

## Concepts in Disaster Medicine





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# What If Nice Terrorist Attack Would Have Happened in Milan? Drawing a Disaster Plan for Mass Casualty Incidents Involving the Pediatric Population

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### Abstract

Terrorist attacks involving children raised concern regarding the preparedness to treat pediatric trauma patients during mass casualty incidents (MCIs). The purpose of this project was to assess the resources available in Milan to respond to MCIs as the 2016 Bastille Day attack in Nice. Literature and guidelines were reviewed and minimal standard requirements of care of pediatric trauma patients in MCIs were identified. The hospitals that took part in the study were asked to answer a survey regarding their resource availability. An overall surge capability of 40–44 pediatric trauma patients was identified, distributed based on age and severity, hospital resources, and expertise. The findings showed that adult and pediatric hospitals should work in synergy with pediatric trauma centers, or offer an alternative if there is none, and should be included in disaster plans for MCIs. Simulations exercises need to be carried out to evaluate and validate the results.

### Background

The pediatric population has been identified as particularly vulnerable during mass casualty incidents (MCIs); however, it was often neglected in MCI response preparedness: in fact, MCI response plans often lack scenarios with pediatric patients.<sup>1</sup>

The concern regarding the management of pediatric patients during MCIs became particularly relevant after terrorist attacks in Europe targeting crowds<sup>2–5</sup> and especially after the Bastille Day attack in Nice in 2016 when 54 children were severely injured and 10 were killed.<sup>6</sup>

Due to the current lack in the metropolitan area of Milan (Italy) of a structured response plan in the event of an MCI resulting in injured pediatric patients, a team of experts in major trauma and pediatric care decided to meet and discuss the preparedness of the hospitals in the area to respond to these types of MCIs.

An MCI response plan takes into consideration a variety of factors, including the identification of the hospitals available and their preparedness to respond to an MCI. A coordinated plan among all the hospitals and Emergency Medical Services (EMS) is crucial to provide the most effective and efficient response. Communication breakdowns—between and among responding agencies and facilities, within various types of print, radio, television, Internet, and social media often occur during MCIs.<sup>7</sup> Therefore, decision making on scene during MCIs could be based on distribution keys, the priority transportation process to distribute an MCI patient to the most appropriate hospital or alternate care site, and on receiving hospitals' preparedness to receive patients declared in previously established Regional Disaster or MCI Response Plans.

### Surge Capacity and Capability

The preparedness to respond to MCIs is assessed by analyzing the surge capacity, the maximal number of patients that each hospital can handle, which represents “the ability of the system to manage a sudden, unexpected increase in the numbers of patients that would otherwise severely challenge or exceed the current capacity of the health care system.”<sup>8</sup>

The Hospital Acute Care Surge Capacity and Hospital Acute Care Surge Threshold have been defined by Bayram et al.<sup>9</sup> as the maximal number of critical casualties a hospital can care for per hour

during office hours and during nonoffice hours, such as nights/bank holidays, respectively. They are directly proportional to emergency department (ED) beds available and inversely proportional to the time spent in the ED, quantitatively benchmarked to be 2.5 h for Hospital Acute Care Surge Capacity and 3.75 h for Hospital Acute Care Surge Threshold.

The target surge capacity is often difficult to achieve when pediatric MCI patients are involved, not due to the limited number of hospital beds but often because of the lack of trained personnel and the need for specific supplies and equipment to care for an injured child. Moreover, the logistic obstacles faced during MCIs are particularly pressing when pediatric patients are involved due to the need for a coordinated action to reunite children with their families. Therefore, the surge capability, the ability “to manage patients who require specialized evaluation or interventions”, eg, highly contagious, burn patients or, as in our case, pediatric patients, also needs to be taken into account.<sup>8</sup>

### *Pediatric Trauma in the Metropolitan Area of Milan*

Between 2018 and 2019, in the entire Lombardy region in Italy, the EMS managed 96,488 rescues involving pediatric patients, 86% of which resulted in the hospitalization of the patients. Trauma accounted for 45,054 (approximately 47%) of the total. A total of 42,789 (44%) of the above-mentioned rescues occurred in the metropolitan area of Milan, with 18,500 trauma and overall, 36,348 hospitalizations (data collected from the SOREU Metropolitana database provided by the working group, not published).

In Italy there are few recognized Pediatric Trauma Centers (PTCs). The regional requirements in Lombardy<sup>10</sup> for the definition of a PTC are:

- Anesthesiologist-intensivist with pediatric expertise present 24h/d;
- Pediatrician and pediatric surgeon present 24h/d;
- Neurosurgeon and orthopedic with pediatric expertise on call 24h/d;
- The presence of a pediatric intensive care unit (ICU);

In Lombardy, which has a population of approximately 10 million inhabitants, there is only 1 designated PTC in the city of Bergamo, approximately 50 km from Milan. No PTC is present in the metropolitan area of Milan. However, there are 2 main pediatric hospitals both with pediatric ICU and surgical units: “Fondazione IRCCS Ca’ Granda – Ospedale Maggiore Policlinico”, identified by the *Direzione Regionale Welfare* of Lombardy as District Adult Trauma Center (ATC) provided with a Department of Neurosurgery, and “ASST Fatebenefratelli—Sacco, Ospedale dei Bambini Buzzi”. In addition, there are 2 multi-specialized hospitals with experience in the management of critically injured pediatric patients: “ASST Grande Ospedale Metropolitano Niguarda”, identified as Highly Specialized Trauma Centre, and “Ospedale San Raffaele”, identified as District ATC provided with a Department of Neurosurgery.

In Italy, Regional Disaster Plans (PEMAF: *Piani di Emergenza per Massiccio Afflusso di Feriti*) are compulsory by law in any hospital with an ED.<sup>11</sup> However, the surge capability for pediatric trauma patients has not yet been identified.

### *Purpose*

The aim of this study is to assess whether the Metropolitan area of Milan would be ready to respond to an MCI with pediatric patients similar to the Bastille Day attack in Nice.

The objectives of this study were to define the minimal standard requirements for the management of pediatric MCI trauma patients to identify the resources available in each hospital to respond and the overall surge capability for an MCI with pediatric patients in the metropolitan area of Milan.

The final aim is to obtain the information required to update the distribution keys based on the hospitals capabilities to receive pediatric patients that could be added to the existing Regional Disaster Plan.

### **Methods**

The work was structured as follows:

- (1) Endorsement of the local health authority: SOREU (*Sala Operativa Regionale dell’Emergenza Urgenza*) Metropolitana, the regional dispatch center, and AAT (*Articolazioni Aziendali Territoriali*) Milano, the operational headquarters for the metropolitan area of Milan.
- (2) Creation of a working group including representatives of the hospitals involved in the care of pediatric trauma patients in Milan:
  - “Fondazione IRCCS Ca’ Granda—Ospedale Maggiore Policlinico,”
  - “ASST Fatebenefratelli—Sacco, Ospedale dei Bambini Buzzi,”
  - “ASST Grande Ospedale Metropolitano Niguarda,”
  - “Ospedale San Raffaele.”
- (3) Identification by the working group of a subcommittee to collect information from peer-reviewed medical literature and guidelines on the topics of MCIs, pediatric trauma, and MCIs with pediatric patients<sup>12–15</sup>;
- (4) Consequent identification by the experts in the working group of minimal standard requirements for the management of pediatric trauma patients in the setting of MCIs used these criteria: pediatric patients included the population between 0 and 12 y of age<sup>10</sup>; JumpSTART triage<sup>16</sup> with NATO triage categories was used to stratify patients: T1 (red triage tag), highest priority, immediate danger; T2 (yellow triage tag), intermediate priority, urgent, not immediate; T3 (green triage tag), deferrable priority.<sup>17,18</sup>
- (5) A survey (*Appendix*), created by the subcommittee and validated by the working group, was distributed to evaluate the maximal surge capability of each hospital.

Each hospital filled in the survey reporting the resources available in a worst-case scenario (nights, nonoffice hours/bank holidays), as multiples of the minimal standard requirements previously identified. Solely personnel on-duty on-site (CT0) and on-call personnel that could respond within 30 min after the activation of the disaster plans (CT30)<sup>19</sup> were considered. This way the surge capability for each hospital at CT30 was identified.

- (6) A proposed simulation exercise, using the MACSIM\* simulation tool,<sup>20</sup> to evaluate and validate surge response capacities and capabilities of the participant hospitals, to recognize lacunae, and to start looking for solutions with the results shared with relevant personnel of the hospitals involved, was unfortunately unable to be carried out due to the Coronavirus disease 2019 pandemic.

Per Italian regulation, submission to the institutional review board for ethical approval was not required as this manuscript does

**Table 1.** Resources for the care of pediatric trauma patients with T1 priority

Parameter	Personnel	Equipment
Front Line	Expert in management of upper airways <sup>a</sup> Expert in ALS and DC surgery <sup>b</sup> Critical care nurse Nurse <sup>a</sup> Radiology technician Healthcare assistant	Ventilator Monitor - defibrillator RX thorax/pelvis US (E-FAST) Medications, wound care, splinters Support lines, tubes, catheters
Back Line	OR	Ventilator Monitor - defibrillator Medications, wound care, splinters Support lines, tubes, catheters
	ICU, radiology, pediatric ward	Ventilator Monitor - defibrillator CT-scan Medications, wound care, splinters Support lines, tubes, catheters

ALS = advanced life support; DC = damage control; US = ultrasound; E-FAST = Extended Focused Assessment with Sonography in Trauma; OR = operating room; ICU = intensive care unit.  
<sup>a</sup>For patients < 3 y old, mandatory pediatric expertise; for patients 3-12 y old, preferably with pediatric expertise.  
<sup>b</sup>Preferably with pediatric expertise.  
<sup>c</sup>Mandatory pediatric expertise.

not include any experimental procedures involving human or animal participants. In the survey used in the study, no personal identifiable information was collected, each hospital voluntarily participated and could withdraw at any time without penalty or repercussions.

## Results

### Minimal Standard Requirements for the Management of Pediatric Trauma Patients

Different requirements were observed depending on the triage priority assigned to the patient. The requirements for the management of patients assigned a T1 priority in both front line (resources that are involved in the primary survey and resuscitation) and back line (all the resources downstream; eg, operating room, ICU, pediatric ward) were summarized in [Table 1](#).

In the case of T1 trauma patients with less than 3 y of age, the personnel responsible for airway management should have experience in the care of pediatric patients. For T1 patients 3-12 y of age, pediatric care expertise was preferred but not mandatory. Pediatric care expertise included either daily management of pediatric patients or possession of certified competency training (eg, postgraduate training in pediatric care, master degree as certified pediatric nurse, or PALS—Pediatric Advanced Life Support), and maintenance of these competencies.

According to Lynn et al.,<sup>12</sup> the required operating rooms to T1 patients' ratio is 1:10. For this reason, the equipped operating rooms were considered back line resources, and it was convened that the front line team (ie, the personnel in [Table 1](#)) could also make up the surgical team in the back line. The presence of an ICU specifically for pediatric patients was not considered mandatory; however, the presence of experienced pediatric intensivists was indicated. On the other hand, the presence of a specific pediatric ward was necessary to admit pediatric trauma patients. The hospital should also have a blood bank with immediate availability of blood products.

For the management of T2 patients ([Table 2](#)), there should be at least 2 medical doctors and 3 nurses for every 3 pediatric trauma

patients: each patient should be assigned a dedicated nurse. For each patient, there should be an oxygen supply port and a monitor—defibrillator. An ultrasound ought to be available in the T2 area to perform E-FAST.

For the management of T3 patients ([Table 3](#)), there should be at least 1 medical doctor and 2 nurses for every 6 pediatric trauma patients.

### Surge Capability

The 4 hospitals included in the study would be able to treat simultaneously 8 patients with the highest priority (T1) - up to 5 with less than 3 y of age and additionally another 3 if older than 3 y of age; 8 to 12 patients with intermediate priority (T2), and 24 patients with deferrable priority (T3). The capacities for each hospital were reported in [Table 4](#). Overall, the surge capability for pediatric patients calculated in the metropolitan area of Milan was of 40 to 44.

### Limitations

The study did not involve the regional PTC, located in Bergamo, because it is out of the metropolitan area of Milan. The contribution of the representatives of the PTC could have been of significant value in terms of knowledge and expertise. The study failed to include other relevant resources:

- An ATC with pediatric expertise 15 km far from Milan City Center (Ospedale San Gerardo di Monza), because at the time of the study, it was located outside the catchment area of the SOREU Metropolitana.
- Ospedale Santi Paolo e Carlo, an entity with both trauma and pediatric expertise located in 2 different structures, part of the same trust after the study was carried out;
- Other hospitals with pediatric wards, although with no expertise in trauma or intensive care.

The working group agreed to approach these in a later phase. Most of the literature available addresses the clinical management of pediatric trauma patients also in the context of MCIs;

**Table 2.** Resources for the care of pediatric trauma patients with T2 priority

Personnel	Equipment
Expert first evaluation/management of trauma patient <sup>c</sup>	Oxygen – aspirator
Pediatrician/neonatologist	Monitor – defibrillator
Trauma surgeon/Emergency emergency doctor with experience in trauma care	Medications, wound care, splinters
Critical care nurse	Support lines, tubes, catheters
Nurses <sup>b</sup>	
Healthcare assistant	

US = ultrasound; E-FAST = Extended Focused Assessment with Sonography in Trauma.

<sup>b</sup>Preferably with pediatric expertise.

<sup>c</sup>Mandatory pediatric expertise.

**Table 3.** Resources for the care of pediatric trauma patients with T3 priority

Personnel	Equipment
Pediatrician/neonatologist	Oxygen – aspirator
Nurse <sup>a</sup>	Medications, wound care, splinters
Nurse <sup>b</sup>	Support lines, tubes, catheters
Psychologist	

<sup>a</sup>Preferably with pediatric expertise.

<sup>b</sup>Mandatory pediatric expertise.

**Table 4.** Surge Capability capability (n = pediatric trauma patients)

Hospital	Triage Priority				Total
	T1 (<3 y)	T1 (>3 y)	T2	T3	
Fondazione IRCCS Ca' Granda Ospedale Maggiore Policlinico	1	1	2-3	6	10-11
ASST Fatebenefratelli Sacco, Ospedale dei Bambini Buzzi;	1	-	2-3	6	9-10
ASST Grande Ospedale Metropolitano Niguarda;	2	1	2-3	6	11-12
Ospedale San Raffaele	1	1	2-3	6	10-11
<b>Total</b>	<b>5</b>	<b>3</b>	<b>8-12</b>	<b>24</b>	<b>40-44</b>

however, the planning of the organized response to MCIs with pediatric trauma patients on a territorial level is less discussed. Furthermore, while many studies have been conducted on the care of single pediatric trauma patients, the standardization of the resources necessary for the concomitant management of multiple pediatric trauma patients is less investigated and deserving of further study.

Last, the survey used in the study was created by the subcommittee of the working group and needs external validation.

## Discussion

In the response to MCIs, including the terrorist attack in Nice, ATCs have been used to treat pediatric patients<sup>21</sup>: hospitals with different skills and resources should collaborate to match resources and patients' short and long-term care needs. The transport of a

pediatric trauma patient to a PTC should be indicated if the patient is stable and the transport time is within acceptable limits. ATCs with pediatric expertise could offer an alternative in case PTCs are not present, too far, or without enough resources to treat all the pediatric victims of the MCI.<sup>22</sup> Pure pediatric centers, which are not prepared to treat critical and trauma patients in their ordinary activity, can contribute by treating less severe patients or eventually admitting transfer patients after resuscitation, damage control surgery, and other stabilization treatments that have been carried out in PTCs or ATCs.<sup>23</sup> This synergy allows increasing scale economies: the overall surge capacity and capability would be higher than the simple sum of the single hospital resources.

For this reason, Disaster or MCI response Plans ought to be drawn considering all the available resources in the geographic area of interest, including PTCs, ATCs with pediatric expertise, pure pediatric hospitals, and general hospitals with pediatric wards and considering scenarios of MCI with pediatric victims.

During the terrorist attack in Nice, many victims, both adults and children, were transported by bystanders and by the first ambulances to the closest hospital, which happened to be a pediatric hospital, before a proper triaging and distribution plan was implemented.<sup>24</sup> Clear, pre-established hospital distribution keys would facilitate the initial response to MCIs and avoid overloading of the hospitals closest to the event with patients that are more appropriately treated at other hospitals that have the appropriate staff, staff, and structures. This is particularly evident if a hospital receives an overwhelming number of patients who self-refer, by their own means, and then would require transfer to a hospital that can attend to their needs.

The aim of the study was to define a method with which the jurisdiction can jointly broach the subject of the response to MCIs with pediatric trauma patients.

The team initially worked to identify the minimal resources needed for the care of pediatric trauma patients in MCIs to then assess the surge capability of each hospital involved in the study. Overall, the 4 hospitals in the geographic area taken into account would be able to treat 40 to 44 pediatric patients, distributed among the 4 structures based on age and severity of injuries. It is important to underline that, in nonexclusively pediatric hospitals, the receptive capability for pediatric patients is not additive to the receptive capacity for adult patients.

Simulation exercises with the MACSIM® simulation tool or 1 of many that can evaluate MCI response plans can be used to maintain competencies with the high impact-low probability MCI occurrence and ultimately improve preparedness and response by improving the plans. The involvement of personnel on the operational level is fundamental to adhere to the best practice and to share knowledge and competencies. Moreover, simulation exercises could be used to validate results and as a conclusive step in the planning of organized responses to MCIs involving pediatric patients. The participation of the Health Authorities, on a regional level and within each hospital, in collaboration with EMS, is crucial for the results of the preparedness process to be endorsed and to become the starting point of a comprehensive plan for the coordinated response to MCIs.

## Conclusions

The study provides an overview of the resources available in the metropolitan area of Milan to be used in the event of an MCI resulting in injured pediatric patients, similar to the 1 that occurred in Nice.



During this work, it emerged the pivotal importance of hospitals other than PTCs, such as ATCs with pediatric expertise, pure pediatric hospitals, and general hospitals with pediatric wards, in the areas where there is no identified PTC, as it is the case in Milan.

**Supplementary material.** To view supplementary material for this article, please visit <https://doi.org/10.1017/dmp.2024.45>

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