CHAPTER 13

EMERGENCY MEDICAL CARE AND ORGANISATION AFLOAT

CONTENTS

ANNEXES

CHAPTER 13

EMERGENCY MEDICAL CARE AND ORGANISATION AFLOAT

1301. General

The Ship's Emergency Medical Organisation is outlined below. The organisation for submarines is laid down in BRd 2170(4) Chap 6. Any embarked personnel (such as EMF, TAG, PCRF) are to be integrated into the Medical Organisation as per Medical Standing Orders (MEDSOs) or as local guidelines dictate. Medical countermeasures and casualty care in a CBRN environment are covered in BRd 2170(2).

1302. Principles

A ship's Emergency Medical Organisation is designed to provide rapid and effective medical care to casualties in peace or war to ensure that personnel efficiency, and hence the ship's efficiency, is maintained at the highest possible level. The immediate treatment of minor injuries may enable personnel to remain at or return to their posts. As such, a continuum of care exists - a casualty should receive immediate life saving first aid treatment, be removed from danger, be treated by specified First Aid Team (FAT) members and then by the ship's medical staff. At the point of wounding all members of the Ship's Company are members of the Medical Organisation and should be competent at delivering immediate life saving first aid treatment. Therefore all RN personnel are to receive basic first aid training through Core Maritime Skills 3 (CMS3) as well as iaw BRd 9274 Chapter 8 Section 2 Serial 802003.

1303. First Aid Training

a. The CO is responsible for ensuring the correct numbers of first aid trained personnel are onboard iaw the latest policy.

b. The Senior Medical Branch Rating (SMBR) is to provide continuation First Aid Training (Level 2 and 3) to all members of the Duty First Aider (DFA) organisation, Standing Sea First Aid Party (SSFAP) and Emergency/Action First Aid Team (FAT) members. They also have responsibility for conducting first aid training in the specialist areas and to the Ship's Company in accordance with BRd 9274 Chapter 8 Section 2.

c. Ships are to ensure that training is carried out in accordance with the PRISM training serials in BRd 9274 Chapter 8. Ships are to conduct first aid training at every available opportunity and to ensure that medical aspects of the CBRNDC response are exercised.

d. A record of all training is to be maintained in the Master CBRNDC Training and Material Assessment Log held by the Whole Ship CBRNDC Qualified (WSQ). The SMBR is to maintain the First Aid Training log and to hold the log within the Sickbay. The First Aid Training log should record the date, subject, duration and names of individual attendees. Over the period of a week, First Aiders should undergo a minimum of 1 hour of theory and 1 hour of practical training.

e. All personnel involved in First Aid duties onboard (DFA, SSFAP, FATs, Boarding Party First Aider) are to be trained as a minimum to Level II First Aid standard (certificated and in date). The SMBR is to train all First Aid Team personnel to the Level 3 standard iaw BRd 9274 Chapter 8 Section 2.

f. All DFAs are to have completed the Level 3 training syllabus on the AMBU, Entonox and AED **prior** to undertaking the role of DFA. FAT members are to have completed this **within 2 weeks** of being assigned to the role in the FAT.

g. All First Aiders are to have a Level 3 taskbook issued, and are to have successfully completed the syllabus **within 4 months** of joining their ship.

1304. The Medical Role

The ship's Medical Officer (MO), SMBR and Medical Branch Rating (MBR) have specific responsibilities in support of the ship's CBRNDC organisation and in maintaining the operational capability. They are to:

a. Maintain the health of the Ship's Company.

b. Provide medical treatment to casualties to maximise the fighting efficiency of the ship.

c. Support the Command during any peacetime emergency.

d. Provide a Medical Organisation for Action/Emergency (MOFA/E).

e. Provide and maintain all emergency medical equipment within the sickbay and throughout the ship.

f. Conduct First Aid training to the Ship's Company, Standing Sea First Aid Party (SSFAP), First Aid Teams (FAT) and other personnel as detailed in BRd 9274 Chapter 8 Section 2.

g. Provide specialist advice on the medical aspects of CBRN defence.

1305. The Dental Role

Whilst the role of the dental team is to provide primary dental care, during action and emergency stations, they are required to work under the functional authority of the PMO/MO/MBR (see BRd 2 Para 1553) and should be appropriately incorporated into the MOFA/E. It is essential that the dental staff are adequately trained for this role.

a. **Dental Officer (DO).** The role of the DO is providing management/clinical support as directed/required by the senior clinician onboard or as operationally required. In capital ships, the DO will have a more formal role iaw local ship's instructions.

b. **Dental Nurse.** The Dental Nurse is as an additional member of a FAT. The minimum level of training for this is FA Level 2 but they are to be Level 3 trained at the earliest opportunity.

1306. Duty First Aiders (see also BRd 2170 (1) Para 2021)

a. All ships alongside in harbour are to have an in-date, First Aid qualified (as per Para 1303 sub para e) member in their Duty Watch organisation. This individual is to be identified on the ship's Daily Orders. The Standing Sea First Aid Party delivers First Aid at sea and are to be nominated on the Watch and Station Bill.

b. All Duty First Aiders (DFA) are to have immediate access to correctly stocked first aid bags at all times. This may be their own personally issued FA bag (if they are also members of the SSFAP/FAT) or may be a nominated DFA bag that is handed over at the beginning and end of each duty. They are to be responsible for the bag throughout their duty. The content of each FA bag is to be iaw the current Medical Equipment Table for Service Afloat (METSA). Fresh water is to be carried in 1 ltr bottles and is to be available at all times.

c. The DFA must wear a red cross surcoat for the duration of their duty. They are not to be assigned to other duties that will prevent them from conducting their primary duty eg BA controller or boundary cooling. The DFA must remain appropriately dressed to respond to an incident at any time.

d. Where a ship has a Duty Medical Branch Rating (usually capital ships outside of base port), a DFA is still required.

e. When assuming FA duties in harbour, the DFA is to conduct a formal handover with the SMBR (or in the SMBR/MBRs absence, the DFA from the previous day).

f. As part of the handover, and in order to ensure familiarity with the emergency medical equipment they may be required to use, the DFA is to conduct the daily check for the emergency medical equipment as detailed at Annex 13D. A log (utilising MOD Form 373) is to be maintained in the sickbay to record the following:

(1) Item of equipment and the checks required.

(2) Name/Rate of person conducting checks.

(3) Reported defects discovered and corrective action taken.

(4) Monthly signature of the Officer with medical responsibility.

1307. Standing Sea First Aid Party (SSFAP)

a. All ships are to have a SSFAP which is to be included within the Standing Sea Emergency Party (SSEP). The SSFAP should consist of the SMBR as overall I/C, a nominated 2I/C (the second MBR if borne) and no less than 4 other Level 3 First Aiders all of whom are to be certificated and in date.

b. All members of the SSFAP should also be trained to Level 3 First Aid standard and in possession of a fully completed Level 3 task book (see Para 1303 sub para e). When the second MBR is not borne, a suitably trained 2I/C is to be nominated.

c. SSFAP personnel should be taken from day worker watches and must be correctly dressed and equipped at all times. All members of the SSFAP are to be issued with foul weather clothing, ear defenders and goggles, which should be easily accessible in the event of an incident. They are to muster with the Standing Sea Emergency Party (SSEP) as directed.

d. With the manning constraints on Survey, Hydrographic and Fishery Protection Squadron units, the following is to be adopted as the minimum manning level for the SSFAP:

(1) **Medical Branch Rating borne:** MBR, a nominated 2I/C and no less than two other trained First Aiders.

(2) **Medical Branch Rating not borne:** A minimum of an I/C and no less than two other trained First Aiders are required to be in the SSFAP.

e. The SSFAP is to muster for all emergencies in accordance with MEDSOs or Ship's General Orders. The SSFAP is to be divided into 2 teams:

(1) Team A should consist of the 2I/C plus two First Aiders and are to muster at to the Forward Control Point (FCP) reporting to the I/C FCP. They are not to enter any smoke boundaries that have been established. They are to carry their First Aid bags, an AMBU box and are to be easily identifiable by wearing Red Cross surcoats.

(2) Team B should consist of the I/C plus two First Aiders and are to muster in the Sickbay or other nominated location (eg SMP) as directed or as the situation dictates. They are to prepare the sickbay/medical position and standby to deal with incidents. They are to carry their First Aid bags and are to be easily identifiable by wearing Red Cross surcoats. When borne, the MO reports to the sickbay with Team B.

f. On MM/PP ships, the medical responsibility falls to the I/C (Coxswain or P2000 XO) and the FAT muster iaw MEDSOs.

1308. Medical Manning in the MOFA/E

a. All members of the Ship's Company have a responsibility to assist casualties to the best of their ability as a part of dealing with the incident as a whole. Operational priorities will dictate the relative importance given to the treatment of casualties with regard to the repair of damage; the Command Aim will reflect this (further guidance on this aspect is given at Para 0105). Unless specifically directed by Command, FAT members are not to be employed in tasks which they cannot be easily and rapidly released from, and which are likely to prevent them from conducting their primary duty within the MOFA/E. Irrespective, **ALL** Ship's Company are required to provide immediate actions to deal with fires and other wholeship incidents if in their immediate vicinity.

b. **State 1 and State 3 (Action and Emergency Stations).** Each manned FAP (depending on class of ship) is to be manned by a team of five; an I/C and two teams of two qualified and in date Level 3 First Aiders (as per Para 1303 sub para c). First Aid Teams should be deployed from the FAP in teams of two. MHQ is to be manned by a suitably trained coordinator or team depending on the size of the ship. Close liaison is necessary between I/C of FAPs, the SMBR and the Medical Coordinator in MHQ, and between MHQ and SCC or HQ1, depending on the size of the ship. Maintenance of an accurate casualty state and knowledge of the location of medical assets are essential information for the Command. Liaison between MHQ/SCC/ Command is necessary to coordinate casualty evacuation and relocation of medical positions as required.

c. **State 2.** In the Defence Watch organisation, there is to be a nominated First Aid Party within each watch. Each Defence Watch First Aid Party (DWFAP) is to consist of a Medical Branch Rating as I/C plus no less than two Level 3 First Aiders. If no MBRs are borne, a suitably qualified I/C should be nominated. The DWFAPs are to be included within the DWEP organisation and are to muster accordingly.

d. **Boarding Parties.** Each Boarding Party is to have a nominated Level 3 First Aider (trained and in date) who is to muster with the Boarding Party iaw local orders.

1309. First Aid Boxes

a. First Aid equipment is to be widely distributed around the ship to ensure flexibility and allow rapid access in case of an emergency. The locations of emergency First Aid boxes are to be indicated on a ship's plan held within the sickbay. Each box should be marked 'For Emergency Use Only' and include a list of contents and expiry dates. First Aid box contents and expiry dates are to be iaw Annex 13D.

b. The compartment custodian is responsible for ensuring the First Aid box within their compartment remains in date and complete. They should liaise with the medical department for replacement contents if used or time expired.

1310. Medical Positions

a. During peacetime operations, the sickbay is the focus of the ship's medical organisation. Its purpose is to maintain the health of the Ship's Company by providing comprehensive primary care, health promotion and public health advice. It must be ready to deal with a medical emergency at any time; therefore all emergency equipment is to be ready for immediate use, with an easily accessible emergency drug tray stocked iaw with current policy.

b. Alternative medical positions are prepared and maintained during peacetime and war. These are First Aid Posts (FAPs) and the Secondary Medical Position (SMP) depending upon the class and type of ship and are specified in NES 106. These areas should provide adequate space and emergency medical equipment for treating larger numbers of casualties and may be used in the event of multiple casualties when the sickbay is untenable or access prevented. They are usually sited within any citadel.

c. During Action or Emergency Stations, the sickbay becomes the Medical Headquarters (MHQ) from where the medical effort is coordinated.

d. In SVHO platforms, there is no requirement for a dedicated SMP. First Aid Team personnel, including the medical coordinator, are to muster as directed by MEDSOs or at an appropriate alternative medical position as directed by the SMBR. During Action or Emergency Stations, the sickbay complex doubles up as the SMP.

e. The functions and details of MHQ, FAPs and SMP are at Annex 13A, Annex 13B and Annex 13C. For MM/PPs see Para 3721.

1311. Emergency Medical Equipment

a. All SSFAP, MOFA/E personnel and those nominated with First Aid duties in Boarding/Recce Parties are to be issued with a First Aid bag for which they are responsible. The contents of each FA bag are to be iaw the current METSA. Fresh water is to be carried in 1 ltr bottles and is to be available at all times. These all need to be signed for on a Loan Record Card (MOD Form 3352A).

b. Within the sickbay, all emergency medical equipment is to be set up for immediate use and located around the resuscitation table. The fixed oxygen, suction apparatus and defibrillator must be positioned so that they reach a casualty lying on the resuscitation table. The table should also be appropriately sited and fixed securely to the deck. Annex 13D details the emergency equipment routine checks. Ready use medical gas cylinders size CD are to be replaced from stock, when they reach ¾ full. Size ZX are to be replaced at ½ full.

1312. Casualty Handling/Manual Handling

a. The SMBR is to ensure that they conduct routine training for their medical emergency teams (SSFAP/FATs) on handling techniques and the procedures for using any form of stretcher. Routine whole ship and FRPP training should also be conducted by the SMBR in casualty handling.

b. During peacetime, the Neil Robertson (NR) stretcher remains the most appropriate for moving casualties around a ship internally when they are incapacitated.

c. During action, manual handling techniques such as the fore and aft or hose lift are more appropriate especially when swift extraction from a compartment is required to allow DC teams into the space. NR stretchers are not routinely to be used during action due to the time constraints and manpower required to complete the task. They may be considered when there is either a lull in action or the threat warning level has reduced with any movement of casualties being achievable without jeopardising the safety or efficiency of the ship ie maintenance of the damage control state.

d. Where a hose lift is conducted, an adequate length must be used to ensure the safe extrication of a casualty. A Size 2 hose is the most appropriate as long as they are not required for FF/DC. The brass fittings of the hose should be controlled to prevent further injury.

1313. Stretchers

a. There are 4 main types of stretchers in use on board RN surface vessels; Neil Robertson (NR); Army Pattern (AP); Aircraft Lightweight (ALW); and Spinal Board (SB).

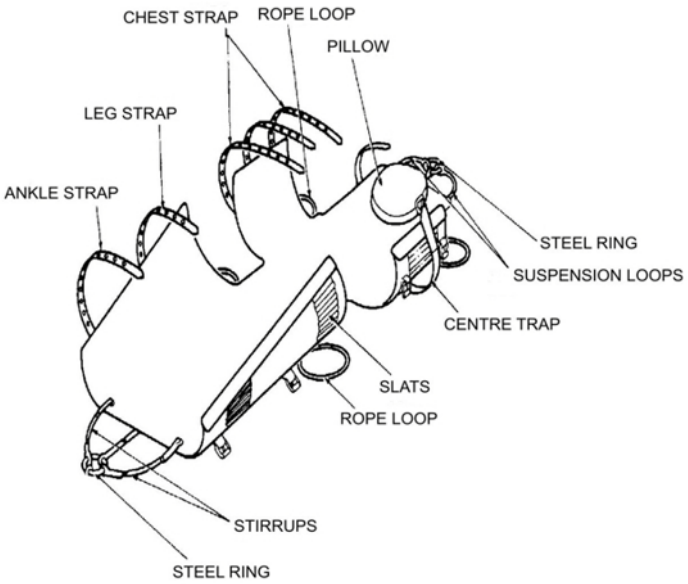
b. Whilst carrying out all casualty handling involving a stretcher, the casualty must be moved feet first at all times. It is acceptable to take a few steps backwards whilst manoeuvring a casualty but someone else must guide this.

c. **Neil Robertson Stretcher (NR)**

(1) **Introduction.** The NR Stretcher (see Fig 13-1) is designed for the transportation of casualties in difficult or unusual circumstances. The casualty is enveloped in a protective flexible case that takes up as little space as possible and can bend slightly to negotiate difficult routes. These stretchers are dispersed as indicated by the Ship Class Book. They are generally stowed in stretcher cabinets, but can be fitted to bulkheads in appropriate positions. Any stretchers exposed to the elements should have a protective covering. They may be lifted or lowered with the patient either in the vertical or horizontal attitude and thus can be used for moving casualties up ladders, down from superstructures, through hatches or in fact from any position of difficult access.

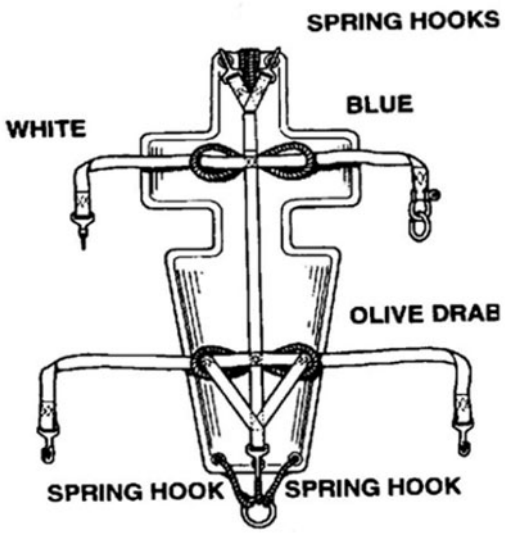
(2) **Description**. The Head Protection Pad shields the top of the head, which should be steadied by the canvas strap, fastened across the forehead. The portion which has the 3 canvas chest straps is wrapped around the chest (notches being cut to fit under the arms), and is secured by the upper and lower straps with the centre strap of the 3 to control the arms of an unconscious patient. In the conscious patient, the head and arms need not be secured if the patient can control himself, in which case the redundant straps are secured around the stretcher. Two straps secure the section that fits around the thighs and legs. Wooden slats sewn into the canvas stiffen the whole stretcher. Rope loops are fitted at the shoulder and thigh positions on either side by which the stretcher party can carry it. At the top and bottom, a steel ring provides for the attachment of steadying lanyards. These lanyards are not to be fitted to stretchers used in ships. However, a 15 m length of 16 mm polyester with a soft eye at one end is utilised as a head rope and is to be stowed with each stretcher. When ordered via Naval Stores (see BRd 2170(3)) the rope comes in 220 m lengths. Therefore caution should be exercised when placing the order. When required, this line can be through-footed to the ring at the head of the stretcher and used as a steadying line when negotiating ladders (up or down). The rope is not to be used as a pulling device. A block and tackle should be utilised by the seaman specialist department. However, should failure of the block and tackle happen it may be used as an emergency back up line. When lifting the stretcher, the team should have one hand on each handle at all times during the lift/lower evolution. When carrying/transferring casualties along passageways etc the head rope should not be attached, as it may become a trip hazard.

Fig 13-1. Neil Robertson Stretcher



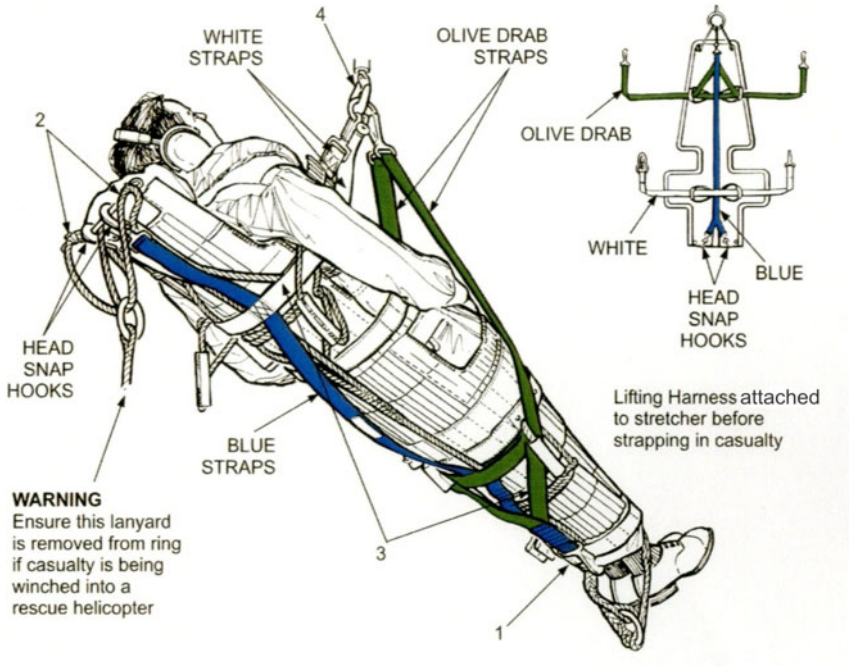
(3) **Harness for Use with the NR Stretcher.** The lightweight transport stretcher is the normal method of transferring a patient in a helicopter. However, in the event that a NR stretcher must be used for the task, a harness for use with helicopters enables the NR stretcher to be lifted with a casualty already strapped in position; these harnesses are carried only by helicopters operating in the SAR role and transferred to the ship when required (see Fig 13-2). The harness, manufactured from polyamide webbing, has a blue centre strap, white shoulder straps and olive-drab foot-straps. Spring hooks are fitted at the following positions; two at the head; one at the foot of the centre-strap; one at the end of each foot strap; and one at the end of the left-hand shoulder-strap. A shackle and ring are fitted to the right-hand shoulder-strap to secure the opposite spring hook and the winch wire.

Fig 13-2. Harness for Use With Neil Robertson Stretcher



(4) **Fitting the Harness to the Stretcher.** The casualty must always be fitted with an Assault Troop Lifejacket (ATLJ) and before the stretcher is lifted, the steadying lanyards must be removed. Illustrations are also provided inside the valise in which the harness is supplied. Fig 13-3 shows the stretcher rigged for a helicopter lift. Fitting and briefing on the operation of the ATLJ is to be carried out by the Chief Bosun's Mate.

Fig 13-3. Neil Robertson Stretcher Rigged for Helicopter Lift



(5) **Maintenance.** NR stretchers are held and maintained by the Medical Branch Rating iaw the UMMS and CMT.

(a) The NR stretcher can be cleaned but if there is any visible contamination (eg bodily fluids, oils, greases), then they are to be exchanged for new via the Logistics Department.

(b) The NR stretcher is not a single use item if used iaw manufacturer's instructions. Similar to ropes or harnesses (ie lifting equipment), they are to be inspected **BEFORE** use for obvious signs of damage or wear to confirm they are fit for purpose.

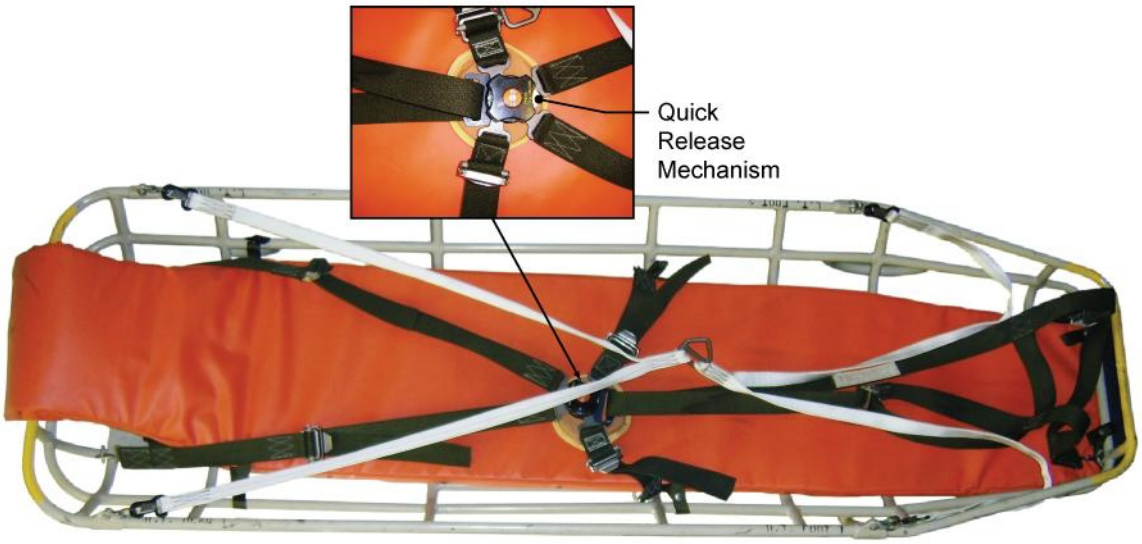
(c) The NR stretcher should be replaced if it has been used to lift a person over the recommended weight limit or it has been subjected to a shock load ie lifters let go of rope when lifting a person then suddenly regain hold to arrest the fall.

d. **Army Pattern.** Generally speaking, this stretcher is not suitable for use on most RN surface vessels between decks due to the limitations of space. The Army Pattern is generally used for moving casualties around during operations ashore.

When moving casualties around on these stretchers, care must be taken to ensure that the restraining belts are used to prevent the casualty falling off. In capital ships Army Pattern stretchers are valuable assets handling casualties during amphibious operations.

e. **Aircraft Lightweight (ALW).** In general, all RN surface vessels have at least one ALW stretcher. These stretchers are specifically designed for helicopter patient transfer and a designated SE specialist on board maintains them. When the ship's flight embarks, they will bring another ALW stretcher with them. Specific training is required in the use of this stretcher, and all Medical Branch Ratings should make themselves aware of the procedures and limitations of these stretchers by consulting with the embarked flight team Senior Maintenance Rating (SMR).

Fig 13-4. Aircraft Lightweight (ALW) Stretcher Rigged for Lift



f. **Spinal Board (SB) and Scoop Stretcher.** These are specialist stretchers and should only be used by personnel who have been trained in their use. Whilst they remain an option for use, casualties should only remain on a SB for a short period (<1hr) and should be transferred to another form of stabilisation as soon as practicable. Scoop stretchers present a more viable option where available. All MBRs are to have undertaken training in the use of these stretchers prior to joining their unit.

Fig 13-5. Spinal Board

1314. Casualty Documentation

a. When a casualty arrives at a medical position, their injuries and treatments must be reassessed and a definitive treatment plan put in place. The MO/SMBR/MBR (or I/C of FAP in their absence) is to review and coordinate treatment. Precise written instructions should be made on each patient's Field Medical Card (FMed 826) and signed on completion. This permits medical staff to question the appropriate person if any queries remain regarding the patient's condition as well as assists with the return of casualties to duty. Recording all casualty details, clinical observations and treatments are important aspects of ongoing care.

b. To aid casualty care an FMed 826 should be complete in the following coloured ink scheme:

(1) The senior clinical authority writes in **RED** (that is the MO when borne, otherwise the SMBR).

(2) Medical Branch Ratings write in **BLUE** (except the SMBR writes in **RED** when no MO is borne).

(3) All FAT members write in **BLACK**.

c. An accurate casualty picture should be maintained by the I/C of the position. This information should be passed to MHQ who will in turn ensure the Command nodes are kept abreast with the casualty picture.

1315. Peacetime (State 3) Casualties/Incidents

a. Upon discovering a casualty, the loud vocal alarm **"CASUALTY, CASUALTY, CASUALTY + LOCATION MARKING"** is to be raised and continued until either it is responded to, or has been piped over the main broadcast preceded by the ship's general alarm. The first priority is to remove the casualty from danger. Although this must be done with due care to the casualty's injuries, it is accepted that in certain circumstances, the urgency of the situation may exacerbate the injuries.

b. The main broadcast may be used to hasten medical help to the scene of the incident in peacetime but it should not be used during action iaw BRd 2170(1) Para 0715 sub para b. Once removed from danger, the casualty should be immediately assessed and treatment commenced following current protocols.

c. The MBRs (plus MO when borne) and the SSFAP will respond to the emergency and attend to the incident at the scene. One member of the SSFAP should be nominated to go directly to the Sickbay. Here he will await instructions such as any additional equipment required at the scene. He will also ensure the Sickbay is prepared to receive a casualty. Ongoing management will proceed as deemed appropriate by the senior medical staff. The Command must be kept informed, and there must be a process in place whereby this can be achieved speedily.

d. Casualties, their injuries and treatments are to be reassessed with documentation raised on arrival in either the sickbay, FAP or SMP.

e. Should the incident necessitate the ship progressing to Emergency Stations, all other members of the FATs should muster at their designated FAPs iaw the Whole Ship Watch and Station Bill (WSWSB) and/or MEDSOs. Those FAT members already dealing with casualties should continue to do so until directed otherwise. Members of the FAT should maintain a presence at the FCP where practicable as directed by the MO/SMBR.

f. Where a Part IV (consolidation phase) MA is borne, he is not to be used as a routine member of the First Aid Team. Part IVs are augmented to the ship for consolidation training and whilst capable of providing medical care, they have not completed any medical specific TEM/PJT. Therefore, these individuals should not be used to replace permanent ship's gaps. It is accepted that on occasions, a temporary gap may appear (courses/compassionate etc) when the Part IV MA may be required to fill the position.

g. Following a Crash On Deck, FAT personnel may be required to attend casualties in the crashed aircraft. Actions are to be taken iaw BRd 2170(5) Paras 0108, Para 0412 and Para 0413 and must include the provision of appropriate PPE.

1316. State 1 Preparation

a. All personnel are to muster as per WSWSB dressed in Action Dress iaw BRd 2170(1) Para 2502, including Red Cross brassards and carrying their personal First Aid bag.

b. The material state of all FAPs and the SMP is to be checked and is to include a full muster of the contents of the FAPs and the SMP iaw current METSA scaling. An oxygen cylinder (Size ZX with masks) is to be distributed from the medical store to each manned First Aid Post. All emergency equipment is to be checked and made available for immediate use, but must be fully secured for action.

c. Whilst strict adherence to civilian drug laws and regulations must be maintained in peacetime, at Action Stations quick immediate access to Controlled Drugs (CD)/ strong analgesia must be available to the Medical Branch staff particularly where no MO is borne. When the order is given to go to Action Stations, the SMBR is to obtain the CD keys from the CO to allow access to the cabinets in both the Sickbay and Medical Store. Morphine auto-injectors or, when personnel are trained and stores carried, fentanyl lozenges are issued to FAPs, SMP, FAT members and Boarding Party First Aiders. They may also be issued to other selected members of the Ship's Company who are trained and have been qualified in its use. Ideally they should also be qualified in First Aid Level 2 or 3.

d. All members of the Ship's Company are to carry First Field Dressings (FFDs). Combat Application Tourniquets (CATs) should be issued to all personnel carrying personal firearms including Upper Deck Weapons crews and all members of Boarding Parties. The FFD and CAT are not be taped or affixed to either personal weapons or life jackets when carried but should be placed in a pocket. All personnel must be trained in the use of the CAT due to the potential dangers when misapplied.

e. Each medical position is to inform MHQ when State 1 preparations are completed noting any deficiencies. When all manning levels are confirmed and preparations completed, MHQ reports to HQ1.

f. After mustering and completing State 1 preparations, FATs are to be briefed with a plain English translation of the Command Aim and their priority areas. At Threat Warning Red, they are to be dispersed in pairs to locations nominated positions by the I/C. The locations of the dispersed personnel is to be recorded. The positioning of the dispersed personnel is to be influenced by the direction of the threat and the availability of suitable locations with means of escape and communications with the I/C of their relevant FAP (see BRd 2170(1) Para 0817 for further details). Where FAT members are already dealing with casualties in the FAP, the I/C must apply discretion as to whether dispersal is appropriate. Generally those required to manage the casualties must remain within the FAP and not disperse.

1317. State 1 Casualties

a. During Action, there will be limited opportunity to provide care to casualties and the survival and fighting effectiveness of the ship will take priority. Whilst at State 1, triage categories are unaltered and treatment is still delivered on the basis of need and resources. However, the Command priority is to maintain the fighting efficiency of the Ship. In recognition of this, more lightly injured casualties who can rapidly be returned to duty following simple and immediate treatments are to receive immediate care. This may be delivered by the First Aiders without reference to the medical staff if the latter are involved in dealing with seriously injured personnel.

Alternatively, simple buddy-buddy care delivered at the SOTI by members of the Ship's Company without needing to involve the FATs, is also effective. All casualties are to receive definitive assessment and care from the medical staff during a suitable lull in the action.

b. At action, casualties are not to be piped iaw BRd 2170(1) Para 0715 sub para b. However, ships without a MHQ (MM/PP) can pipe casualty alarms over the main broadcast as the Coxswain/XO may not be in a position to respond to casualty information being passed by telephone.

c. First Aid Teams are to be deployed from their position to assist the injured. The casualty is to be removed away from immediate danger to the nearest place of relative safety (which does not impede damage control teams or other command priorities), and treatment directed at saving life or stabilising injuries. This evacuation should always be made with consideration for the overall situation and in consultation with MHQ and/or SCC/HQ1 where necessary. Casualty evacuation must not jeopardise the ship eg by opening doors or hatches and breaching smoke boundaries or impeding emergency teams. Where such actions are necessary, the local DC Incident Manager is to be consulted. The MO and MBRs will initially aim to remain within the FAP to assess and direct the care of casualties as they are received, however must be prepared to leave the FAP and go the scene of an incident if their presence on site is requested by the First Aiders.

d. FATs deployed from a FAP need to carry their First Aid bags and any specific medical equipment required. They may also be carrying survival equipment but are not required to carry Emergency Escape Breathing Device (EEBD). They should be aware of the location of this equipment at all times.

e. Other factors that need to be considered during action are:

(1) The need for accurate debriefing of casualties for information that may assist the damage control or firefighting teams.

(2) Returning casualties to duty, even in a limited capacity.

(3) Priorities for evacuation to higher level of medical care should the opportunity present itself.

f. Casualties, their injuries and treatments must always be reassessed with appropriate comments recorded on FMed 826s on arrival at the FAP, SMP or when in the Sickbay (see Para 1314 for further details).

g. FAP I/Cs are to maintain an accurate casualty state and damage control picture for the whole ship. This is important so as to identify any threats to medical positions, plan safe routes for medical personnel and FATs and to plan the relocation of FAPs should this be necessary. At all times there should be a contingency plan for relocation. The exact areas of responsibility will differ in different ships but in general, qualified medical staff should cover distinct areas of the ship and should not congregate in one area unless there are extenuating circumstances.

h. During Action, appropriate bracing drills (see Para 2524 for further details) are to be applied by all FATs and casualties. Casualties, if conscious and with the use of functional limbs, are to be instructed by Medical staff and First Aiders to brace themselves as effectively as possible while the FATs braces themselves. If the casualty is unconscious/incapacitated, the FATs can brace the casualty but the bracing must be effective. If an effective brace cannot be achieved, the medical staff/FA must brace themselves only.

1318. Casualty Triage

a. When there is more than one casualty, there needs to be a system to prioritise treatment. There are a number of systems for doing this. The RN uses the system outlined in STANAG 2879, applied using the instructions in Clinical Guidelines for Operations (JSP 999). This is summarised below:

(1) **T1 Immediate Treatment.** Those with injuries that are likely to be fatal unless immediate treatment is given.

(2) **T2 Urgent Treatment.** Those with injuries that require urgent treatment but some delay is acceptable.

(3) **T3 Delayed Treatment.** Those with injuries which are not likely to be fatal and for whom treatment can be delayed.

(4) **DEAD.** Self explanatory.

(5) **T4 Expectant Treatment.** Those whose injuries give no hope of recovery and if treatment were attempted other casualties who could have been saved may die (this category is not to be used unless directed by Joint Force Command/CTG (Medical)).

b. Triage is an active process and the category awarded will change with variation in the clinical condition of the individual or changes in the numbers of other casualties awaiting treatment. FATs are to be trained in applying the simpler and strictly-formatted Triage SIEVE process. Medical Staff will supervise the Triage SORT process once the situation has subdued (usually in the FAPs) and will also overlay their clinical judgement and apply more considered triage categories. Whilst at State 1, triage categories are unaltered; however see Para 1317 sub para a on the relative prioritisation of casualties at Action.