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# REVIEW OF CLINICAL RESPONSE TO SOUTHPORT MAJOR INCIDENT 29 JULY 2024: ACTION PLAN AND RECOMMENDATIONS

*CMMTN & NWChMTN Southport Major Incident Clinical Review Report*

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The NHS is a learning organisation and is committed to continuous improvement.

As per the NHS England [Major Trauma Clinical Network Specification](#) one of the functions of the Major Trauma Networks is to improve quality, safety, experience and outcomes.

Following the major incident that took place in Southport on the 29th of July 2024, the Cheshire and Mersey Major Trauma Network (CMMTN) and the North West Children's Major Trauma Network (NWChMTN) were requested by the National Director for NHS Resilience to lead and coordinate a review of the clinical response to the incident.

The action plan and recommendations that have been produced following the review are being shared with you as part of the NHS commitment to continuous improvement and in order to improve quality, safety, experience and outcomes.

Although clinical reviews are a normal part of practice across Specialised Services Clinical Networks and the wider NHS it must be acknowledged that this review relates to an incident that has resulted in significant public interest. The victims and their families are and will remain to be the priority of the NHS and our partner agencies. Confidentiality must be maintained in order that we do not add to their distress or cause any additional impact on them.

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<b>Organisation</b>	Cheshire & Mersey Major Trauma Specialised Services Clinical Network (CMMTN) North West Children's Major Trauma Operational Delivery Network (NWChMTN)
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<b>Description</b>	This document is the summary of recommendations and actions from the Southport Major Incident, Clinical Case Review Meeting
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## Contents

<b>1.0 Executive Summary</b> .....	3
<b>2.0 Recommendations and Actions Table</b> .....	4
<b>3.0 Glossary</b> .....	8

### 1.0 Executive Summary

Following the major incident that took place in Southport on the 29th of July 2024, the Cheshire and Mersey Major Trauma Network (CMMTN) and the North West Children’s Major Trauma Network (NWChMTN) were requested by the National Director for NHS Resilience to lead and coordinate a review of the clinical response to the incident.

Both Networks have established governance processes and regularly facilitate case reviews at an individual patient basis as part of the Networks commitment to learning from incidents or excellence. While this incident was on a larger scale, the clinical review process followed the standard Networks processes as highlighted in the Networks Terms of Reference.

In accordance with NHS Code of Practice regarding confidentiality, and as to not influence or compromise any coronial, judicial, or other statutory reviews being undertaken concurrently or in the future, the content within this document is anonymised to facilitate the sharing of the actions and recommendations to support the opportunities for learning with stakeholders at both a local and national level at the earliest opportunity.

Although the remit of the review was to focus on the clinical response and management of patients, it has also highlighted elements of the EPRR processes which had a direct impact on the clinical management of the patients involved.

This document has been produced to support the wider communication of the recommendations and actions of the review meeting and to influence the future management of paediatric or other mass casualty/ major incidents. Whilst the potential scale and impact of any future incidents is difficult to predict, it is important that we continue to learn the lessons from recent events and utilise this to influence change and inform the clinical management for patients involved in the event of future, comparable, scenarios.

## 2.0 Recommendations and Actions Table

Major Incident Alert Actions	Action Owners
<ul style="list-style-type: none"> <li>i. A review of major incident alerts and cascading of communication should be performed by prehospital services and Regional ICB EPRR Teams.</li> <li>ii. Prehospital services to review the use of HALO's during a major incident response.</li> </ul>	Prehospital Regional ICB EPRR Teams
Existing pre-hospital divert, and deflection policy should be reviewed specifically relating to paediatric major trauma, to determine processes for patients where there may already be potential for extended travel times and to consider conveyance to the next available Children's MTC during a Major Incident, where it is clinically and logistically feasible to do so.	Prehospital Regional ICB EPRR Teams
Prehospital Setting Actions	Action Owners
Review use of chest seals by zero responders	Clinical Response to Major Incidents (CRMI) – Casualty Management Subgroup
Review of MITT and TST in penetrating trauma regarding: <ul style="list-style-type: none"> <li>i. Prioritisation for interventions i.e. blood products</li> <li>ii. Use in penetrating trauma due to all patients being assessed as P1's including those with bystander or zero responder application of tourniquet</li> </ul>	CRMI Clinically Focused Command Subgroup
For prehospital services to review triage process for identification and prioritisation patient markings for Major Incidents.	Prehospital Services
It is recommended that there be a national review of the MITT to review how prioritisation of clinical interventions and critical care team distribution can take place during a major incident.	CRMI Casualty Management Subgroup
A review of the triaging at scene and clearing of the site has been recommended by the reviewers and any learning points be fed back as part of the review process.	Prehospital Services
Review access to Airwaves Major Incident Channel for out of region mutual aid responders	NHSE Resilience
It has been recommended that the prehospital service review communication between the Complex Incident Hub and clinician in command at scene regarding allocation and arrival time of assets on scene.	Prehospital Services
<ul style="list-style-type: none"> <li>i. To review access of video footage from prehospital responder cameras to help capture critical decision making and interventions at future major or mass casualty incidents.</li> <li>ii. To explore whether footage can be used for learning and improving major incident scene management.</li> </ul>	National Ambulance Resilience Unit
Review the threshold for moving patients across regional boundaries when mass casualty threshold is not reached in special circumstances.	Regional NHSE EPRR Leads NHSE Resilience
NW NHSE EPRR have been requested to review the regional mass casualty distribution matrix to ensure it reflects current clinical capacity, provision and capabilities in units.	Regional NHSE EPRR Leads

Regional Major Trauma Networks and NHSE EPRR teams should work together to review regional major/mass casualty distribution plans ensuring that there is understanding of the status and capabilities of each organisation regarding injured children and that these capabilities are reflected in the plans.	Regional MT Networks Regional NHSE EPRR Leads
It is recommended that all adult standalone TUs and MTCs should ensure they have appropriately sized equipment available for all age groups.	Standalone Adult MTCs / TUs
The review recommends that prehospital services consider keeping families together, when possible, for the patients ongoing care as part of the major incident distribution plan.	Prehospital Services
A review should be undertaken to determine the feasibility of standardising HEMS clinical capabilities nationally.	CRMI – Casualty Management Subgroup
The review recommended that the clarification of the formal death diagnosis process be sought during major incidents.	NHSE Resilience
<ul style="list-style-type: none"> <li>i. As part of the learning from this review the process around child death in the prehospital setting during a major incident should be reviewed to ensure the families receive bereavement support and sudden unexpected death processes are commenced.</li> <li>ii. Further clarification needs to be sought around appropriate processes for traumatic child deaths and police investigations to ensure that any learning /new processes include children who are unable to be conveyed to hospital as part of criminal investigations.</li> </ul>	NHSE Resilience
Review and learning of paediatric analgesia administration in the prehospital setting	Prehospital Service CRMI Analgesia Subgroup
<b>Blood and Transplant Services Actions</b>	<b>Action Owners</b>
Network to link in with NHS Blood and Transplant Service to enquire if national blood shortage impacted on blood product availability during the major incident.	MT Networks
Defining actions to be taken during major incident stand-by and full declaration need to be clarified, specifically relating to availability of blood products to ensure that additional blood product stocks are provided to the correct organisations.	MTC / TU EPRR NHSBT
<b>Blood borne virus screens and immunisations actions</b>	<b>Action Owners</b>
All hospitals should have in place a local guideline for the screening of blood borne viruses and immunisations in the case of penetrating injury and/or major incident/mass casualty events where there is a risk of exposure.	All Hospital Trusts
<b>Reception and Resuscitation</b>	<b>Action Owners</b>
<ul style="list-style-type: none"> <li>i. Reviewers recommend that all adult stand-alone TUs and MTCs should ensure that they have paediatric sized equipment including chest drains available for young people.</li> <li>ii. Standalone adult MTCs and TUs need to ensure that they have access to paediatric guidelines and resources to ensure they can meet the needs of young people during a mass casualty/major incident.</li> <li>iii. Standalone adult MTCs and TUs to be offered paediatric trauma training</li> </ul>	Adult standalone MTCs / TUs

<p>i. Major Trauma Clinical Reference Group (MT CRG) to consider if the updated MT service specification should include availability of two CT scanners on a MTC site as a service quality standard.</p> <p>ii. For units with 1 CT scanner mitigations should be drawn up for loss of CT scanner capabilities and this should include inclusion on the Trusts risk register</p> <p>iii. Units with one CT scanner will be required to develop or review/update any existing BCPs regarding access to CT scanning capabilities in the event of unexpected outage or planned maintenance. Development and review of BCPs should be completed in conjunction with pre-hospital providers, regional EPRR teams, Major Trauma Networks and other relevant stakeholders who may be impacted.</p>	<p>MT CRG</p> <p>MTCs</p>
<p>Review of best practice to effectively deliver warmed blood to children to include:</p> <ul style="list-style-type: none"> <li>• Prehospital and reception and resuscitation</li> <li>• Equipment</li> <li>• Training and education</li> <li>• Best practice guideline development</li> </ul>	<p>CRMI – Blood Products Subgroup</p>
<p>i. Consideration if enhanced prehospital care teams can be redirected to TUs as part of a major incident plan to support the clinical capabilities in those units who have limited experience of traumatic cardiac arrest in paediatrics.</p> <p>ii. To review clinical governance arrangements for enhanced pre hospital care teams to enable them to work across hospital trusts</p> <p>iii. It was recommended that there be a review of resuscitative thoracotomy capabilities both in the prehospital and ED settings (to include training and equipment)</p> <p>iv. To review access to paediatric trauma skills courses nationally.</p>	<p>Regional NHSE EPRR Team</p> <p>NHSE Resilience</p> <p>MT CRG</p>
<p>It was recommended that regional NHSE EPRR and MTCs consider the setting up of a remote clinical advice service to include Trauma Team Leader, Trauma Surgeon, Anaesthetist and other specialities dependant on types of injuries.</p>	<p>Regional NHSE EPRR Team</p> <p>MTC EPRR</p>
<p>During a major incident, the regional trauma principles should be utilised to support the transfer of patients to the most appropriate hospital to ensure their holistic needs are met. It should be noted that this maybe via the tactical command and should be formalised as part of the hospital's major incident pathways.</p>	<p>LEHs / TUs / MTCs</p>
<p><b>Interhospital Transport Service Actions</b></p>	<p><b>Action Owners</b></p>
<p>Clarification of the role and remit of the paediatric transport service as part of a major incident / mass casualty event should be determined.</p>	<p>Regional Paediatric Transport Services</p> <p>Regional NHSE EPRR Leads</p>
<p><b>Definitive Care Actions</b></p>	<p><b>Action Owners</b></p>
<p>There should be a review of the national data to ascertain best practice for children regarding primary wound washout and closure rather than having repeat surgical interventions.</p>	<p>BSCOS</p> <p>BAPRAS</p>
<p>The regional Paediatric Critical Care Operational Delivery Networks should be involved in regional major incident / mass casualty planning this should include:</p>	<p>PCC ODNs</p>

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<ul style="list-style-type: none"> <li>• Bed capacity (regional/national)</li> <li>• Surge plans</li> <li>• Process for transfer of patients out of PCC level 3 centres</li> <li>• Care of a critically sick child / young person under 16 years outside of paediatric critical care level 3 environment in extreme and exceptional circumstances policy</li> </ul>	
It is recommended that there is planning in place around paediatric surgery in major incidents.	SIC ODNs
To ensure equity of access to services regarding ongoing clinical management and rehabilitation care it was recommended that the regional ICB establish daily meetings with all impacted sites, designated MTCs, MT Network to reduce inequity of access to specialist services.	Regional ICBs
<b>Rehabilitation Actions</b>	<b>Action Owners</b>
Regional NHSE EPRR Teams and ICBs teams to ensure that psychological hubs are available in the event of a major incident, this should include support for staff.	Regional NHSE EPRR Teams ICBs
MTCs and TUs should support the return to school and work for patients impacted by major trauma events.	MTCs / TUs
All patients to be offered appropriate charity and third sector support	MTCs / TUs
<b>Staff Health and Wellbeing Actions</b>	<b>Action Owners</b>
<ul style="list-style-type: none"> <li>i. Regional EPRR teams to ensure that psychological hubs are available in the event of a major incident, this should include support for staff.</li> <li>ii. All Trusts review their staff health and wellbeing support in a major incident including potential trauma risk management courses</li> <li>iii. Trusts should also ensure that communications are sent to all staff groups regarding the ICB psychology hub support</li> </ul>	Regional NHSE EPRR ICBs TUs / MTCs
Organisations to identify a 'buddy' organisation to enable TRIM sessions to run effectively.	MTC / TU
<b>Major Trauma Operational Delivery Network Actions</b>	<b>Action Owners</b>
Networks should in partnership with the ICB EPRR teams agree their role in a major incident / mass casualty event.	MT SSCNs/ODNs
Networks should follow their normal governance processes around incidents and, morbidity and mortality reviews. Following a major incident this should be completed in conjunction with regional and national NHSE EPRR teams.	MT SSCNs/ODNs

### 3.0 Glossary

Abbreviation	Definition
BAPRAS	British Association of Plastic, Reconstructive and Aesthetic Surgeons
BSCOS	British Society for Children's Orthopaedic Surgery
CMMTN	Cheshire & Mersey Major Trauma Specialised Services Clinical Network
CRMI	Clinical Response to Major Incident Working Group
CT	Computerized Tomography
EPRR	Emergency Preparedness, Resilience and Response
FOI	Freedom of Information Act
HALO	Hospital Ambulance Liaison Officer
HEMs	Helicopter Emergency Medical Service
ICB	Integrated Care Board
LEH	Local Emergency Hospital
LSI	Lifesaving Interventions
MITT	Major Incident Triage Tool
MTC	Major Trauma Centre
MT CRG	Major Trauma Clinical Reference Group
NHSFT	NHS Foundation Trust
NHSBT	NHS Blood Transfusion
NW	North West
NWChMTN	North West Children's Major Trauma Operational Delivery Network
P1	Priority 1
PCC ODN	Paediatric Critical Care Operational Delivery Network
SiC ODN	Surgery in Children Operational Delivery Network
ODN	Operational Delivery Network
SSCNs	Specialised Services Clinical Networks
TST	Ten Second Triage
TU	Trauma Unit