadn't been declared a major incident in the early stages there was no parking point or officer, so cars were parking in different places and DCAs were being asked to move. Access and egress for vehicles was an issue.	**IP**	**SPTMI01** **SPTMI07**	
Resourcing and allocation			
I think there was a short delay in allocating HART to the incident, I would have expected the allocation to be an automatic one.	**PES6F**	**SPTMI01** **SPTMI07**	
En-route to the incident I had contacted my opposite team leader in Manchester, to inform him of the incident and monitor what was happening. I expected the Manchester HART to be re-located to Warrington in case they were needed to assist, this request was denied, and they were informed to stay on station at Manchester.	**PES6F**	**SPTMI01** **SPTMI07**	
Role conflict			
Lack of structure on arrival and overall scene management seemed to be lacking. Higher ranking staff were getting involved in treatment of patients instead of stepping out and dissecting the whole scene as to what was needed, this could be as they were thrust into a position they have never done or been trained to do so were unaware of what was needed.	**PES3F**	**SPTMI01** **SPTMI07**	
One of the problems which may have been a factor is one AP getting drawn into clinical treatment of a patient in the very early stages, however I do not know the circumstances around this.	**PES23F**	**SPTMI01** **SPTMI07**	
Communication			

Communication was difficult between crews about what was needed and, in some aspect, back to control to relay info.	**PES3F**	**SPTMI01** **SPTMI06** **SPTMI07** **SPTMI08** **SPTMI09**	
When crews left scene with patients, some put in standbys and others tried but couldn't as radio was down.	**IP**	**SPTMI01** **SPTMI06** **SPTMI07** **SPTMI08** **SPTMI09**	
Nobody ever expects a major incident to happen especially involving children. This is an extremely difficult situation for ANY clinician or commander to be involved in. Not being told about multiple children was not surprising due to being 3mins away from scene and I'd assume the volume of calls that are required to go through the pathways system would not allow the ICC staff to pass this information on quickly. It would be helpful to allow the METHANE report to be sent to all attending crews via the MDT so we have an idea of what we are attending en route to the incident.	**PES17F**	**SPTMI01** **SPTMI06** **SPTMI07** **SPTMI08** **SPTMI09**	
I was immediately told there were multiple casualties not the one we were expecting, and tasked with looking after two patients.	**PES18**	**SPTMI01** **SPTMI07**	

Communication seemed to be one way into ICC with no questions being asked back to the staff on scene who were relaying information. It felt to some of the staff on scene that they were passing enough of the right information to ICC but they now note it hadn't been.	**IP**	**SPTMI01** **SPTMI06** **SPTMI07** **SPTMI08** **SPTMI09**	
There was confusion regarding giving standbys to [receiving hospital]. We were told it wasn't required as it was a major incident by the commander on scene. On the drive to [hospital] I was contacted by 2 different controllers asking for a standby.	**PES15F**	**SPTMI01** **SPTMI06** **SPTMI07** **SPTMI08** **SPTMI09**	
I was not informed what I would be attending until I had a discussion with the MERIT DR I picked up. Communication on the open channel was hit and miss, I did not hear a METHANE message passed/updated (I may be mistaken as I was driving).	**PES9F**	**SPTMI01** **SPTMI06** **SPTMI07** **SPTMI08** **SPTMI09**	
Triage and treatment			
TST was utilised for triage which was quick to establish, almost all outcomes where P1 in nature which left a difficult task for the primary triage to sort out and prioritise people.	**PES6F**	**SPTMI01** **SPTMI07**	

Mass casualties with consistent pattern of thoracic injury overwhelming initial responses and likely capabilities of the nearest MTC. I prioritised preserving life by directing initial lifesaving treatments, I then had to determine the time order and dispersal of casualties for surgical intervention.	**PES7F**	**SPTMI01** **SPTMI07**	
I was one of the few people on scene with true overview and situational awareness, from a crew perspective each clinician determined their patient to be critically injured which was correct, however they did not understand there were other patients on scene who required surgical intervention on a more urgent basis.	**PES7F**	**SPTMI01** **SPTMI07**	
Ten second triage was not used as it was an ever-changing scene, things were dealt with on face value as more children appearing around them	**IP**	**SPTMI01** **SPTMI07**	
Equipment			
I was driving to the incident as a solo responder, so it was not possible to read [action cards] during my journey.	**PES5F**	**SPTMI07** **SPTMI08**	
Lots of kit getting mixed up and moved from varying vehicles. This resulted in some critically unwell patients being transported in vehicles with missing essential kit.	**PES11F**	**SPTMI07** **SPTMI08**	
Didn't occur to some staff to complete a PRF but the group felt that paper PRF's are needed for incidents like this. They were unable to find things to write on, the group suggested major incident pack to contain PRF's	**IP**	**SPTMI07** **SPTMI08**	

All the kit was taken off the first ambulance – everyone took their patients and just went without their kit	**IP**	**SPTMI07** **SPTMI08**	
NWAA had Shiller and crews in Mersey haven't got these yet	**IP**	**SPTMI07** **SPTMI08**	
In future I will wear my camera (clip was absent), bring incident log book, wear earpiece, wear tabards (absent), use Dictaphone to log my decisions.	**PES7F**	**SPTMI07** **SPTMI08**	
I did not book out a personal body cam on the day of the incident, this may have been a source of information gathering post incident.	**PES6F**	**SPTMI07** **SPTMI08**	
I may have been wrong but I only saw myself and the NILO wearing BWC	**PES9F**	**SPTMI07** **SPTMI08**	
I did not book out a personal body cam on the day of the incident, this may have been a source of information gathering post incident.	**PES6F**	**SPTMI07** **SPTMI08**	
Supernumerary staff didn't have radios	**IP**	**SPTMI07** **SPTMI08**	
Preparedness			

The problems are that when a major incident happens NWAS don't ever have the appropriate trained staff for the multitude of rolls that are supposedly needed at a major incident. I believe that our major incident training needs looking at and we need to simplify thinks in order to realistically co- ordinate major incidents better in future.	**PES8F**	**SPTMI01** **SPTMI07**	
Most casualties P1 and children - different to what was expected.	**PES11F**	**SPTMI01** **SPTMI07**	
Didn't feel prepared to use some of the new equipment. The training had been minimal, just a bulletin and no time off the road for training or practice.	**IP**	**SPTMI01** **SPTMI07**	
Training seems to be aimed at leaders, the further up the more training. The expectation seems to be there will always be someone from that role. There is JESIP training on the mandatory training but no major incident training.	**IP**	**SPTMI01** **SPTMI07**	
Looking on the training I have received, I feel it is has been aimed at arriving to a major incident, an example being a train crash. I have not got much recollection of any emphasis being if you are on scene with a major incident unfolding without all resources being immediately available.	**PES24F**	**SPTMI01** **SPTMI07**	
Post incident welfare			
Filming on social media – have been plastered all over the internet and media	**IP**	**SPTMI01**	
At Aintree for about an hour, police impounded the vehicles and so all had to be transported to the debrief.	**IP**		

Didn't know what to expect with the hot debrief but didn't expect it to be filmed. The staff felt there shouldn't have been people at the location who hadn't been involved, or so many managers. They also felt Teams was inappropriate, there were virtual people and other people who thought is was 'nice to be there' which was not appropriate. It should have been the debriefer and those who were involved. There were comments made at the debrief about being psychologically traumatised as it's the worst incident they had ever been to, that there was no thought or compassion, no post incident welfare. Some staff would have preferred a local debrief due to the travel distance. Some felt it was inappropriate to have the first person to stand up and relive it while people watched.	**IP**	**SPTMI10** **SPTMI11**	
Query over post incident welfare support – some felt it wasn't appropriate for people to come back into work, they needed time to decompress; some wanted to go to the station, others didn't know what they wanted to do. It was commented that different staff were being treated differently depending on what level they were. This lead to people feeling isolated and that no one cared.	**IP**	**SPTMI10** **SPTMI11**	
There was a perceived management reluctance for staff to attend the funerals. Some of the staff felt that this helped to close a chapter, they wanted to do what they felt was right for them personally. The felt it was important and not allowed, that it was the least that they could do for closure for staff as well as closure for the families.	**iP**	**SPTMI10** **SPTMI11**	
Trauma counselling was not available, and staff felt it was needed.	**IP**	**SPTMI10** **SPTMI11**	

Paraphrased Bank staff who attended and have been signed off sick can't complete their contracted hours and don't get paid. Member of staff felt like they had been dismissed.	**IP**	**SPTMI10** **SPTMI11**	

Notable Practice			
Item	**Identified by**	**Rec. no.**	**Comments**
Scene management			
There was clearly a CCP, after that it was organised chaos.	**PES2F**	**SPTMI01** **SPTMI07**	
There was a large emergency service presence with multiple Police cordon tapes to navigate. On arrival I was met by SPTL (bronze/ops commander) and another AP. They directed me to a patient in traumatic cardiac arrest and assisted with my response kit. I received clear direction of what my role was and carried out my assigned duties.	**PES5F**	**SPTMI01** **SPTMI07**	
The AP and SPTL had control of an evolving scene. They identified my skillset as being appropriate for this patient and tasked me to care for her and lead the team already caring for this critically injured child. My focus was on the task at hand and the direction I received was entirely appropriate.	**PES5F**	**SPTMI01** **SPTMI07**	
I was immediately met by the SP who was first on scene and given details of the incident, there was not many in terms of patient count as I was one of the first ambulances to arrive and the severity of the situation was still unfolding. I was given an immediate role by the SP first on scene. The full extent of the incident was not known at my point of arrival, as one of the first crews on scene. First paramedic/SP on scene gave really good first report and direction to myself and crew mate. HART & AP not on scene due to distance from incident location	**PES10F**	**SPTMI01** **SPTMI07**	

Initially I didn't identify the operational commander but I did liaise with the most senior staff member I could identify who was an AP. I received an initial brief from the AP and I tasked the HART operatives with casualty care within the CCP.	**PES6F**	**SPTMI01** **SPTMI07**	
On arrival we made our way to the ambulance commander on scene where we were given a situational update of how many patients, casualties and severity. Several JESIP meetings were held by AMBULANCE, POLICE and FIRE throughout out time on scene. I think the ridged times set for JESIP meetings was good. The information shared was informative and the plans put in place by each service was good.	**PES9F**	**SPTMI01** **SPTMI07**	
I identified the operational commander and I made myself available to him for any further direction. It was agreed during a JESIP meeting that HART and FRS staff would conduct a search within the front gardens of the road up to the levels of the police cordon. this tasking was completed once the CCP had been reduced to a manageable number of casualties.	**PES6F**	**SPTMI01** **SPTMI07**	
When we arrived, the scene was already being well managed. The dead and seriously injured had been dealt or were being dealt with by other crews. Our patient had been triaged and had some initial treatment to her wounds by the police.	**PES15F**	**SPTMI01** **SPTMI07**	
When I arrived I was met with multiple polices officers already in attendance. I was met by the acting scene manager who was able to tell me that there were multiple critically injured children. Before I was able to have a proper briefing a member of the public grabbed me and pulled me towards a child in cardiac arrest. I was told by the commander to take my kit and deal with that patient.	**PES17F**	**SPTMI01** **SPTMI07**	
Access and egress from scene was effortless with good scene control.	**PES19F**	**SPTMI01** **SPTMI07**	

It was a bit hectic at first. SPTL was in charge of the scene until relieved, he declared the Major Incident which was correct. HART had set up a CCP/CCS that worked well. Some of the ambulances were a good distance away.	**PES20F**	**SPTMI01** **SPTMI07**	
The lead SPTL was guiding people to the necessary areas of the event. Remember seeing the children receiving medical treatment. I was guided to the first patient by the SPTL to assist the other crews. Fire and Police assisting where needed. This scenario is very extreme, and nothing could have prepared anyone, was not sure of truly what I was attending but was directed accordingly on scene.	**PES22F**	**SPTMI01** **SPTMI07**	
Clinical leader was identified, and everyone worked from them and listened to them. He voiced the decision he had made and how he was thinking as he was doing it.	**IP**	**SPTMI01** **SPTMI07**	
I felt at the stage of the incident we turned up at things were under control apart from at one JESIP meeting POLICE had one extra casualty compared with AMBULANCE and FIRE. A DCA was requested to scene without delay until it was confirmed that deceased had been accounted for prior by Ambulance personnel.	**PES9F**	**SPTMI01** **SPTMI07**	
At the time it appeared to be chaos but in reflection things what needed to be done was done.	**PES16F**	**SPTMI01** **SPTMI07**	
It appeared that ICC/CIH did fantastically well with execution of the PDA and CIH with the allocation of EPHC teams, being able to treat and transport in a timely manner undoubtedly had a huge impact in outcomes.	**PES19F**	**SPTMI01** **SPTMI02** **SPTMI07**	
Communication			

I was asked to change airwave channel to the MI talk-group 131 this enabled me to listen into an initial first report from scene and a subsequent METHANE message. This gave me an understanding of the severity of the incident and the fact the attacker had been apprehended, I could then formulate a plan prior to arriving at scene.	**PES6F**	**SPTMI06** **SPTMI07** **SPTMI08** **SPTMI09**	
I briefed my team en-route to the incident and requested that certain equipment be taken to the scene on arrival.	**PES6F**	**SPTMI06** **SPTMI07** **SPTMI08** **SPTMI09**	
I do believe that a lot of time was saved due to the initial information being passed about the attacker being apprehended, this enabled staff to go straight to scene and commence casualty care as soon as possible.	**PES6F**	**SPTMI06** **SPTMI07** **SPTMI08** **SPTMI09**	
Open speech was a huge benefit and gave context, everyone found it really helpful as they felt prepared for what they were going to.	**IP**	**SPTMI06** **SPTMI07** **SPTMI08** **SPTMI09**	
Triage and treatment			

I am bronze trained so I used the ten second triage as my rule for patient care and recognising severity of injury and fatality numbers, which would then inform ICC and my decision-making process as to decide if a Major incident declaration was appropriate.	**PES1F**	**SPTMI01** **SPTMI07**	
Our patient did deteriorate rapidly and so the decision was made for Helimed to take her which happened very seamlessly and patient was able to get definitive care.	**PES3F**	**SPTMI01** **SPTMI07**	
We treated the patient with the help of police officers who were fantastic throughout with patient, mum and crews.	**PES3F**	**SPTMI01** **SPTMI07**	
The CCP was naturally in place as most casualties had already been brought to said location before our arrival. To my mind the CCP was in a good location geographically as it was in the middle of a road with access and egress from both sides, this enabled easy access for casualty loading. I believe that the CCP had occurred naturally without being officially appointed but it was in an ideal location and worked. I felt the casualties were treated and transported to definitive care in a timely manner, there didn't appear to be any delay.	**PES6F**	**SPTMI01** **SPTMI07**	
Casualty triage centre set up and worked well. Difficulty getting some patients to centre but all there eventually	**PES11F**	**SPTMI01** **SPTMI07**	
I was informed there where a number of casualties located at an address in the road, I tasked x2 members of staff to make an assessment and retrieve these casualties to the CCP.	**PES6F**	**SPTMI01** **SPTMI07**	

Casualty collection point was set up – 20ft /20ft square set up by fire, it was sheet on the floor and this worked really well – right person in charge to make those decisions.	**IP**	**SPTMI01** **SPTMI07**	
HART assisted with the loading of casualties onto ambulance stretchers under the direction of the HART SP who had been allocated the role of Primary triage officer. On removal of all casualties it was agreed with the operational commander that HART would collect all ambulance equipment left on scene and return it to the HART base station where it had been agreed that a hot de-brief would take place post incident.	**PES6F**	**SPTMI01** **SPTMI07**	
I made my way straight to the casualty clearing area, I made myself known to other members of staff and started assisting in the treatment of a child.	**PES13F**	**SPTMI01** **SPTMI07**	
As we got to the scene the Team leader tasked myself and another HART operative to go to one of the gardens and triage casualties that were known to be there. We arrived at the garden in question and triage had already happened. we then assisted the casualties to a designated CCP. I and the other HART operative were then tasked alongside some fire personnel to go forward to clear any gardens of any other casualties. after the gardens had been cleared, we then went to assist in the CCP.	**PES14F**	**SPTMI01** **SPTMI07**	

When we arrived at the incident it became clear really quickly that a lot of the initial triage and treatment had already taken place. CCP was set up really quickly from the time of our arrival and the area for this had already been identified by the AP at scene. Further assessment and treatment began quickly and efficiently. Once ambulances and conveying resources started arriving decisions were made quickly as to which hospital each patient was to attend and the loading of patients to be moved to definitive care started happening.	**PES14F**	**SPTMI01** **SPTMI07**	
Being on scene very early on I found it went chaotic, however as more support arrived, people found a role, this being dealing with the casualties on a 1-2-1 basis, others began setting up the casualty clearing station.	**PES24F**	**SPTMI01** **SPTMI07**	
When I went into the house to triage the four casualties that were in there in the initial stages, I worked with the police and members of the public, who all really pulled together to help the casualties. When I triaged these patients, every one of them that needed it, already had chest seals applied by the police, which undoubtedly help with the outcome of these patients.	**PES23F**	**SPTMI01** **SPTMI07**	

All the high priority patients had either left scene or were being treated by EPHC teams, which was brilliant. There was ample availability of NWAS resources for treatment and transport should it have been required. There were multiple EPHC teams available and on scene to provide enhanced care to patients and critical interventions were able to be carried out. Communication between clinical teams on scene was great and we had full understanding of each other roles and capabilities and we were able to formulate plans for what was still to be done.	**PES19F**	**SPTMI01** **SPTMI07**	
Team work			
Ambulance staff at scene really came together and I was really proud how well we work as a team to get tasks done and help patients.	**PES8F**	**SPTMI01** **SPTMI07**	
The people who went did the best they could in a situation that they hadn't planned or prepared for.	**PES2F**	**SPTMI01** **SPTMI07**	
We were made aware on route by our Team leader what we expected to be dealing with so on route we were tasked with getting our MTA and triage bags out to go forward and start triage any of the casualties.	**PES14F**	**SPTMI01** **SPTMI07**	
Good team effort from all that attended, very difficult scenario to attend. Crews worked together and faced the problem head on, everyone had a role to play. Even though the scene was very stressful communication was good, and a plan of action was implemented.	**PES22F**	**SPTMI01** **SPTMI07**	
I witnessed some incredible teamwork between NWAS members and also the police. It felt like we were all working together once roles had become more established.	**PES23F**	**SPTMI01** **SPTMI07**	

The professionalism and capabilities of all people on scene but especially the clinical teams was a credit and from what I witnessed provided patients with care, compassion, and safety in a stressful, high-pressure environment.	**PES19F**	**SPTMI01** **SPTMI07**	
On arrival at Southport someone was waiting on the step to received. At Alder Hey they were in high vis on road. Aintree were ready to take on patients. It was all smooth.	**IP**	**SPTMI01** **SPTMI07**	

Commander session

Feedback

Areas for Improvement			
Item	**Identified by**	**Rec. no.**	**Comments**
Information flow			
Notification			
I phoned the other on duty NILO and they told me they had found out about the job from a colleague who was looking on C3. The NILO had gone into ICC to find out the situation. This was prior to me being contacted. They had started to call partner agencies.	**C3F**	**SPTMI01** **SPTMI04** **SPTMI05** **SPTMI06** **SPTMI07**	
I was made aware by ICC which is part of the notification cascade, but the previous contact made by the other NILO at a different ICC was either not logged or not shared which caused duplication. The first actions of a NILO are not well articulated on the action card and this should be reviewed.	**C3F**	**SPTMI01** **SPTMI04** **SPTMI05** **SPTMI06** **SPTMI07**	

From my perspective, the initial notification was absent. I was alerted to the incident by a colleague and not through ICC (I was on call as NILO on the day).	**C5F**	**SPTMI01** **SPTMI04** **SPTMI05** **SPTMI06** **SPTMI07**	The other on call NILO was notified at around the same time through the ICC notification cascade.
It felt like the incident was well under way before the on-call structure were notified. As a commander not on call, I wouldn't expect to be notified, however as the sector manager for the area in which the incident was occurring there should be a notification process. This would help with staff welfare processes and as a link into the area.	**C9F**	**SPTMI01** **SPTMI04** **SPTMI05** **SPTMI06** **SPTMI07** **SPTMI09**	
Ensure the overly-complex cascade and notification process is addressed as a priority area of systemic learning. At present, predetermined attendance is clearly defined within the Integrated Contact Centres (ICC) for all Major Incident Standby and Major Incident Declared situations. However, complexity and role definition has resulted in apparent confusion between the Emergency Operations Centre (ICC), Complex Incident Hub, and Regional Operational Coordinating Centre (ROCC) which needs to be resolved.	**C10F**	**SPTMI01** **SPTMI04** **SPTMI05** **SPTMI06** **SPTMI07** **SPTMI09**	

Calls coming into 3 different areas. – MERIT got the notification they should – resources yes was correct, command staff no. Some people contacted some weren't.	**IP**	**SPTMI01** **SPTMI04** **SPTMI05** **SPTMI06** **SPTMI07** **SPTMI09**	
Calls from SMA first to ask others weren't aware – some commanders notified quickly no rush or urgency in message passing, flow of information was poor early in.	**IP**	**SPTMI01** **SPTMI04** **SPTMI05** **SPTMI06** **SPTMI07** **SPTMI09**	
Correct channels were not followed in relation to the information being passed. SMA been contacted by CIH, CIH flooded the scene. Traditional channels where not followed for information being passed.	**IP**	**SPTMI01** **SPTMI04** **SPTMI05** **SPTMI06** **SPTMI07** **SPTMI09**	

Inconsistent message, poor report and difficulty getting the information out. Lots of different methods of communication. Process not people issue.	**IP**	**SPTMI01** **SPTMI04** **SPTMI05** **SPTMI06** **SPTMI07** **SPTMI09**	
I had received multiple phone calls on the way to scene because there appeared to be an information vacuum from scene to ICC and into the wider command team, ICC or the Strategic commander had no idea on firm casualty numbers, the casualty management/distribution plan. From talking with the ops commander, it was clear there was a grip in terms of patients and numbers, but this information hadn't found its way up into NWAS.	**C2F**	**SPTMI01** **SPTMI04** **SPTMI05** **SPTMI06** **SPTMI07** **SPTMI09**	

I'm aware that the NWAS tac commander lacked information that they required from ops command. Tac had been speaking to the formally dispatched NILO whilst they were en route, but I was unaware of this information gap when I temporarily took up the NILO role. I think that the limitations of a single open channel makes staff use additional side comms channels to get around this. Tac spoke directly to the NILO en route, I spoke to another colleague who was on C3 to get up-to-date information e.g. had MI been declared? casualty numbers? etc. Every major incident that I have attended I have ended up on the phone to a trusted colleague (inc CIH) in addition to having the radio channel open to gain info such as ambos on scene or on route, information about best access or actual location, safety information. People also use WhatsApp, Teams etc which demonstrates the need for a media-rich method of asynchronous communication	**C11F**	**SPTMI01** **SPTMI04** **SPTMI05** **SPTMI06** **SPTMI07** **SPTMI09**	
Exec on call not notified	**IP**	**SPTMI01** **SPTMI04** **SPTMI05** **SPTMI06** **SPTMI07**	
Actions aren't rapid and take time. Groups are good but need control as it results in self deployment. ICC aren't always aware of which managers are on duty as they don't sign on using the green room.	**IP**	**SPTMI01** **SPTMI04** **SPTMI05** **SPTMI06** **SPTMI07** **SPTMI09**	

Command and control			
Scene management			
I was surprised to see another ambulance NILO at scene as I wasn't aware of their deployment, they also left almost immediately after my own arrival so I assumed the NILO role from them. I didn't know what they'd done NILO wise so I started at the beginning.	**C2F**	**SPTMI01** **SPTMI06** **SPTMI07**	
I didn't get passed the location of an RVP or the FCP, so had to walk approx a mile to the incident ground, getting a lift from a passerby to the cordon	**C2F**	**SPTMI01** **SPTMI06** **SPTMI07**	
Road staff wait for a 'leader' – have we taken leadership from staff and taking the decision making away? Staff no longer feel empowered to make decisions as we have made them 'ask for assistance and advice' instead of making the decisions themselves. Loss of empowerment – told to ring for advice and embedded in their role absence of decision making, new staff in the area ensure that there is cross level experience in the teams.	**IP**	**SPTMI01** **SPTMI07**	
APs on scene took on some command role functions. Commanders on scene did not take on command roles and responded as clinicians. felt like a hybrid response that was clinically based and not necessarily following the IRP expectations.	**C9F**	**SPTMI01** **SPTMI06** **SPTMI07**	Unclear if this had a positive or negative effect

The sheer devastation on scene affected staff ability to think properly about command and control. They reverted to clinicians and treated patients. This is not unusual as these staff are not immersed in command and control. NWAS needs to think about who they are putting on RRVs and who is acting in a command role. Staff need increased familiarity, training and exercising if they are to be expected to act in those roles effectively.	**C9F**	**SPTMI01** **SPTMI06** **SPTMI07**	
No handover when arrived ambulances all pointing towards each other without anywhere for egress. no parking role established, collection point, each patient had a crew with them very small area had been set up and very cramped. No formal structure other than casualty collection point.	**IP**	**SPTMI01** **SPTMI06** **SPTMI07**	
Scene was very busy due to how the street was, huddles worked well, welfares on crews that weren't dealing with patients. No formal locations in place but this was a response as per a normal incident and dealt with accordingly, not necessary a major incident more principles. Posture was possibly correct of being MI as they were still not aware of the risk to anyone following the initial attack.	**IP**	**SPTMI01** **SPTMI06** **SPTMI07**	
A review of the trust Incident Response Plan would be beneficial to ensure safe and efficient working practice is maintained in the management of all MI situations, without creating well-intentioned but overly bureaucratic / overly complex incident response plans aligned to individual action card requirements. Whilst the severity of the unprecedented attack on innocent children and adults was highly traumatic for all emergency responder agencies, the establishment of functional roles within the IRP would have potentially delayed early intervention for those most seriously injured and desperately in need of advanced life support.	**C10F**	**SPTMI01** **SPTMI06** **SPTMI07**	This is being addressed through national Clinical Response to Major Incidents workstreams to produce recommendations through learning. NWAS will align with the new guidance, as it has aligned with current guidance.
Multiagency coordination			

I felt like most of my role was trying to bring the services together to build a common operating picture rather than providing any specific tactical advice. I also found myself QAing some of the operational activity and decision making at the incident ground.	**C2F**	**SPTMI01** **SPTMI06** **SPTMI07**	
There seemed to be a lack of clarity in regard to JESIP working in that there had been some JESIP taking place however it wasn't immediately clear when the last meeting was or when the next one was planned for. The Police commander seemed very busy on the phone so it was difficult to get that going. Clearly JESIP did show its value when we got together, de-conflicted our understanding and discovered that there was an additional deceased child at scene.	**C2F**	**SPTMI01** **SPTMI06** **SPTMI07**	
Paraphrased It was distressing to learn that there was a breakdown of JESIP whereby the one patient the police were referring to was different to the one we were. All patients were accounted for, but the conversations were confused due to terminology. There wasn't any triage bands in situ or records to suggest we had already undertaken TST/MITT to indicate they were beyond help.	**C2F**	**SPTMI01** **SPTMI06** **SPTMI07**	
Police incident officer changed, which questioned about the diagnosis of death on one patient, no centralised tracking process which should have been used and wasn't on this occasion.	**IP**	**SPTMI01** **SPTMI06** **SPTMI07**	

I should have pushed harder for an updated multi-agency METHANE to be shared sooner. There may have been a benefit in completing an ERDA with [another NILO] so we had a plan should the situation have changed (second attack site for example). I need to consider how I can best support an incident as it progresses and whether I have the right equipment to do so. Having been included in internal meetings chaired by the strat comm and facilitated by the ROCC, I started to engage in activity external to scene which felt was good for my situational awareness but not necessarily for maintaining command discipline.	**C2F**	**SPTMI01** **SPTMI06** **SPTMI07** **SPTMI09**	
I think that the FIM needed more time to decide that a TCG needed forming. The delay in this I felt delayed my application of a tactical plan.	**C7F**	**SPTMI01** **SPTMI06** **SPTMI07**	
In TCG we were aware of the patient flow numbers – as this was relayed from the scene via phone. Numbers were confirmed to all required. Numbers given to the commander and different numbers and locations were wrong this came from the comms – numerous errors in the comms piece – because information was verified from scene and from CAS bureau this was allowed to be amended to the correct figures. Patient information was not able to be given as wasn't all received. We need one process for information all the way through.	**IP**	**SPTMI01** **SPTMI06** **SPTMI07** **SPTMI09**	
Roles			

At times if felt like there was command overreach in some areas and confusion with the role of the ROCC.	**C2F**	**SPTMI01** **SPTMI05** **SPTMI06** **SPTMI07** **SPTMI09**	
Action card for ICC needs reviewing in terms of when things happen. Complex Incident Hub needs clarity on role.	**C9F**	**SPTMI01** **SPTMI06** **SPTMI07**	
Over complexity – too many action cards	**IP**	**SPTMI01** **SPTMI07**	
CIH deployed people Drs ring the CIH for transport. No one sure as to who should be doing what CHI, ICC, ROCC. Over complex.	**IP**	**SPTMI01** **SPTMI06** **SPTMI07** **SPTMI09**	
Complexity of CIH when it comes to a MI – different scripts needs to be adopted and they need to be difference between BAU and MI	**IP**	**SPTMI01** **SPTMI06** **SPTMI07** **SPTMI09**	

Clear instructions given that when crews left they called CIH to inform hospitals of what they were receiving. Crews were putting in the pre alerts to hospitals.	**IP**	**SPTMI01** **SPTMI06** **SPTMI07** **SPTMI09**	
Complex incident hub deployed resources and told resources which hospitals to go to. This wouldn't be a CIH function, MERIT doctors would decide where patients went to, not sure this happened. Was the mass casualty plan enacted?	**C9F**	**SPTMI01** **SPTMI06** **SPTMI07** **SPTMI09**	
Communication			
Telling ambulance crews the exact patient they are going for is not helpful. I feel they should be dispatched to the CLP (casualty loading point) and then they will be briefed on the specific patient they will be taking as this can change, and did change during the incident. We found in some cases that crews thought they were attending patient "A" but actually when they arrived patient "B" required transport first so thus the crew had an element of "Red mist" in some way which could have been avoided. A clear CLP instruction should be given and maintained throughout so that it is clear where attending crews should go to so they can be briefed etc. Information about the patients are ever changing and need to ensure that people know about the job rather than specific patients so they aren't shocked.	**C4F, IP**	**SPTMI01** **SPTMI06** **SPTMI07** **SPTMI09**	

[NILO] had been talking to Mersey Police [message passed on Airwaves indicating this] which is not what we agreed but obviously he got the information and shared it which is positive. In future I would make sure that the comms between the NILOs in terms of roles and taskings were understood as a collective, and any NILOs added to the response link in with clear comms options.	**C3F**	**SPTMI01** **SPTMI06** **SPTMI07** **SPTMI09**	
Over the incident I had no contact with partner agencies, received some updates from NILO on scene and little from NILO at TCG.	**C3F**	**SPTMI01** **SPTMI06** **SPTMI07** **SPTMI09**	
I did not receive any information from Resilience Direct via my email at any time during the incident. (I could not access or see any information on the normal RD log in). I was not invited to any TCG meetings. I had to ask [MERIT Manager] for help getting an invite on MS Teams. It seemed to me that MERIT had been forgotten. I have a feeling that if I hadn't contacted a NILO or the tactical commander I wouldn't have been contacted by them. I think they would have been too busy to consider MERIT role at the beginning of the incident. (That is not a criticism). It would be easier if we were all at a single control location, but that was not realistic early in the incident. The geographical nature of the NWAS area makes it difficult. I think a formal system to set up a MS Teams meeting for commander and command support would be a beneficial development to aid communication and addressing JESIP principles within NWAS.	**C6F**	**SPTMI01** **SPTMI06** **SPTMI07** **SPTMI09**	

En route to the JCC I had conversations with the tactical commander regarding where they were being deployed to (scene vs JCC). I felt they should attend JCC.	**C5F**	**SPTMI01** **SPTMI06** **SPTMI07** **SPTMI09**	The Tactical commander was on their way to scene (shown in the logs)
There was limited information being passed on the open airwaves channel. When I arrived and located the operational commander, it was apparent that no seriously injured casualties remained on scene. I ensured that the dead had been formally ROLE'd - this had already taken place. I 'checked in' with my AP colleague GF on scene as a reliable source of information and priorities and liaised with the HART T/L whom I know well and recognise as another reliable source of information.	**C11F**	**SPTMI01** **SPTMI06** **SPTMI07** **SPTMI09**	
The CAD shouldn't have all the information on there it should just be a notepad as its hard to find the information required.	**IP**	**SPTMI01** **SPTMI06** **SPTMI07** **SPTMI08** **SPTMI09**	
I did not receive a stand down message. I remained available with radio on **I&S** until control reported **I&S** was closing down.	**C6F**	**SPTMI01** **SPTMI06** **SPTMI07** **SPTMI09**	
Equipment			

Limited ear piece utilisation.	**C2F**	**SPTMI01** **SPTMI07** **SPTMI08**	
On scene I noted that airwaves earpieces were not used and I did not see action cards in use. I think that the lack of earpieces meant that command colleagues were less likely to pass large amounts of information over the open channel due to the sensitivity of the content. Earpieces will never be used by crews because in the heat of battle, fitting them and getting them to work is a major faff. Command radio traffic shouldn't always have to go over the same open channel used by all crews unless it supports situational awareness.	**C11F**	**SPTMI01** **SPTMI07** **SPTMI08**	
Very limited bwvc use at scene.	**C2F**	**SPTMI01** **SPTMI07** **SPTMI08**	
As my role was more of welfare support it did not cross my mind to turn on my BWVC - this is something I would consider doing in the future in case I became more involved in any decision making.	**C8F**	**SPTMI01** **SPTMI07** **SPTMI08**	
Ops commanders should have a more suitable vehicle that we can utilise as an area to brief in etc. rather than an unmarked car which, other than the lights and sirens, is exactly what you buy from the dealer.	**C2F**	**SPTMI01** **SPTMI07** **SPTMI08**	

I would have liked to have had access to some better-quality kit to help me undertake my role, this includes uniform and tabards. It would be nice to have had some lighter weight uniform and or tabard as I was overheating and sweating due to the high temperatures on the day of the incident. Having kit that would allow us to wrap around the support functions for the command would be useful.	**C2F**	**SPTMI01** **SPTMI07** **SPTMI08**	
It was a hot day but no staff were in high visibility clothing or wearing a helmet. The helmet wasn't really a problem but when there a lots of staff at scene it is easy to lose dark green across the incident ground. I also feel our staff hung about a bit unnecessarily which left them exposed to really upsetting elements which could have been avoided.	**C2F**	**SPTMI01** **SPTMI07** **SPTMI08**	
I didn't follow the NILO action card because I didn't feel it was useful for the incident I was presented with.	**C2F**	**SPTMI01** **SPTMI07** **SPTMI08**	
The ops commander, MERIT doctor and myself were in tabards but there was no wider use at scene, no functional roles were clear although the ops commander had allocated those he felt were useful. Two of the FRS commanders at scene were NILOs but I am unaware if they were undertaking that function because there wasn't a NILO tabard worn to indicate this. The Police commander was wearing their tabard.	**C2F**	**SPTMI01** **SPTMI07** **SPTMI08**	
Post incident procedure and welfare			

Hot debrief was difficult as there is minimal guidance within the template document. It was a hot debrief across a number of parts of the organisation so had clinicians from the scene present and ICC / CIH. The staff clearly felt shell shocked by the events and it was difficult to engage them in what went well / what didn't / lessons learned. This may have been better suited as a chance for staff to meet and decompress with their colleagues. Although there was around 1.5hr of time to do this informally before the debrief started.	**C9F**	**SPTMI01** **SPTMI07** **SPTMI10** **SPTMI11**	
Only 2 staff at the debrief were SORT trained staff. this is surprising if there is a requirement for SORT attendance on this type of incident.	**C9F**		
Attempts to gather vital supporting evidence - including vehicle and body worn video camera data and lock-down of key reporting systems - appeared to initially be problematic. An apparent over-reliance on Service Delivery commanders to coordinate a variety of key actions requires a more structured approach from support service colleagues, particularly as a number of commanders were soon over-stretched in managing a series of challenging and widespread social disorder incidents. A viable suggestion would be to replicate the established multi-agency approach of 'blue-light' Incident Response with (as early as possible) simultaneous establishment of a dedicated Incident Recovery Group (led by Local Authority and supported by key partners). Within large organisations such as NWAS, this recovery and coordination function should be established by Corporate support team colleagues following a well-established and robust functional model.	**C10F**	**SPTMI07** **SPTMI10** **SPTMI11**	

TRIM need to be appropriate for this event and when appropriate – local managers be able to manage the process with guidance – staff welfare got taken away from local management which could have been dealt with locally – teaching people to do something and empowering them to do it. Do we need to look at personal resilience – if it was brough 'in house' then people would have thought more of the management rather than it being a wider 'NWAS' thing. Local level was that everyone involved in the response was visited by the king. Decompression sessions arranged and these were basically a debrief and they felt worst than before and those who weren't on scene felt worst as they were.	**IP**	**SPTMI01** **SPTMI07** **SPTMI10** **SPTMI11**	
2 days post incident and nothing gone out and lots of arranging was going on behind the scenes leaving people to 'fill the void' and it shouldn't have taken that long. No one in charge the following day which needs looking at.	**IP**	**SPTMI01** **SPTMI07** **SPTMI10** **SPTMI11**	
Hot debrief should be more welfare – there could have been more of a debrief with the crews individually. Crew expectation as to what a hot debrief should have been was not delivered – this is down to staff and commanders training. Debrief could be done at the hospital with a crew which is more personal, localised.	**IP**	**SPTMI01** **SPTMI07** **SPTMI10** **SPTMI11**	

Notable Practice			
Item	**Identified by**	**Rec. no.**	**Comments**
Information flow			
I had a very short briefing from the first person on scene	**C1F**	**SPTMI01** **SPTMI06** **SPTMI07**	
I did receive a briefing from the operational commander and broadly speaking it did cover all aspects of the IIMARCH however not in a structured sense. I did feel though like I had reasonably good situational awareness from this	**C1F**	**SPTMI01** **SPTMI06** **SPTMI07**	
From talking with the ops commander it was clear there was a grip in terms of patients and numbers	**C2F**	**SPTMI01** **SPTMI06** **SPTMI07**	
I heard [NILO] pass an effective brief on open channel to say that the scene was safe to attend. He had been talking to Mersey Police which is not what we agreed but obviously he got the information and shared it which is positive.	**C3F**	**SPTMI01** **SPTMI06** **SPTMI07** **SPTMI09**	

I also made Assistant Director Resilience aware in case he was asked about it. There is no process for it, but I recognise the implications of the leader of Resilience being in a NWAS or external meeting and being caught on the back foot. I made it clear we didn't need him to do anything, it was for awareness only.	**C3F**	**SPTMI07** **SPTMI09**	
The information I received was concise and accurate. It appeared that those on scene had communicated well and good note taking had taken place. The crews appeared to 'help each other out' at the hospital and were very supportive of each other.	**C8F**	**SPTMI01** **SPTMI06** **SPTMI07**	
Scene management			
Based on the information received through the incident command team, the entire scene appeared to have been cleared relatively quickly with the benefit of on-scene clinicians and arrival of Helimed doctors mobilised to support the incident response.	**C10F**	**SPTMI01** **SPTMI06** **SPTMI07**	
Key individuals took responsibility in relation to scene management which is believed to have sustained life amongst a number of severely injured children suffering significant puncture wounds and lacerations, together with a smaller number of seriously injured adults.	**C10F**	**SPTMI01** **SPTMI06** **SPTMI07**	
I realised that the ground-assigned NILO had not yet arrived, so took my clinical equipment back to my car and got my NILO tabard out and rejoined the operational commander. My priority was to ensure that all casualties had been located, accurate casualty numbers were in hand, and then that the first steps of recovery were undertaken - immediate staff welfare and recovery of staff, vehicles, and equipment to an NWAS site (Storrington Ave as suggested by HART T/L).	**C11F**	**SPTMI01** **SPTMI06** **SPTMI07**	

TM arrived as the ground-assigned NILO and I handed over to him as I was not yet officially on the NILO rota.	**C11F**	**SPTMI01** **SPTMI07**	
I didn't contact the hospitals directly as per Action Card 17, point 12. All casualties were evacuated quickly, it appears efficiently, and I received this information after they had left scene and at that stage pre alert messages (I assume) would have informed receiving hospitals.	**C6F**	**SPTMI01** **SPTMI06** **SPTMI07**	Shows action card was referenced.
Triage, treatment and transport			
TST bands - triage process took place on P1s but no band application as it was so quickly and each patient had a crew – so didn't need a triage as it was a clinical triage rather than a numbers triage as we had enough resources in places.	**IP**	**SPTMI01** **SPTMI07**	
Coordination			
I suggested that, as I was remote and in an office, I should be the static point of contact finding information and making contact with partner agencies as my colleague was better placed to attend TCGs and couldn't effectively do the calls while driving. This was agreed.	**C3F**	**SPTMI01** **SPTMI05** **SPTMI06** **SPTMI07** **SPTMI08**	

I put a message onto our Team channel to ask available staff to book on to the greenroom so ICC and others could see they were available to respond if needed. I got a phone call from [NILO] to say he had booked on, spoken to ICC, and was on route to scene as NILO. I kept the team up to date on the Teams chat without sharing anything inappropriately.	**C3F**	**SPTMI01** **SPTMI05** **SPTMI06** **SPTMI07** **SPTMI09**	
[NILO] recognised he was relatively near scene, experienced working there, and having a NILO at scene to support the commander was entirely appropriate. He booked on and let a Duty NILO know. NILO attendance at scene is covered in the IRP and action card but the coordination does not explicitly exist in any of our processes. This showed situational awareness from training and experience.	**C3F**	**SPTMI01** **SPTMI05** **SPTMI06** **SPTMI07** **SPTMI09**	
I was tactical medical advisor. I contacted tactical commander and NILO by phone. I made myself available for advice and provide support. I informed them that [MERIT doctor] was going to scene as operational medical advisor. I felt I could be more useful and efficient working remotely than trying to work on the role whilst travelling to Southport from Penrith.	**C6F**	**SPTMI01** **SPTMI05** **SPTMI06** **SPTMI07** **SPTMI09**	
Paraphrased – Although there was in initially confused picture due to notifications and messages, we established trust response to a Major Incident - defined within Incident Response Plan (IRP) and aligned to JESIP principles along with NARU guidance - worked well.	**C10F**	**SPTMI01** **SPTMI06** **SPTMI07** **SPTMI09**	

Providing support in AOCC worked well. It allowed some work to be removed from commanders and an extra set of ears / hands.	**C9F**	**SPTMI01** **SPTMI05** **SPTMI06** **SPTMI07** **SPTMI08** **SPTMI09**	
After contacting key individuals to gather situational awareness I requested ROCC Tx to establish an initial Southport MI Review Meeting of key trust personnel on MS Teams for 13:10. I chaired the meeting outlining the JDM model to be followed by all attendees and then requested updated situational awareness from key individuals to establish risks and develop a working strategy. Details of the trust tactical plan (CSCATTT) were requested with a stated intention to minimise any potential for delay of casualties from scene. Good cooperation received from all meeting attendees with focus on MI response plan, intended recovery plan and anticipated requirements to establish comprehensive psychological support to trust personnel - as deemed appropriate. Direction followed established JESIP principles, NARU guidance, NWAS Trust Incident Response Plan, and established College of Policing multi-agency working (MAGIC).	**C10F**	**SPTMI01** **SPTMI05** **SPTMI06** **SPTMI07** **SPTMI08** **SPTMI09**	
Good partnership working with police and fire.	**C4F**	**SPTMI01** **SPTMI07**	

Receiving of the patients was excellent and hospitals where very complimentary of NWAS – Aintree took a child which they didn't have to do – all received. All hospitals and Major Trauma where put on standby to receive.	**IP**	**SPTMI01** **SPTMI05** **SPTMI06** **SPTMI07**	
loggists were updated and made aware of what they were going to and what they would hear. Preparing for the job, nice to have the heads up from people to make awareness of the 'type of job'.	**IP**	**SPTMI01** **SPTMI06** **SPTMI07** **SPTMI09**	
Resourcing			
I felt that despite no designated roles, tasks got completed and patients got treated in a fluid manner.	**C4F**	**SPTMI01** **SPTMI07**	
There was the correct number of resources in attendance in a timely fashion and there has been learning from previous incidents.	**C4F**	**SPTMI01** **SPTMI07**	
MERIT got the notification they should – resources was correct.	**IP**	**SPTMI01** **SPTMI04** **SPTMI07**	

Everyone (Resilience) who was available was asked to make themselves shown on the greenroom.	**IP**	**SPTMI01** **SPTMI06** **SPTMI07** **SPTMI09**	
Post incident and welfare			
The brief was good, I felt I had a good understanding of what the staff members had witnessed and it enabled me to be more sensitive with the staff I spoke to. I spoke to the crews about attending the HART base where a debrief was going to take place.	**C8F**	**SPTMI01** **SPTMI06** **SPTMI07** **SPTMI10** **SPTMI11**	
On arrival to the HART base there was initially some confusion about who was going to do the debrief but that was soon rectified. There had been good communication with ICC to ensure that despite the crews attending various hospitals across the region, all were able to relocate to the HART base for debrief. I felt that the location of debrief was arranged well - it was private, so staff did not have to hide emotions, welfare provisions had been arranged and the debrief was done in a constructive way. I initially thought I would have to assist with the debrief but on arrival to the HART base a more senior manager and managers from the Merseyside area attended.	**C8F**	**SPTMI01** **SPTMI06** **SPTMI07** **SPTMI10** **SPTMI11**	

We believed that one of the ambulance crews that had taken a casualty in cardiac arrest to Southport Hospital had returned to scene and taken another casualty to Ormskirk. I recommended that I deploy to Ormskirk to support the welfare of that crew and to recover them back to Storrington Ave. The crew had not actually transported the casualty in arrest and were ok.	**C11F**	**SPTMI01** **SPTMI06** **SPTMI07** **SPTMI10** **SPTMI11**	

APPENDIX 2 – MS Forms questions and responses

PES

24 respondents

- When you were sent to the incident, did you know that it was a Major Incident?
  - 17 x yes
  - 7 x no
- When you arrived at scene on the 29th, what did you expect to happen?
  - NARRATIVE PROVIDED
- What actually happened or what did you see happening? What was your experience of attending the incident?
  - NARRATIVE PROVIDED
- Why do you think the things that you talked about in question 3 happened?
  - NARRATIVE PROVIDED
- Is there anything that you would do differently next time you go to a major Incident?
  - NARRATIVE PROVIDED
- Did you look at your Action Cards?
  - 4 x yes
  - 20 x no
- Did you have an earpiece for your Airwave radio?
  - 8 x yes
  - 16 x no
- Did you wear your Earpiece?
  - 0 x yes
  - 8 x no
- Did you have a BodyWorn Camera?
  - 2 x yes
  - 6 x no
- Did you use your BWVC?
  - 1 x yes
  - 1 x no
- Did you dock your BWVC?
  - 1 x yes
- Did you change your Airwave Talkgroup when you were on scene?
  - 16 x yes
  - 8 x no

ICC

21 respondents

- Were you aware that this call had been classed as a major incident?
  - 20 x yes
  - 1 x no
- When did you become aware that this incident was declared as a Major Incident?
  - NARRATIVE PROVIDED
- When you were assigned to this call, what did you expect to happen?
  - NARRATIVE PROVIDED
- What actually happened or what did you see happening? What was your experience of dealing with the incident?
  - NARRATIVE PROVIDED
- Why do you think the things that you talked about in question 3 happened?
  - NARRATIVE PROVIDED
- Is there anything that you would do different next time you deal with a major Incident?
  - NARRATIVE PROVIDED
- Did you look at your Action Cards?
  - 10 x yes
  - 11 x no
- Did you move to the Major Incident Suite?
  - 0 x yes
  - 21 x no
- Was the Major Incident Suite fit for purpose? Did all of the equipment work?
  - N/A
- If you didn't move to the Major Incident Suite, is there a reason that you are aware of?
  - 9 x yes
- (If yes) Why was the Major Incident Suite not used?
  - The room is step up as a meeting room does not radio or live C3 terminals to monitor or manage an incident
  - The equipment was perceived to not work and the respondents said they needed to have a real time situational awareness of the incident as well as supporting the staff in the dispatch suite
  - Respondent was needed in Clinical Hub
  - It was in another ICC so not required in the one where the respondent was based (x2)
  - There isn't one set up in the given location (CAM)
  - Not the respondent's role (unclear if that means to set it up, authorise it, or use it) (x3)
- Did you use a BWVC?
  - No x21
- Did you dock your BWVC?
  - N/A

Commanders

11 respondents

- How prepared did you feel to respond to a major Incident? (score out of 5)
  - 6 x score 4
  - 5 x score 5
- When you were sent to the incident, did you know that it was a Major Incident?
  - 6 x yes
  - 5x no
- When you arrived at your command location on the 29th, what was planned or what did you expect to happen? Please include your location, either on scene or where your remote locations was.
  - NARRATIVE PROVIDED
- What actually happened or what did you see happening? What was your experience of attending the incident?
  - NARRATIVE PROVIDED
- Why do you think the things that you talked about in question 3 happened?
  - NARRATIVE PROVIDED
- Is there anything that you would do differently next time you go to a major Incident?
  - NARRATIVE PROVIDED
- Did you use your Action Cards?
  - 5 x yes
  - 6 x no
- Did you wear a Tabard?
  - 3 x yes
  - 8 x no
- Did you use TST Triage Cards?
  - 11 x no
- Did you have an earpiece for your Airwave radio?
  - 10 x yes
  - 1 x no
- Did you wear your Earpiece?
  - 4 x yes
  - 6 x no
  - 1 x no response
- Did you have a BodyWorn Camera?
  - 3 x yes
  - 7 x no
  - 1 x blank
- (of those who responded yes to having a camera) Did you use your BWVC?
  - 1 x yes
  - 2 x no
- (of those who responded yes to having a camera) Did you dock your BWVC?
  - 1 x yes
- Did you change your Airwave Talkgroup when you were on scene?
  - 8 x yes

    - 2 x no
    - 1 x blank
- How did you record your decisions?
    - 8 x Written log
    - 8 x Notebook (and transferred to log)
    - 1 x Dictaphone
    - 1 x BWVC
    - 2 x Airwave radio

APPENDIX 3 – Glossary

APP	Advanced Paramedic Practitioner
CSP	Clinical Safety Plan
DCA	Double crewed ambulance
EOC	Emergency Operations Centre
ESICTRL	Emergency Services Intercontrol Room Talk Group
FCP	Forward Command Point
ICC	Integrated Contact Centres
IIMARCH	Briefing tool – Information, Intention, Method, Administration, Risk, Communication, Human rights
IRP	Incident Response Plan
JDM	Joint decision model
MERIT	Medical Emergency Response Intervention Team
METHANE	Situation report – Major incident declared/standby, exact location, type, hazards, access and egress, number and type of casualty, emergency service on scene and required
MOP	Member(s) of the public
NILO	National Interagency Liaison Officer
NWAS	North West Ambulance Service
PES	Paramedic Emergency Service
PPE	Personal Protective Equipment
PTS	Patient Transport Service
REAP	Resource Escalation Action Plan
RHCD	Regional Health Control Desk
ROCC	Regional Operational Coordinating Centre
RRV	Rapid Response Vehicle