CSOP 021 – Major Incident

Version No: 2.1 Effective date: 24/11/2020

APPROVALS

Original Document Author:	Name Alex Toft	Date	Signature
Revised Document Prepared by:	Jake Turner – Doctor Stu Reid – Doctor		
Reviewed by:	Karl Bexon – DLRAA Airbase Manager Leon Roberts – Doctor Phil Bridle – Head of Operations		
CGG Chairman Approval:	Justin Squires – Deputy Clinical Lead		
Next Review Date:	Nov 2022		

HISTORY

Effective Date	Version No.	Summary of Amendment
25/02/2014	1.0	Creation of document
February 2017	2.0	Reviewed and significant changes made
November 2020	2.1	Reviewed and significant changes made

Appendix/Annexes	
Appendix 1	Initial Actions - EOC
Appendix 2	Initial Actions – TAAS Manager
Appendix 3	NARU Action Cards
Appendix 4	Relevant WMAS cards
Appendix 5	CBRN initial management

REFERENCES

1. Purpose

This document sets out the expected response of The Air Ambulance Service to a major incident.

The Joint Emergency Services Interoperability Program (JESIP) defines a major incident as:

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"An event or situation requiring a response under one or more of the emergency services' major incident plans. A major incident may be declared by a single blue light service, or jointly."

2. Scope

This SOP applies only to major incidents affecting the NHS ambulance service. This SOP does not relate to internal major incidents declared within the charity; please refer to the Charity's business continuity plans for this information.

Quick reference information

A NARU action card set containing essential information regarding the actions of staff during a major incident is available on the base ipads/iphones in the files or books apps. This should be referred to at the earliest opportunity and contains a checklist for key actions. Key NARU action cards are also included in appendix 3.

Additional documents

This SOP must be read in conjunction with guidance published by JESIP, who provide resources for all emergency responders. The SOP must also be read in conjunction with the WMAS and EMAS major incident policies. Hard copies of the ambulance service policies are available on both bases. The National Ambulance Resilience Unit (NARU) has issued further guidance and all staff should be familiar with this.

3. On scene - Initial actions

It is anticipated that TAAS resources may be the first clinical resource on scene. In general, TAAS staff should follow the generic guidance issued by JESIP and the national ambulance resilience unit (NARU) – see base Ipads and appendix 3 – however whilst the EMAS major incident plan utilises this, the WMAS plan uses their own which may differ. It should be remembered that as experienced and highly visible clinicians, TAAS staff might be looked upon to provide support and guidance to NHS ambulance crews and other responding agencies.

If a TAAS crew finds themselves first on scene, priorities should include (CSCATTT):

- Establishing command and control
- Assessment of scene safety
- Initial METHANE update to control
- Rapid triage of casualties
- Appropriate treatment and transportation

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JESIP Principles of Joint Working:

1. Co-locate
2. Communicate
3. Co-ordinate
4. Jointly understand risk
5. Shared situational awareness

Utilising step 123 principles, consider if a CBRN / HAZMAT incident could have occurred, and if so follow the Home Office CBRN initial response guidance (appendix 5)

Model command and control structure guidance is available on page 9 of NARU action cards. Traditional nomenclature of bronze, silver, gold tiers of command has been replaced by **operational, tactical and strategic** tiers respectively.

Major incidents are inherently complex, will develop rapidly over the first hour and may require handover of tactical command as soon as appropriate resources arrive. TAAS staff should take direction from ambulance service commanders, remembering that initial medical intervention is likely to be limited. Where appropriate, TAAS staff should highlight to operational and tactical commanders that further critical care assets may be beneficial. If resources permit, the TAAS CCPs or Doctors may be asked to operate as medical incident adviser (MIA) at tactical level until the ambulance service on call MIA arrives on scene.

Where resources permit, contemporaneous logs of critical decisions made in the early stages of a major incident are essential. An EMAS logist would be the gold standard, but audio recordings may also be used so long as they can be provided to future investigations.

Where notes cannot be made immediately, they should be recorded as soon as resources permit, with an explanation of why they could not be made at the time. While such note taking can be seen as arduous, incident logs will be closely examined at inquests relating to high profile major incidents.

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4. On scene – developed incident

TAAS clinicians may be expected to undertake a number of roles. It is impossible to specify exactly what may be required and as such all TAAS clinicians should be familiar with the following roles/working areas:

- First on Scene
- Medical Advisor
- Forward Doctor
- CCS Medical Lead

Further guidance relating to these roles is outlined in the NARU, EMAS and WMAS major incident guidance. See appendix 3 for NARU action cards.

During a major incident, a medical incident advisor or officer (MIA/MIO) must authorise advanced interventions such as rapid sequence induction. TAAS staff may be able to offer expert knowledge in this field or indeed be fulfilling the MIA role, but must remember the principles of mass casualty management. If advanced interventions are authorised, TAAS clinicians must provide the same level of care as in standard incidents, including a team approach, checklist use and full monitoring where required.

With multiple critical patients there may be pressure for TAAS CCPs to work outside of their usual scope of practice, for example conveying a post RSI patient without a doctor, this is not acceptable and must not be treated as normal practice. An ambulance service MIA cannot authorise temporary PGDs or deviation from safe practice. Guidance should be sought from TAAS supervisors if truly exceptional circumstances occur. In all likelihood, if demand is sufficiently stretched to cause this scenario, advanced intervention will not have been authorised by the ambulance service MIA.

In incidents involving multiple TAAS aviation or clinical assets it may be prudent to deploy a TAAS manager or CCP to act as an on scene liaison and welfare officer for TAAS crews, as well as feeding information to strategic and operational managers within TAAS. This role may also involve acting as a tactical advisor to the incident/tactical commander. Allocation of this role should not take precedence over clinical roles, as the local ambulance service should have plans to implement a similar structure on scene. If TAAS managers are not on scene, they should not contact operational crews unless entirely unavoidable. This is to reduce the demand on TAAS crews and on the communications system.

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5. EMAS Major Incident Plan – specifics

EMAS UTILISE NARU ACTION CARDS

- EMAS ambulance incident commander tabards are available on all TAAS assets.
- If first on scene, utilise NARU 'first resource on scene' action cards
- Pass a METHANE report to the EMAS HEMS desk
- TAAS CCP should assume the role of Tactical Commander (Ambulance Incident Commander) until an EMAS AIC arrives.
- Utilise standard EMAS crews arriving for triage and aid at scene
- TAAS HEMS Doctor may be required to assume the role of medical incident advisor (tactical level)
- Beyond the above, TAAS CCPs or Doctors may be asked to perform other command support roles as per the NARU action cards
- If asked to perform a triage role, utilise the SMART card system
- TAAS teams are at liberty to use any clinical intervention they see fit, as long as the medical incident advisor is in agreement.
- EMAS have a casualty regulation plan containing pre-determined numbers of casualties that hospitals in the region can receive. TAAS are not expected to take control of the process of casualty distribution beyond advice as to individual patient need
- EMAS employ a strategic medical advisor tier but this role is likely to be remote to scene
- Invocation of the 'expectant' category is a decision for EMAS and likely the strategic medical advisor

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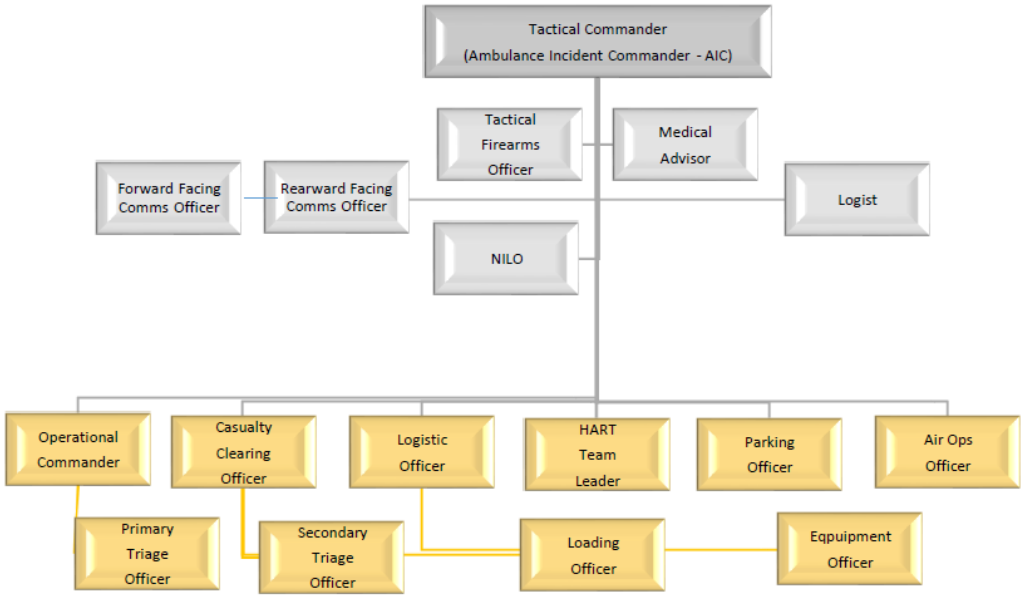
6. WMAS Major Incident Plan – specifics

WMAS DO NOT UTILISE NARU ACTION CARDS, PACKS CONTAINING WMAS ACTION CARDS WILL BE AVAILABLE AT SCENE

The WMAS command structure is as follows:

The reporting structure on scene should be as per the following diagram. Whilst the Medical Advisor is shown as subordinate to the Ambulance Incident Commander, these two roles should work as a team.



This list is not exhaustive, an Operational Commander may be allocated to any site-specific supervisory role.

- TAAS will be tasked through WMAS Air Desk or Regional Trauma desk as you would for any job within WMAS area of Operations.

- WMAS standard PPE at a major incident scene is hi visible jacket, helmet and a tabard with role displayed. TAAS teams should use the EMAS tabards available on all platforms but be mindful that the WMAS tabards may differ and have a slot for role description.

- If TAAS are first on scene, the TAAS CCP should perform the role of ambulance incident commander until relieved by a suitably trained member of WMAS staff.

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- WMAS will deploy a tactical medical advisor to scene, but a TAAS Doctor or CCP may be required to fulfil this role in the interim. An action card is available for this role.

- WMAS have a casualty regulation plan containing pre-determined numbers of casualties that hospitals in the region can receive. TAAS are not expected to take control of the process of casualty distribution beyond advice as to individual patient need

7. Internal escalation

Where a TAAS asset is deployed to a major incident, or potential major incident (I.e. major incident standby) the tasking ambulance service will immediately contact a senior TAAS manager (Appendix 1: Contact details for control rooms). This contact will allow for the rapid activation of TAAS' major incident plan, with a view to increasing the resources available to the ambulance service. In the rare event that TAAS is deployed to a region other than EMAS or WMAS, EMAS will inform the TAAS manager.

Upon receiving notification of a major incident involving TAAS assets, the TAAS manager will inform the wider charity and senior managers as appropriate.

8. Off duty crew

It is anticipated that off duty crews may wish to assist with any major incident. If this is required, contact will be made, possibly via WhatsApp, by a senior TAAS manager with clear instructions on where to respond to. If staff do not wish to receive this information, they should opt out in advance by notifying their relevant airbase manager. Responding while off duty is voluntary and as such this does not constitute an on call arrangement. Responding TAAS staff must adhere to all normal road traffic regulations.

Aviation assets are likely to be an extremely scarce resource during a major incident. Unless an incident creates mass travel disruption affecting all bases, TAAS aviation assets will not collect any member of staff from their home or work location. Any decision to deviate from this will require the approval of the Head or Director of Operations and Chief Pilot.

TAAS clinicians should only respond to the prehospital phase if doing so will not have negative impact on their primary employer's response to the major incident. Staff should also be aware that some clinicians will not be deployed in order to maintain TAAS activity in the hours and days following the major incident.

Staff who may attend a major incident should ensure that their PPE is readily available and TAAS ID badges will be essential. Base flight suits, boots etc. should not be relied upon in the context of a major incident. It may not be possible to respond to your normal airbase if significant travel disruption has occurred. TAAS

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managers will hold a spare key for lockers so that PPE can be gathered if required – this will only be used during a major incident.

9. **The Children's Air Ambulance**

In the event of a major incident tCAA may be called upon to provide an additional aviation resource. All tCAA pilots are able to fly to such scenes. When notified of a major incident involving TAAS HEMS assets, the air desk coordinators will liaise with the tCAA crew and TAAS managers. Any planned tCAA tasking should have consideration given to its suspension, this will only be done by TAAS/TCAA managers. If the tasking is deemed an emergency transfer by the teams, it may be conducted only with the express permission of a TAAS manager. The aircraft should be refuelled and consideration should be given to returning it to its home base. Immediate lifesaving tasks may be undertaken only where ground resources are unable to provide a service and with the express authorisation of the Head or Director of Operations. Such tasks will likely only be permitted when there is no alternative and the aircraft will only perform essential legs – that is to say it will not return teams to their hospitals after the patient has moved.

Re-rolling of the aircraft is unlikely to be required as tCAA is most likely to be used to carry prehospital teams and equipment to and from the scene, however it is technically feasible for tCAA aircraft to be utilised as primary HEMS assets. In the recovery phase of a major incident, tCAA may see exceptional demand, particularly if the incident has involved a number of critically injured paediatric patients. The tCAA Operations coordinators will keep all clinical partner teams updated regarding the current availability of tCAA assets, their likely return to tCAA duty and any ongoing operational restrictions. No other information regarding the major incident (i.e. location, type) should be passed to the clinical partner teams who will have their own plans for such incidents.

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10. Transporting non-TAAS personnel

Requests may be received to transport non-TAAS personnel to scene. Examples may include requests to move ambulance service MIAs, senior officers and HART staff to the scene. Any such requests must be directly authorised by the Head or Director of Operations, Chief Pilot and TAAS management.

11. Mutual aid requests

Mutual aid requests from neighbouring ambulance services for the assistance of TAAS in supporting their major incident response are to be directed to EMAS or WMAS. The director of operations will then decide as to whether TAAS will provide such support based on our local service provision requirements.

12. Specific Incidents:

CBRN Incidents
TAAS staff are neither trained nor equipped to operate within the warm or hot zones of a CBRN incident. Initial management should follow standard ambulance service guidelines, which will broadly involve:

- Approaching the scene from upwind and ideally uphill
- Containing the contaminated casualties and preventing new casualties
- Initial casualty disrobing and dry decontamination
- Considering emergency fire service decontamination
- Mobilising specialist resources

Nerve agent antidote Duodote pens are carried in the spares bags on both the RRV (8 injectors) and the aircraft (6 injectors). All injectors will be secured in the bright yellow counter measures bag for ease of identification. Instruction for use are clearly displayed on the packaging.

Active shooter incidents
Active shooter incidents are likely to be dynamic events with moving warm and hot zones. TAAS staff are not trained to operate within these hot zones, nor is the PPE carried on the aircraft. Moreover, the value of TAAS clinicians is likely to be their ability to accurately triage and treat large number of casualties, rather than performing rescue based roles. Additional consideration should be given to deploying the aircraft to such scenes and the safety of any landing site. Armed police resources are unlikely to be available to guard the aircraft, which may be a high profile target. Pilots and crew should consider relocating the aircraft and returning only when required.

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'Rising tide' incidents

Ambulance services may declare a major incident when natural disaster or high call volumes place an unmanageable demand upon their resources. In the event that a rising tide major incident is declared, the ambulance service will inform a senior TAAS manager. The TAAS manager will determine how TAAS assets can be utilised, for example by broadening tasking criteria, supporting mobile treatment centres or, counter-intuitively, ensuring TAAS resources are only deployed to immediately life threatening emergencies (regardless of response target classification). This is a high level decision which must be authorised by the Director or Head of Operations with input from the clinical lead.

Specific sites

There are a number of specific sites of interest across the East and West Midlands, many of which have specific emergency plans in place. Staff should be particularly aware of the emergency plans for Coventry, Birmingham and East Midlands Airport, all of which are available through the local ambulance service.

East Midlands Airport Incidents

There is a detailed East Midlands Airport Aerodrome Emergency Plan, the salient points of relevance to TAAS are summarised below:

- A NARU action card for an airport incident exists, this is on page 147 of the NARU action cards set, although the EMA Aerodrome Emergency Plan does not reference this.

- Aircraft incidents relevant to TAAS are classified as follows:

  Aircraft Accident
  "An aircraft accident which has occurred on or in the aerodrome surroundings."

  Aircraft Ground Incident
  "Where an aircraft on the ground is known to have an emergency situation other than an accident, requiring the attendance of emergency services."

  Aircraft Full Emergency
  "An aircraft approaching the aerodrome is, or is suspected to be, in such trouble that there is imminent danger of an accident."

  Local Standby
  "An aircraft approaching the aerodrome is known, or is suspected to have developed, some defect but trouble is no such as would normally involve any serious difficulty in effecting a safe landing."

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Aircraft Accident Imminent
Aircraft accidents which are inevitable on or in the vicinity of, the aerodrome.

Aircraft Accident (Location Unknown)
When an accident has occurred or is considered imminent but the location is unknown. Once the aircraft's location has been established, the incident will be upgraded to an aircraft accident.

Off-Aerodrome Incidents
Aircraft accidents occurring outside the aerodrome boundaries.

- In line with NARU, for aircraft related incidents at EMA the emergency services have pre-determined attendances (PDA) for the number of appliances/responders that they send to the airport initially.

- Leicestershire Fire and Rescue Service and EMAS are alerted of the incident by an auto dialler system which gives them a pre-recorded message that there has been an incident at EMA. A telephone call is then made to Leicestershire Police to give them further details of the incident who then cascade this to LFRS and EMAS.

- The PDA for LFRS and EMAS is a 2 tiered system based on the size of aircraft and number of people on board. The definitions used for this are as follows:

  Initial – All cargo aircraft and all passenger aircraft of CAT 3 (roughly 18 metres length / 10 passenger seats) or below

  Enhanced - All passenger aircraft of CAT 4 (roughly 24 metres long / 48 passenger seats) and above, and any military aircraft where the persons on board may exceed 20 in number. A Boeing 737 is a CAT 5 aircraft by way of comparison.

- EMAS will send the following PDA:

  - **Initial**
    2 dual manned ambulances
    Nearest Officer
    HART team

  - **Enhanced**
    6 dual manned ambulances

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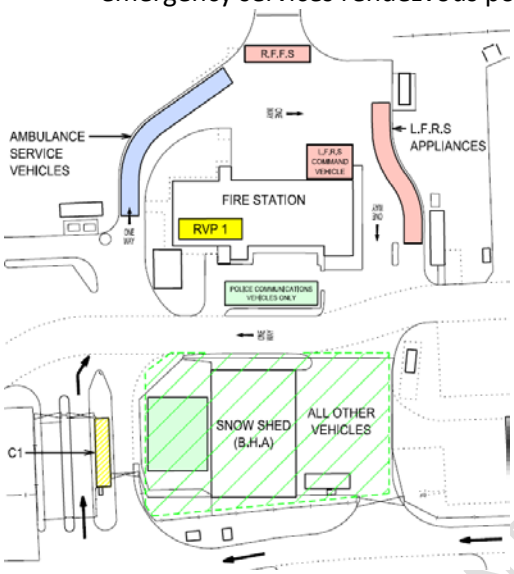
2 nearest Officers
HART team

- Should the accident be escalated then all agencies will declare a major incident and additional resources will be sent to EMA as required.

- A TAAS crew may be asked to form part of the pre-determined attendance at one of the two emergency services rendezvous points. ESRVP 1 is located in the appliance bays at the fire station:



- ESRVP2 is used if ESRVP1 is unavailable due to incident site. ESRVP2 is situated within the west 1 gatehouse building.
- Within ESRVP1 there are white boards and radios available for use. The purpose of the white boards is to note the vehicles which are currently on site and where they have been mobilised to. The boards are not to be used as an incident log. A white board will be completed at the start of the incident by the EMA Ops Liaison Officer which gives the initial details of the incident. The EMA Ops Liaison Officer will then update a second board with the following details only for the duration of the incident:
  - Total number of passengers
  - Total number of crew
  - Number of passengers evacuated/removed from aircraft
  - Number of people taken to hospital
  - Number of deceased
  - Number in Survivor Reception Centre

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- A forward control point will be established by the airport incident team, this is the point which coordinates the multi-agency response at the incident site and requests further resources as and when required. The FCP will also be the point where all messages are agreed and disseminated from. The aerodrome emergency plan recognises the JESIP recommendations for scene management.

- East Midlands Airport emergency dressings packs have been provided by EMAS to assist with the aftermath of a major incident which results in mass casualties within the terminal building. The purpose of these packs is to hand out dressings to casualties in the interim time before they can be seen by the ambulance service.

- East Midlands Airport has a designated survivor reception centre (SRC) located in the west pier. The primary purpose of the SRC is as a secure area in which survivors not requiring acute hospital treatment can be taken for short-term shelter and first aid, however the airport incident plan states that if there are numbers of P3 casualties that cannot be managed at the scene, these patients may be directed to the SRC. A TAAS team may be asked to work in the SRC.

- Within the SRC a dedicated first aid area is located at gate 18. This will be screened off from other areas to ensure the privacy of those being cared for. If passengers require hospital treatment they will wait in this area and then be taken to the ambulance via gate 18. Personnel in the area will be primarily EMAS staff, although a Police Casualty Clearing Officer will also be present to record who is going to hospital and where they are going.

- It is also possible that EMAS could be called to the friends and family reception centre which is located in the east lounge, and the welfare reception centre that is located in the west pier.

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Coventry Airport Incidents

Coventry Airport Incidents

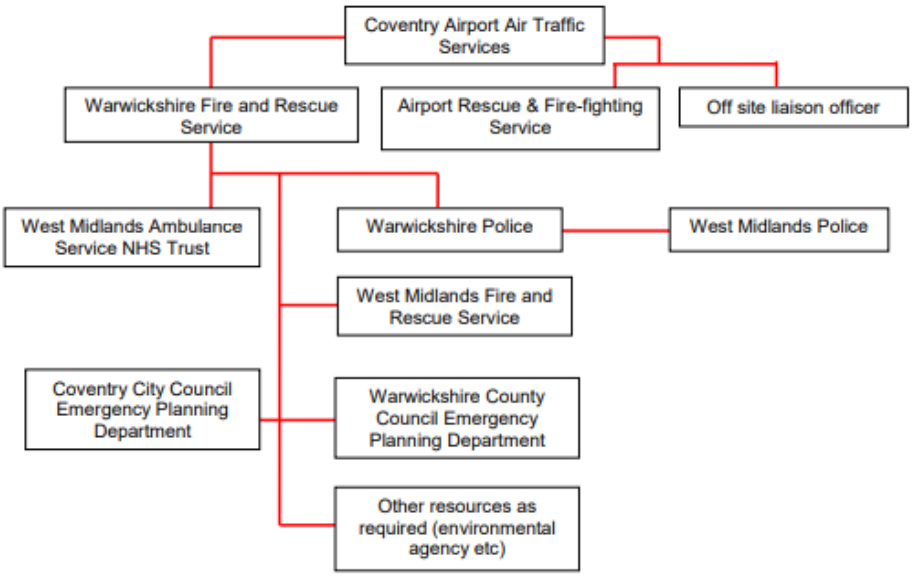
There is a detailed Coventry Airport Emergency Plan, the salient points of relevance to TAAS are summarised below:

In line with NARU, for aircraft related incidents at Coventry Airport the emergency services have pre-determined attendances (PDA) for the number of appliances/responders that they send to the airport initially.

Should the accident be escalated then all agencies will declare a major incident and additional resources will be sent to Coventry Airport as required.

A TAAS crew may be asked to form part of the pre-determined attendance at one of the emergency services rendezvous points.

6.0 Emergency Services Alerting System (Aircraft accident / accident Imminent / Full Emergency)



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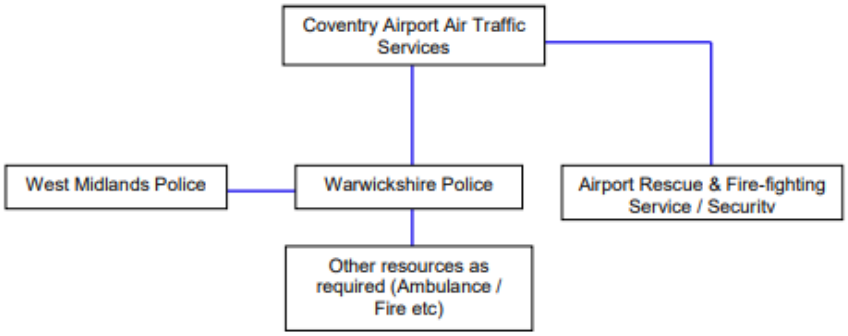
6.1 Emergency Services Alerting System (Suspect Package / Bomb Threat / Aviation Security related Incidents)



13. Media releases

Media releases will be made by the tasking ambulance service in line with their major incident policies. TAAS operational managers will notify the charity that the service is attending a major incident. No further details should be released to the press until expressly authorised by the Head or Director of Operations following liaison with the tasking ambulance service. Crew run social media accounts should not be used for the duration of the major incident.

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14. Definitions/Acronyms:

Acronym	Description
EMA	East Midlands Airport
EMAS	East Midlands Ambulance Service
EOC	Emergency Operations Centre
ESRVP	Emergency Services Rendezvous Point
HART	Hazardous Area Response Team
HEMS	Taken to be HM53&54 and Medic 53&54
JESIP	Joint Emergency Services Interoperability Program
MIA	Major Incident Adviser
NARU	National Ambulance Resilience Unit
TAAS	The Air Ambulance service
tCAA	The Children's Air Ambulance
WMAS	West Midlands Ambulance Service

End of Document

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Appendix 1

Initial actions – EOC

In the event that Helimed 53, Helimed 54, Medic 53 or Medic 54 are deployed to ANY major incident, or declare an emergency incident from scene, please immediately inform one of the following managers:

Richard Clayton 07787 241115

Philip Bridle 07817 875484

Philippa Gibbs 07825 634102

Karl Bexon 07790 377214

This is to allow additional air ambulance resources to be prepared.

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Appendix 2

Initial Actions – TAAS Manager

When notified that a TAAS asset has been deployed to a major incident:

1. Notify the Head &Director of Operations, who will inform the wider charity
2. Notify the Clinical Lead, who will inform the clinical supervisor group
3. Determine the likely requirement for additional TAAS resources
4. Inform Sloane Helicopters and Specialist Aviation Services that their aircraft and pilots may be involved, or that resource reallocation may be required (i.e. change from tCAA to HEMS)
5. TCAA supervisors review planned tCAA transfers until requirement for tCAA aircraft is determined
6. Ensure all operational crews have been notified
7. Determine the need for additional crews to be deployed
8. Contact off duty crews informing them of a potential major incident
9. Consider requirement to attend scene

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Appendix 3 – NARU Action Cards

- First on Scene
- Ambulance operational commander
- Medical Advisor
- Forward Doctor
- CCS Medical Lead
- Incident commander - tactical

National Ambulance Resilience Unit
NARU

1.0 First Resource On Scene - Attendant

FIRST RESOURCE ON SCENE - ATTENDANT
1

TASK	DESCRIPTION	✔	TIME
1	Park as near to the scene as safety permits, upwind and uphill of the incident and adjacent to Police and Fire Controls if possible.		
2	Assume the role of **Operational Commander** until relieved by an appropriate Ambulance manager.		
3	Don appropriate PPE.		
4	**Stay focussed on your role. DO NOT ATTEMPT RESCUE OR TREATMENT OF CASUALTIES.**		
5	Assess the scene and if determined safe to enter, carry out reconnaissance of the scene and report the following to Emergency Operations Centre (EOC) using **METHANE(S):** **M** Major Incident Declared or Major Incident Standby **E** Confirm exact location of the incident **T** Type of incident with brief details of types and numbers of vehicles, trains, buildings etc **H** Identify hazards present and potential **A** Determine best access/egress routes and RVP **N** Estimate number of casualties eg dead/injured **E** Identify whether other Emergency Services are on scene and what further resources are required **(S)** Start a log book		

CONTINUED OVERLEAF

FIRST RESOURCE ON SCENE - ATTENDANT
1

National Ambulance Resilience Unit
NARU

TASK	DESCRIPTION	✔	TIME
6	Ascertain the requirement for specialist teams eg SORT, MERIT, HART, BASICS, Air Support and specialist equipment.		
7	In liaison with the other **Emergency Services,** initially identify: RVP; criteria –avoid objects ie waste bins, check for suspect packages, rotate RVPs –don't always have them at predetermined points Ambulance Parking and Ambulance Control Point (normally situated with Police Control and Fire Control) Location for a Casualty Triage; collection and clearing points Ambulance Loading Point Area for decontamination (if appropriate)		
8	On arrival of additional staff designate further roles as required.		
9	Prepare a brief for the first **Ambulance Commander** on scene.		

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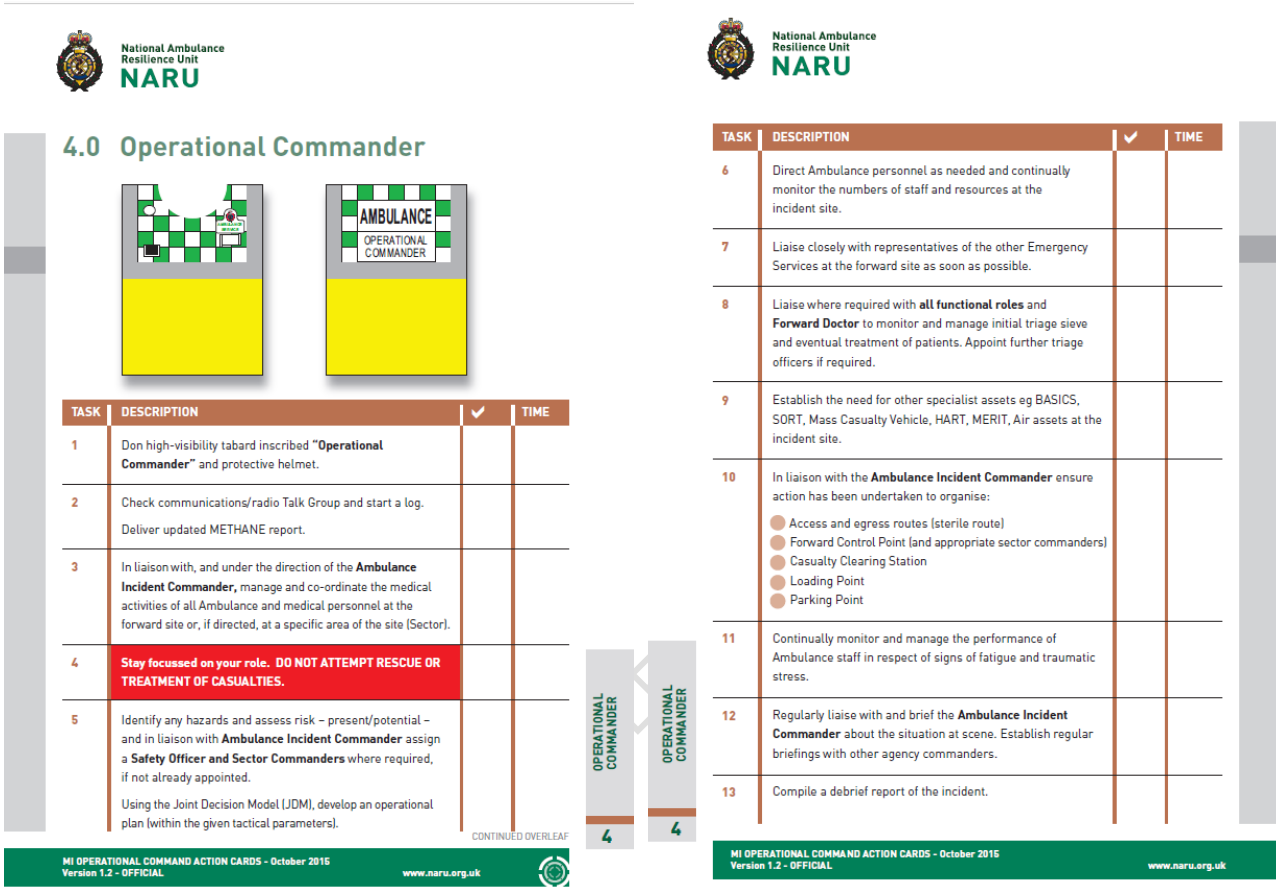

National Ambulance Resilience Unit
NARU

4.0 Operational Commander

TASK	DESCRIPTION	✔	TIME
1	Don high-visibility tabard inscribed **"Operational Commander"** and protective helmet.		
2	Check communications/radio Talk Group and start a log. Deliver updated METHANE report.		
3	In liaison with, and under the direction of the **Ambulance Incident Commander,** manage and co-ordinate the medical activities of all Ambulance and medical personnel at the forward site or, if directed, at a specific area of the site (Sector).		
4	**Stay focussed on your role. DO NOT ATTEMPT RESCUE OR TREATMENT OF CASUALTIES.**		
5	Identify any hazards and assess risk – present/potential – and in liaison with **Ambulance Incident Commander** assign a **Safety Officer and Sector Commanders** where required, if not already appointed. Using the Joint Decision Model (JDM), develop an operational plan (within the given tactical parameters).		

CONTINUED OVERLEAF

OPERATIONAL COMMANDER 4

OPERATIONAL COMMANDER 4

National Ambulance Resilience Unit
NARU

TASK	DESCRIPTION	✔	TIME
6	Direct Ambulance personnel as needed and continually monitor the numbers of staff and resources at the incident site.		
7	Liaise closely with representatives of the other Emergency Services at the forward site as soon as possible.		
8	Liaise where required with **all functional roles** and **Forward Doctor** to monitor and manage initial triage sieve and eventual treatment of patients. Appoint further triage officers if required.		
9	Establish the need for other specialist assets eg BASICS, SORT, Mass Casualty Vehicle, HART, MERIT, Air assets at the incident site.		
10	In liaison with the **Ambulance Incident Commander** ensure action has been undertaken to organise: ● Access and egress routes (sterile route) ● Forward Control Point (and appropriate sector commanders) ● Casualty Clearing Station ● Loading Point ● Parking Point		
11	Continually monitor and manage the performance of Ambulance staff in respect of signs of fatigue and traumatic stress.		
12	Regularly liaise with and brief the **Ambulance Incident Commander** about the situation at scene. Establish regular briefings with other agency commanders.		
13	Compile a debrief report of the incident.		

MI OPERATIONAL COMMAND ACTION CARDS - October 2015
Version 1.2 - OFFICIAL
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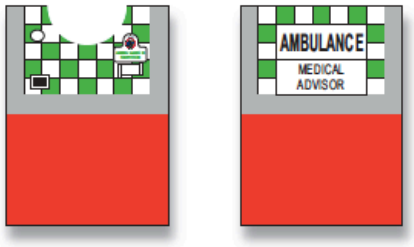
National Ambulance Resilience Unit
NARU

2.0 Medical Advisor



MEDICAL ADVISOR 2

MEDICAL ADVISOR 2

TASK	DESCRIPTION	✔	TIME
1	Don high-visibility tabard inscribed **"Medical Advisor"** and protective helmet.		
2	Check communications/radio callsign and start a log.		
3	Liaise with the **Ambulance Incident Commander** and obtain a full briefing. Work in conjunction with the **Ambulance Incident Commander** for the triage, treatment and transportation of all casualties. Open dialogue with the receiving hospital(s). Request permission from **Strategic Medical Advisor** to invoke expectant (P4) triage category if required or indicated due to mass casualty volume/capacity issues.		
4	Co-locate with the **Ambulance Incident Commander** or **Operational Commander** throughout the incident. Regularly brief the **Strategic Medical Advisor**.		
5	**Stay focussed on your role. DO NOT ATTEMPT RESCUE OR TREATMENT OF CASUALTIES.**		
6	Establish communications between all BASICS doctors operating at the incident.		

CONTINUED OVERLEAF

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TASK	DESCRIPTION	✔	TIME
7	Check all doctors' ID Cards, as bogus doctors are not uncommon at incidents.		
8	Appoint doctor(s) to designated Operational areas. ● **Forward Doctor** (to work with **Operational Commander**) ● Casualty Clearing Stations ● Body Holding Area (in order to confirm life extinct)		
9	In conjunction with the **Casualty Clearing Officer**, ensure the effective throughput and evacuation of casualties, remain constantly aware of bed status at the Receiving Hospital(s) and plan the distribution of casualties accordingly.		
10	In consultation with the **Ambulance Incident Commander and Strategic Medical Advisor**, consider all other relevant and available means of evacuation eg Helicopters, buses, coaches.		
11	Ensure that Receiving Hospital(s) are kept informed of the numbers and type of casualties that they are to receive. Monitor bed and acceptance status.		
12	Liaise with the **Ambulance Incident Commander** to identify suitable specialist hospital treatment centres if required.		
13	Arrange for the relief of medical staff as necessary.		
14	Provide technical medical advice to all services and agencies at the site.		
15	In conjunction with **Ambulance Incident Commander**, arrange medical cover for rescue personnel during the recovery phase after all live casualties have been removed.		
16	After consultation with the **Ambulance Incident Commander** stand down **MERIT** and consider welfare requirements.		
17	Ensure all medical staff are included at the hot debrief.		
18	Compile a report for the AIC and attach all documentation relating to the incident.		

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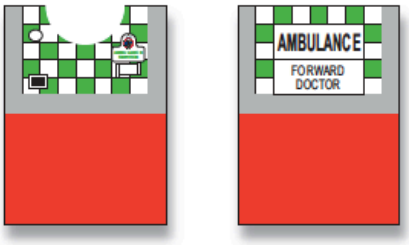
3.0 Forward Doctor



TASK	DESCRIPTION	✔	TIME
1	Don high-visibility tabard inscribed **"Forward Doctor"** and protective helmet. Ensure that your personal protective equipment is suitable for the task.		
2	Present your ID to the **Operational Commander** on scene.		
3	Liaise with the **Operational Commander** and obtain a full briefing. Work in liaison with the **Medical Advisor** for the triage, treatment and transportation of all casualties in the sector allocated.		
4	Check communications/radio callsign and start a log.		
5	Ensure that you have a method of communication between yourself, the **Medical Advisor** and other medical assets on scene. You should be issued with a radio by the Ambulance Service.		
6	Work within sector allocated by the **Operational Commander**. Regularly brief the **Medical Advisor**. **Forward Doctor** may be deployed to: ● Casualty Clearing Station ● Body Holding Area (in order to confirm life extinct) ● Incident Ground		

CONTINUED OVERLEAF

FORWARD DOCTOR 3

FORWARD DOCTOR 3

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TASK	DESCRIPTION	✔	TIME
7	**Stay focussed on your role. DO NOT BE TEMPTED TO GET INVOLVED IN OVERALL MEDICAL COMMAND.**		
8	If located in the Forward Area, make yourself known to the **Ambulance Sector Commander** and **Primary Triage Officer**.		
9	Work in the Forward Area to ensure the most appropriate medical management of casualties is undertaken and that clinical records are commenced.		
10	If located in the Casualty Clearing Station, work with the **Casualty Clearing Officer** and **Loading Officer** to ensure the effective throughput and evacuation of casualties.		
11	Ensure that casualty treatment records are completed and that all interventions are indicated with their time.		
12	If allocated to the Body Holding Area ensure that the appropriate examinations to recognise life extinct are undertaken and that appropriate records are made.		
13	Indicate to the **Medical Advisor** any casualties who will require a Trauma Centre or specialist intervention eg head injuries and burns.		
14	Identify to the **Medical Advisor** when relief of medical teams might be indicated.		
15	Provide technical medical advice to all services and agencies at the sector in which allocated.		
16	Do not leave the allocated sector without the **Ambulance Sector Commander's** permission.		
17	Attend the hot debrief.		
18	Compile a post incident report and attach all documentation relating to the incident.		

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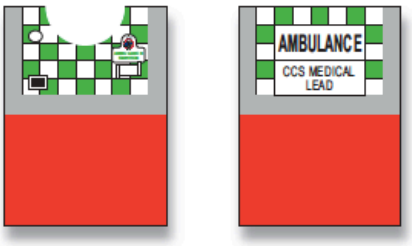
4.0 Casualty Clearing Station Medical Lead



TASK	DESCRIPTION	✔	TIME
1	Don high- visibility tabard inscribed **'CCS Medical Lead'**.		
2	Check communications/radio call sign and start a log.		
3	Liaise with the **Ambulance Incident Commander** and obtain a full briefing.		
4	On arrival at CCS – liaise with **Casualty Clearing Officer** and **Loading Officer** to gain shared situational awareness before commencement of post.		
5	Obtain accurate up to date information regarding capability and capacity of surrounding hospitals (including specialist units).		
6	Consider appropriate facilities such as minor injury units, walk in centres and primary care centres in addition to treat and discharge from scene.		
7	Establish medical lead of the CCS and ensure all staff are aware of the management structure.		
8	Provide oversight and support to medical care and where appropriate treat patients within the CCS.		

CONTINUED OVERLEAF

CCS MEDICAL LEAD 4

CCS MEDICAL LEAD 4

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TASK	DESCRIPTION	✔	TIME
9	Coordinate any extra clinical resources available at the scene (enhanced care teams, Aeromedical teams, BASICs.		
10	Provide specialist guidance and support to ambulance clinicians, in triaging, treating and providing advanced clinical interventions to casualties.		
11	Ensure casualty treatment records are completed with all available information and that all clinical interventions are indicated with their time.		
12	Give clear information to the CCO and Loading Officer regarding casualties who will require transfer to specialist units or those that may benefit from specialist interventions. Ensure appropriate skill mix is maintained during any transfer.		
13	Attend the hot debrief.		
14	Compile a post incident report and attach all documentation relating to the incident.		

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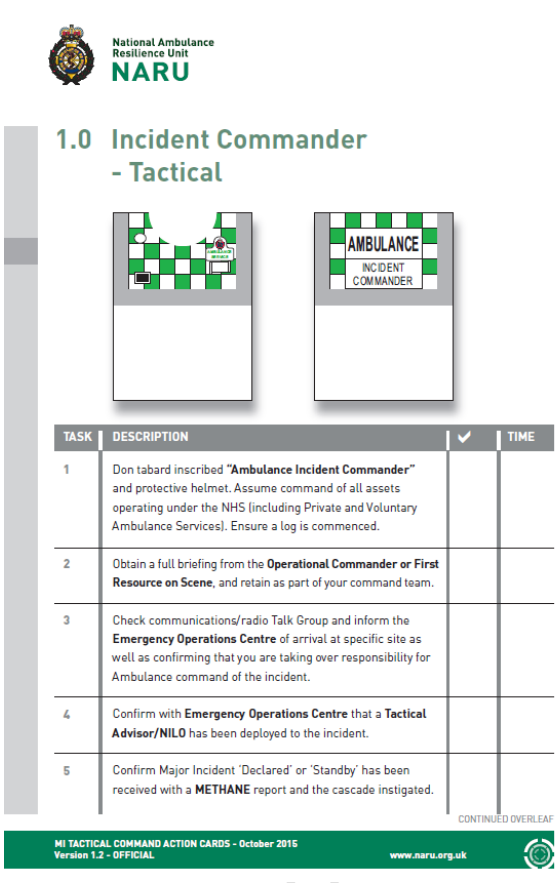

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1.0 Incident Commander - Tactical

TASK	DESCRIPTION	✓	TIME
1	Don tabard inscribed **"Ambulance Incident Commander"** and protective helmet. Assume command of all assets operating under the NHS (including Private and Voluntary Ambulance Services). Ensure a log is commenced.		
2	Obtain a full briefing from the **Operational Commander or First Resource on Scene**, and retain as part of your command team.		
3	Check communications/radio Talk Group and inform the **Emergency Operations Centre** of arrival at specific site as well as confirming that you are taking over responsibility for Ambulance command of the incident.		
4	Confirm with **Emergency Operations Centre** that a **Tactical Advisor/NILO** has been deployed to the incident.		
5	Confirm Major Incident 'Declared' or 'Standby' has been received with a **METHANE** report and the cascade instigated.		

CONTINUED OVERLEAF

INCIDENT COMMANDER - TACTICAL
1

INCIDENT COMMANDER - TACTICAL
1

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TASK	DESCRIPTION	✓	TIME
	METHANE(S) **M** "Major Incident Declared" or "Major Incident Standby" **E** Confirm exact location of the incident **T** Type of incident with brief details of types and numbers of vehicles, trains, buildings etc **H** Identify hazards present and potential **A** Determine best access / egress routes and RVP **N** Estimate number of casualties eg dead/injured **E** Identify whether other Emergency Services are on scene and what further resources are required **(S)** Start an Incident Log and request a **Loggist** to assist. Within 15 minutes of Major Incident Declaration/Standby liaise with the Strategic and Operational Commanders, Tactical and Strategic Advisors, and Emergency Operations Centre Manager.		
6	Consider the activation of the Airwave interoperability Talk Groups in line with standard operating procedures.		
7	Following co-location with partner agency commanders develop a tactical plan utilising the Joint Decision Model and Joint Understanding of Risk.		
8	Confirm with EOC the numbers of resources deployed are sufficient and via the **Tactical Advisor** that specialist assets have been considered. Escalate to **Strategic Commander** as appropriate.		
9	Ensure that all **Operational command support roles** have been allocated, and designate other roles eg Air Ambulance Support as necessary.		

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INCIDENT COMMANDER - TACTICAL
1

TASK	DESCRIPTION	✓	TIME
10	Confirm times of regular Tactical Commander meetings - Tactical Co-ordinating Groups.		
11	Consider the sectorisation of the incident, if required, and ensure they match police/fire service sectors. Allocate **Sector Commanders via the Operational Commander**.		
12	Ensure appropriate staff are allocated and deployed to further establish: ○ The RVP is in place, safe and appropriate ○ An Ambulance Control Point ○ Ambulance Parking ○ Primary Triage ○ Casualty Clearing Station/ Secondary Triage and Treatment ○ Ambulance Loading ○ Ambulance Decontamination (if appropriate) ○ Ambulance Equipment Point ○ Ambulance Air Support (if appropriate)		
13	Ensure all designated officers have established callsigns and radio communications / Talk Group.		
14	Consider the need for other specialist assets eg BASICS, SORT, Mass Casualty Vehicle, HART, MERIT, Air Assets.		
15	Confirm that radio communications between **Emergency Operations Centre** and the site of the incident and receiving hospitals via **Hospital Ambulance Liaison Officer** are established and maintained.		
16	Consider an early request for Mutual Aid support and escalate to Strategic.		
17	Establish regular contact with the **Communications/Media Officer** on site.		

CONTINUED OVERLEAF

National Ambulance Resilience Unit
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TASK	DESCRIPTION	✓	TIME
20	Ensure effective deployment of: ○ Resources ○ Personnel ○ Specialist assets		
21	Liaise with the **Tactical Advisor** to ensure that the Major Incident Plan is being followed and any further specialist advice is followed.		
22	Liaise with **Operational Commander** to ensure functional roles are being undertaken.		
23	Arrange for non-medical transport for non-injured patients via Local Authority and/or other. Consider: ○ Non-emergency/Schedule Transport Service vehicles ○ Buses/coaches		
24	Consider welfare arrangements for yourself, managers and crews if the incident is likely to be protracted.		
25	Agree and initiate "Major Incident-Stand Down" authorisation when appropriate and inform EOC.		
26	Ensure that a "hot debrief" is facilitated immediately after the incident.		
27	Collect and secure all documents relating to the incident and prepare a report for the CEO.		
28	Ensure a debrief of the incident is carried out.		

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Appendix 4 – Relevant WMAS action cards

ACTION CARD 6 – Ambulance Tactical Commander

AMBULANCE TACTICAL COMMANDER

All staff arriving on scene should report their arrival to the EOC by radio or telephone and in person at the Ambulance Parking Point before entering the scene

OVERALL ROLE: Responsibility for all activity of ambulance personnel at the scene in conjunction with a Medical Advisor and has responsibility for effective use of clinical resources at the scene.

ROLE FILLED BY: Attendant of First Crew on Scene/Operational Manager initially until relived by appropriately trained and competent Tactical Commander

LOCATION:	Scene (or near to scene)	
CALL SIGN:	Tactical Commander	
TABARD INSERT:	**Tabard worn with White side showing**	

NB: In the event of escalation to a multi-point incident each scene will be treated as a separate incident, each with its own Ambulance Tactical Commander coordinated through Strategic Control.

Ser	ACTIONS	Time
1	Don the appropriate high visibility jacket, Tabard and helmet	
2	Start personal incident log, constantly update	
3	Change to major incident talk group as directed by ICD and utilise ARP earpiece if available	
4	Receive briefing from the current Ambulance Incident Commander. Assume command of all NHS resources.	
5	Have due regard for the safety and welfare of staff at all times, ensure staff receive a safety brief, liaise with other emergency services regarding their safety risk assessment and escalate any issues appropriately.	
6	Provide updated METHANE through Rearward Facing Communications Officer (RFCO) if available or in person to ICD – Remember to keep messages **A**ccurate **B**rief **C**lear	
7	If suspected or confirmed CBRN incident Complete Tactical CBRN Assessment and report assessment to ICD through RFCO.	
8	Management of the scene can be achieved by following the process below (CSCATTT) • **Command and Control** • **Safety** • **Communication** • **Assessment** • **Triage** • **Treatment** • **Transport**	
9	Establish Ambulance Tactical Command Cell to include: • Ambulance Incident Commander • Medical Advisor (See Action Card – MA) • Tactical Logist (see Action Card – Tactical Logist) • Rearward Facing Communications Officer (See Action Card RFCO)	

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	• Forward Facing Communications Officer (See Action Card FFCO) • Entry Control Officer (See Action Card ECO) • Sector Commanders (See Action Card SC)	
10	Confirm establishment of a multi-agency co-located command presence.	
11	Ensure regular and continued liaison with other Emergency Services. Ensure that the following issues are discussed using the JESIP National Joint Decision Model **Police** / **Fire and Rescue** Nature of incident -? Deliberate / Hazards and Firefighting response Receiving and Supporting Hospitals / Victim Location Officer – rescue to entrapped casualties Arrangements for management of deceased / Ensure Operational Liaison between HART and Fire USAR where appropriate Accessing or commandeering transport for minor injury casualties /	
11	Consider sectorisation of the scene if required. This should match Police and Fire Sectors where possible.	
12	Using action cards designate appropriate staff into the following roles ensuring communications are established via the appropriate major incident talk groups: Primary Triage Officers / Secondary Triage Offices Forward Incident Officer(s) / Casualty Clearing and Loading Officers Ambulance Parking Officer / Equipment Officer Ambulance Decontamination (if required)	
13	With Medical Advisor, establish Casualty Clearing points, determine requirement for additional medical resources and communicate this to Strategic Commander. (**BURNS** – more than 5 major burns – alert ICD)	
14	Arrange for additional resources and stock replenishment through the Logistical Support Officer	
15	Confirm that radio communications between Ambulance ICD, Command Vehicle, Ambulance Tactical Command Cell and Receiving Hospital(s) are established. Maintain regular communication with Ambulance Points to ensure continued staff, equipment and vehicle availability. This will be achieved by allocating operational and tactical talk groups, in discussion with the EOC Tactical Commander	
17	Pass any requests for sustained additional resources or mutual aid to Strategic Commander.	
18	Liaise with the Police to inform them of the receiving and supporting hospitals being used and arrangements for management of the deceased	
19	Liaise with Fire Service regarding the rescue of (trapped) casualties.	
20	Decide if any specialist equipment (example lighting) is required; make this request via ICD or Strategic Commander as appropriate.	
22	In the event that the incident is protracted and you are relived from your post by another Officer – ensure that a full handover briefing is provided – Annex B details the elements which should be included	
23	Notify EOC "**Casualty Evacuation Complete – Scene Clear**"	
24	Provide a full report, Tactical Log and any other notes to the Emergency Preparedness Department and attend subsequent debrief (s)	

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ACTION CARD 12– Operational Commander

OPERATIONAL COMMANDER

All staff arriving on scene should report their arrival to the EOC by radio or telephone and in person at the Ambulance Parking Point before entering the scene

OVERALL ROLE: To manage the incident response at the operational level, directly controlling resources under the direction of the Ambulance Tactical Commander

N.B. There may be more than one Operational Commander required if an incident is zoned operating under the direction of the Ambulance Tactical Commander to directly manage clinical resources within the site or sector.

LOCATION:	Scene
CALL SIGN:	Forward (maybe suffixed by number if incident sectorised)
TABARD INSERT:	**Operational**

Ser	ACTIONS	Time
1	Don high visibility jacket, Tabard and helmet. Change ARP to operational talk group as directed by RCC (use ARP earpiece if available)	
2	Start personal incident log, constantly update	
3	Implement the instructions of the Ambulance Incident Commander to directly manage and coordinate medical activities at the incident (or specific sector) providing updates to the AIC as required.	
4	Be aware of multi agency interoperable airwave talk group	
5	Direct Ambulance personnel as needed/consider use of specialised units and equipment	
6	Ensure sufficient equipment and staff is available within the forward area to rapidly triage, treat and extricate patients.	
7	Liaise with the Medical Advisor (MA) and assist in the directing of medical teams as needed. Ensure Ambulance Incident Commander is aware of such teams on site.	
8	Liaise, where required, with the MA to monitor and manage initial triage and treatment to enable rapid extrication to a CCP/CCS	
9	Provide flexible managerial control of the forward area.	
10	Monitor the working environment for safe working practices ensuring a safe system of work is in place at all times.	
11	In liaison with the Ambulance Incident Commander, ensure: • That appropriate access/egress exists • The setting up of a Forward Triage Area/process • The setting up of an Ambulance Loading Point • The setting up of an Ambulance Parking Point • Casualty Decontamination Area (as required).	
12	Maintain a high degree liaison with other Emergency Service representatives utilising the JESIP principles and National Joint Decision Model	
13	In liaison with the Ambulance Incident Commander, allocate staff as required to meet the ongoing needs of the incident.	
14	Inform the Ambulance Incident Commander when casualty evacuation is complete in sector of responsibility.	
15	Ensure a full report is provided and attend any subsequent debrief.	

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ACTION CARD 14 – First Ambulance On Scene – Attendant

FIRST AMBULANCE ON SCENE – Attendant

All staff arriving on scene should report their arrival to the EOC by radio.

! DO NOT STOP TO TREAT!

Do not become involved directly in the rescue or treatment of casualties

The attendant of the first ambulance on scene assumes the role of Ambulance Incident Commander until relieved by a suitably trained officer.

LOCATION:	Scene
CALL SIGN:	Usual Call Sign
TABARD INSERT:	**N/A**

Ser	ACTIONS	Time
1	Don high visibility jacket and helmet. Change ARP to operational talk group as directed by EOC (use ARP earpiece if available)	
2	Start personal incident log and constantly update	
3	Provide Ambulance RCC with an initial visual report using METHANE method **M** Major Incident — Call Sign Standby/Declared and your time **E** Exact Location — Grid Reference, directions etc. **T** Type of Incident — Rail, Chemical etc **H** Hazards — Present and potential **A** Access — Direction of approach/egress, location of RVP **N** Number of Casualties — Number, severity and type **E** Emergency Services — Present and required	
4	Carry out reconnaissance of incident & liaise with other emergency services if present.	
5	Report back to Ambulance EOC the following updated **METHANE** format message: **M** Major Incident — Call Sign Standby/Declared and your time **E** Exact Location — Grid Reference, directions etc **T** Type of Incident — Rail, Chemical etc **H** Hazards — Present and potential **A** Access — Direction of approach/egress, location of RVP **N** Number of Casualties — Number, severity and type **E** Emergency Services — Present and required	
6	In liaison with other emergency services, set up the following: • Access and egress to site • Ambulance Parking Point • Casualty Clearing Point	
7	Provide briefing to Ambulance Incident Commander on arrival	
8	Following handover to Ambulance Incident Commander, then undertake duties as directed	
9	Provide a report and attend any debrief as instructed.	

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ACTION CARD 7 – Medical Advisor		
MEDICAL ADVISOR		
All staff arriving on scene should report their arrival to the ICD by radio or telephone and in person at the Ambulance Parking Point before entering the scene		
LOCATION:	Co located with Tactical Commander	
CALL SIGN:	Medical Advisor	
TABARD INSERT:	**Medical Advisor**	

Ser	ACTIONS	Time
1	Don high visibility jacket, Tabard and helmet.	
2	Start personal incident log, constantly update	
3	Report to the Ambulance Tactical Command Cell	
4	The MA and Ambulance Incident Commander (AIC) should be co-located at the Ambulance Tactical Command Cell for the duration of the incident	
5	Check the identities of medical resources present on scene and ensure their presence is recorded in the log	
6	Assume command of all medical resources on scene and in conjunction with the Ambulance Incident Commander allocate medical resources to the following • Operational Sectors (if required – to assist with triage and treatment) • Casualty Clearing Station – to assist with triage and treatment • Body Holding Area – to confirm life extinct	
7	In conjunction with the AIC and Strategic Commander consider initiation of expectant P1 Hold (Red P1 card, blue folded corner) triage category.	
8	**Confirm with Ambulance Incident Commander** • **Receiving and supporting hospitals being used** • **Provide regular updates on casualty numbers and movements – working with the Casualty Clearning Station Officer and Ambulance Loading Officer to the AIC** • **Determine the process for the management of the deceased**	
9	Ensure Forward Doctors and Medical Teams working in the CCP/CCS liaise with the Ambulance Loading Officer following triage sort and ensure accurate information regarding numbers and category of patients is reported to them.	
11	Provide updates on the medical response and casualty information to the SOC, and assist in the development of media messages where required.	
12	In liaison with the Ambulance Incident Commander agree 'Scene clear' time when appropriate	
13	Provide a report and attend subsequent debrief	

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Appendix 5 – CBRN initial management

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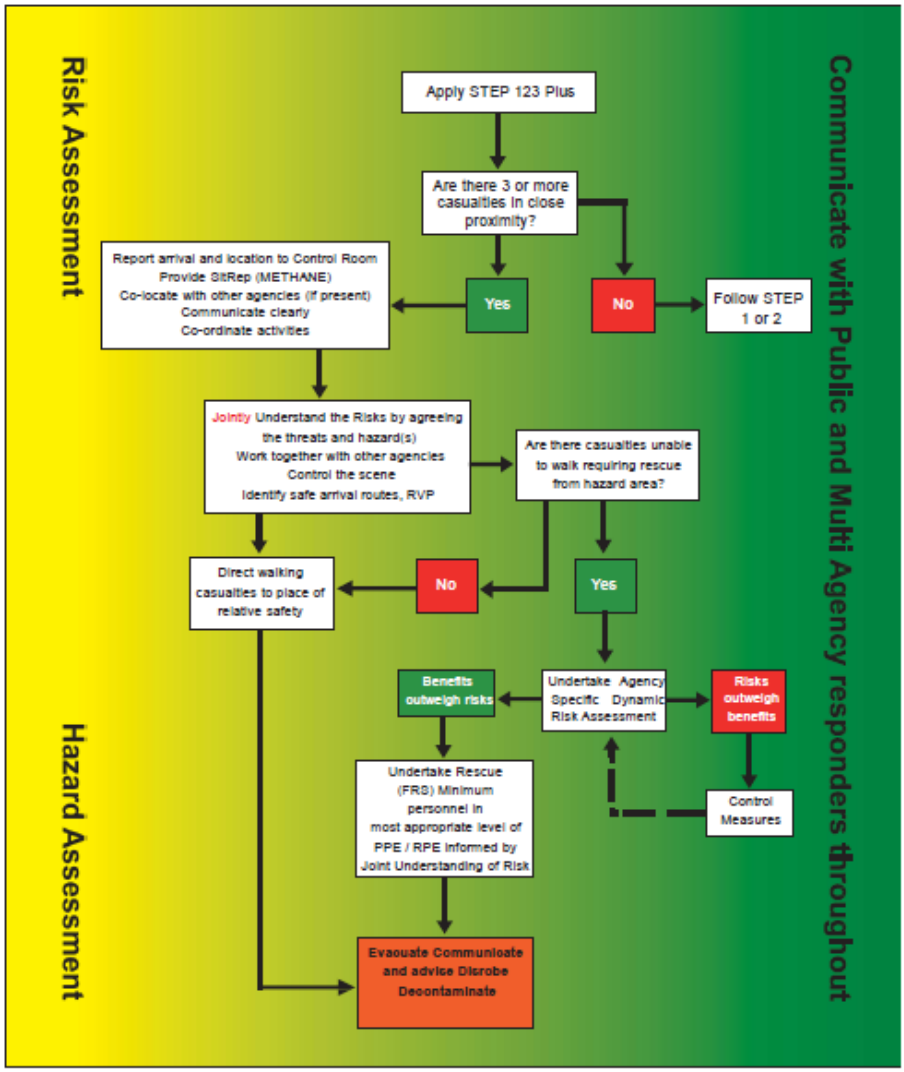
CBRN First Responder Flowchart (Figure 1)



For further details on the initial organisational response to a CBRN incident:

https://www.jesip.org.uk/uploads/media/pdf/CBRN%20JOPs/IOR_Guidance_V2_July_2015.pdf